Care Quality Commission

Royal Cornwall Hospitals NHS Trust

Royal Cornwall Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Inadequate
Medical care (including older people's care)	Requires improvement
Surgery	Good
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Inadequate
Outpatients and diagnostic imaging	Requires improvement
Sexual health services	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 is not a Foundation Trust and performance is monitored by the Trust Development Authority (TDA).

The Trust serves a population of around 450,000 people, a figure that can be doubled by holidaymakers during the busiest times of the year.

This is the second comprehensive inspection we have carried out at Royal Cornwall Hospital NHS Trust. The first being in January 2014 when the Trust was rated as requires improvement. In June 2015 we carried out a follow up to the first inspection and found the trust had not made sufficient progress in urgent and emergency services, medical care and surgery. At this time we issued the trust with a section 29A warning notice in regard to concerns around staffing in the emergency department and the high care bay on Wellington ward. We returned to the trust in October 2015 to review progress against the warning notice and found the trust had made improvements and met the requirements of the notice. Due to the lack of sufficient progress in all areas since January 2014, we decided that a second comprehensive inspection was required.

We inspected the trust on 12 – 15, 19 and 20 and 26 of January 2016 and visited:

- Royal Cornwall Hospital
- St Michael's Hospital
- West Cornwall hospital

We did not inspect:

- Penrice birthing unit

Overall the trust was rated as requires improvement, with Royal Cornwall Hospital rated as requires improvement, West Cornwall Hospital as good and St Michael's Hospital as good. We rated safe, effective, responsive and well led as requires improvement and caring as good overall.

We wrote to the trust shortly after the inspection asking them to send us action plans for some of the concerns we found. This was to ensure action was being put in place in ahead of the report being published. The areas of concern were:

- Ongoing delays for cardiology patients,
- Lack of robust recording of patient early waring scores leading to delays in escalating concerns to a doctor
- The continued situation of only 51% of stroke patients spending 90% of their time on the stroke unit (the contracted target was 92%).

The trust provided us with an update of actions being taken for all of the above which included:

- Provision of cardiology procedures at another provider organisation to reduce the length of time patients had to wait
- A programme of real-time audit and feedback of patient early warning scores in the emergency department supported by a programme of staff education and awareness
- Review of the bed management and outlier policy to ensure the site and bed management teams have a clear process to adhere by and which can be monitored.

Our key findings were as follows:

Summary of findings

Safety

- Nursing staff levels remained a challenge for the trust in particular areas of medicine, surgery, theatres, and the trust continued to use a high level of bank and agency staff to maintain planned staffing levels. Although at times registered nurse shifts were filled with healthcare assistants. While staffing had improved in the emergency department there were insufficient numbers of consultants to provide cover in line with guidelines.
- We did however find the respiratory high care bay was staffed to the required levels even though there was reliance on agency staff patients were safe.
- A rapid assessment and treatment system had been implemented in the emergency department and this had improved the initial assessment of ambulance patients.
- In the emergency department we found that staff did not always record National Early Warning Score (NEWS) at the required frequency and at times escalation of a patient's condition did not follow the trust guidelines for medical review. Audits of NEWS in other areas showed improvement but not all wards were consistent in this.
- Staff we spoke with understood their responsibilities to raise concerns and report incidents and they told us they were encouraged to do so. They confirmed that they received feedback when they reported concerns.
- In critical care there was a safe environment and the right equipment and the unit was clean with low rates of infection.
- Safety in surgery using checklists and briefings, was seen to be good.
- Most staff had a good understanding of their responsibilities for safeguarding people. However some junior doctors were not up to date with this training.
- We found there were inconsistencies in the completion of patient records. This was in relation to the recording of mental capacity assessments around a patient's ability to make decisions regarding whether to attempt patient resuscitation. We found patient safety was potentially compromised by these records not being completed.
- We saw in several outpatient clinics where patient records were not stored securely and could have been accessible to unauthorised people.
- Best practice in hand hygiene was variable with some areas meeting compliance levels and others not consistently applied.

Effective

- The trust flagged as an elevated risk for Dr Foster Hospital Standardised Mortality Ratio (both weekday and weekend) in May 2015. It flagged as a risk for in-hospital mortality for cardiological conditions and procedures and in-hospital mortality for infectious diseases.
- The trust flagged as an elevated risk for three other indicators for Patient Reported Outcome Measures post-surgery and the Sentinel Stroke National Audit Programme.
- Performance against national standards in relation to stroke care had made significant improvements. Although aspects of the stroke pathway which were dependent on patient flow continued to be poor, with only 51% of stroke patients spending 90% of their time on the stroke unit (the contracted target was 92%). The number of patients directly admitted to the stroke unit within 4 hours was 38% against the contracted target of 67%.
- The hospital was not meeting the best-practice outcome for patients requiring surgery for a fractured neck of femur. In the first quarter of 2015/16 (April to June), 68% of patients were operated on within 36 hours. This improved to 82% in quarter three. In January 2016, the percentage had declined to 67%.

Summary of findings

- Patients' needs were assessed and their care planned and delivered in line with evidence-based guidance, standards and good practice such as National Institute for Health and Care Excellence (NICE) guidelines.
- Staff demonstrated a good understanding of their responsibilities in relation to consent, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). However, there had been no improvements following trust audits of consent documentation which fell below required levels of compliance. In relation to end of life care we found patients who had information recorded about resuscitation that had not had an assessment of their capacity completed. It was not possible to be assured patients or relatives had been involved appropriately about decisions about whether they would have resuscitation attempted if this became a possible action.
- Nursing staff were not well supported with clinical supervision. Appraisal rates across the divisions were poor, ranging from 20 to 100% of staff having been appraised as at December 2015.
- There were a range of clinical nurse specialists who provided advice, support and training to staff trust-wide. These included nurses who specialised in the complex needs of older people and specialist learning disability nurses who were noted to be well accessed by staff and patients to ensure needs were met.

Caring

- Feedback from patients and their families had been almost entirely positive. Patients we met spoke without criticism of the service they received and of the compassion, kindness and caring of all staff.
- Staff name badges were printed with 'Hello, my name is…' Patients and relatives told us they liked this initiative as it made conversations already more personal. It also gave the relatives an opportunity to say who they were as some commented that, in the past, they had either not been asked, or not included in the conversation.
- At West Cornwall hospital there was a 'memory café' in the day room on a weekly basis. Patients and family members could attend for free and were invited to engage in singing, quizzes and games to help engage people living with dementia.

Responsive

- The ambulatory care unit adjacent to the emergency department was operating well but limited in terms of its capacity to offer a better service.
- Maternity services had at times struggled to meet women's needs and staff were pleased to hear a business plan for redevelopment of the service had been approved which included the development of a birth centre with four en-suite delivery rooms with birth pools. Building was anticipated to take two years and start during 2016.
- People with a learning disability were flagged on the trust computer system to ensure staff could respond and refer for input from the learning disability nurses.
- Bed capacity and patient flow were constant challenges within the trust and the impact was often felt in the emergency department who were unable to meet the standards for seeing and admitting patients due to a lack of bed availability. Patients did not always receive care and treatment in the most appropriate clinical setting. This meant inequitable standards of care were provided, with some patients having to wait longer for specialist support.
- A significant number of patients who had their operation cancelled on the day they were due to arrive were not treated within 28 days of the cancellation.
- Some patients waited too long for diagnostic cardiology procedures because elective cardiac beds were being used to accommodate medical outliers.
- Stroke patients did not always receive specialist care on a stroke ward.
- The service at St Michael's hospital had low numbers of cancelled operations over the past year.

Summary of findings

- The trust worked with partners to maintain flow and reduce the amount of patients who were ready to be discharged but unable to be due to lack of appropriate onward care.As a result the impact on the hospital and the emergency department continued, with crowding and long waits for patients needing admission.
- Complaints were investigated and responded to in a timely way.
- The trust met most of the cancer targets for outpatient appointments, however some other speciality clinics were not meeting the required timescales for new and follow up appointments.

Well led

- The trust had a clear vision simply expressed that refers to outstanding care and better health outcomes. The trust had recently refreshed their values and did this in a collaborative way. Awareness of these values was variable across the trust.
- An external review of governance arrangements had identified a number of cross cutting themes. The board were committed to improving governance arrangements but progress in implementing the recommendations of the review was limited. Significant changes, including new divisional structures and changes to the governance and risk frameworks were underway.
- There had been significant and continuing instability at board level however the appointment of an experienced chairman in 2015 was having an impact and there was a sense that the leadership team which included an interim chief executive, an interim human resources director and a seconded nurse director were working well together.
- It was recognised that improvements in culture were needed but despite the continued poor staff survey results staff at the trust were dedicated, caring and passionate about doing the right thing for patients.
- There was a strong and vibrant community of volunteers who were well organised and supported and were making a significant contribution.
- Innovation was encouraged and rewarded and there were a number of examples where participation in research had led directly to improved patient care. Whilst the trust had been under sustained financial pressure there was no evidence that this had impacted directly on patient safety.

We saw several areas of outstanding practice including:

- Kerensa ward had been appropriately designed to provide a safe and suitable environment for patients living with dementia.
- Advanced nurse practitioners in acute oncology provided an effective 24 hour telephone advisory service for patients receiving chemotherapy treatment. There was an established pathway for patients with suspected neutropenic sepsis, who were seen promptly by an advanced nurse practitioner in the Acute Admissions Unit or the Ambulatory Emergency Care Unit.
- A system of escalating concerns had been introduced, comprising communication prompts which were used to alert clinician colleagues of concerns which required immediate attention. SBAR - Situation, Background Assessment, Recommendation is a nationally recognised communication tool. This had been adapted to include 'Decision'. SBAR-D information was recorded on bright yellow 'escalation of care' labels, which were affixed in patients' notes.
- Surgical services had a compassionate and caring approach to people with a learning disability. There was a team of experienced staff to support people with different needs, and an innovative approach to meeting their needs, which included carrying out procedures at home if this was safe.

Summary of findings

- There was an outstanding example of individualised and multi-professional care for a patient who had been in the critical care unit for 10 months. The critical care team, the ambulance crew, the family and community teams were all instrumental in enabling the patient to go home safely. A member of the team arranged what was described as a "huge meeting with all the people who needed to be there to formalise [the patient's] discharge." There had been the arrangement of two visits home for the patient to build their confidence before the permanent move.
- The medical simulation training program training provided to obstetrics and gynaecology services (and other specialties) was outstanding. Training was provided every month and could be arranged on any of the obstetric clinical environments, or within a dedicated simulation suite. There was an emphasis on learning through the debriefing sessions that immediately followed simulation sessions. Staff feedback was consistently positive stating it enhanced team working, learning and confidence.

- Training programmes for staff on the paediatric units which involves allied health professionals and the regular use of simulation training. A programme of training was organised for clinical staff and allied health professionals to take part in. This involved multi professional meetings with specialist speakers, reviewing cases to share any learning points and a programme of using simulation training on a fortnightly basis. The simulation training was shared across the hospital and alternated between neonatal and paediatric scenarios. The scenario was videoed for future reference and sharing with colleagues who were unable to attend. Discussion and critique was a valuable part of the process and staff valued these opportunities to improve their skills without patient risk.
- Processes to engage with patients and the wider community such as the use of Facebook for surveys, using schools to consult with how children would like to see the service improve, using a form of real time feedback and responding to comments. There was a trial where medical and nursing students consulted with patients and families and fed back results to staff immediately. Staff said they had found this motivating and could deal with issues as they occurred.
- The interventional radiology team had won an innovation award for their success with the vascular access service. The vascular nurses used an ultrasound scanner to guide venous access for patients who were difficult to cannulate. They had extended this service to provide assistance to other teams within the trust where arterial access was difficult to achieve. The British Society of Interventional Radiology had awarded the interventional radiology department 'exemplar' status following an inspection in April 2015
- In the fracture clinic, a quick response code that could be read by personal mobile phones was attached to patients plaster casts that when scanned, provided information specific to the individual regarding their plaster care.

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

Importantly, the trust must:

- Ensure all patients are clinically assessed by a competent member of staff within fifteen minutes of arrival in the emergency department.
- Ensure deteriorating patients are recognised and treated quickly and are monitored effectively in the emergency department.
- Ensure staff are trained to recognise sepsis and that sepsis guidelines are followed in the emergency department.
- Ensure patients presenting to the emergency department are not re-directed to primary care services before being assessed by a competent member of clinical staff.
- Ensure there are systems in place to prevent repeat doses of medicines being given in error in the emergency department.
- Ensure patients' pain is assessed on arrival in the emergency department, treated quickly and re-assessed regularly

Summary of findings

- Ensure systems and process for quality monitoring and governance in the emergency department operate effectively to identify risk. Results from clinical audits must be reviewed and lead to changes in practice to improve patient safety. Performance data must be collected and discussed at relevant governance meetings.
- Take action to improve substantive staffing levels across the clinical divisions and reduce reliance on temporary staff who may not be suitably skilled or experienced. This will reduce the risk that patients' care and treatment is delayed or compromised. Also ensure nursing staff levels enable managerial staff to fulfil their responsibilities.
- Strengthen the nursing levels and reduce the number of agency staff used in critical care to reduce pressure on substantive staff. Alongside this, ensure there are full time managerial supernumerary roles, including the role of the clinical nurse educator, in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards.
- Must ensure there are sufficient numbers of medical staff in obstetrics and gynaecology and the emergency department to provide care and treatment to patients in line with national guidance.
- Ensure there are sufficient staff in the clinical decision unit and children's emergency department.
- Take action to ensure that all staff are supported and enabled to undertake regular mandatory and professional training.
- Ensure staff working with children in the outpatients and diagnostic services are adequately trained in safeguarding children level three as recommended by the intercollegiate guidelines published by the Royal College of Paediatrics and Child Health in March 2014.
- Ensure that staff receive regular supervision and performance appraisal in all divisions.
- Ensure that staff who set up syringe driving equipment are appropriately trained.
- Ensure that medical patients are admitted to the most appropriate specialty ward, according to their clinical needs. This should include the review of the outlier policy and the consistent application of bed management and escalation policies and processes designed to ensure that stroke and cardiology patients receive prompt and appropriate care and treatment.
- Take immediate steps to ensure that the backlog of patients awaiting cardiology procedures is eradicated.
- Continue to take steps to reduce the incidence of avoidable harm as a result of falls.
- Provide care and therapy to patients to enable them to receive an enhanced recovery from orthopaedic surgery.
- Ensure the documentation around consent is improved and demonstrate the audit of consent records is being acknowledged and improvements follow.
- Improve bed management for elective surgery patients to ensure it is meeting the needs of all patients needing surgery in a timely, safe and responsive way.
- Ensure all patients whose surgery is unavoidably cancelled are treated within 28 days of their cancellation.
- Ensure the access and flow of patients in the rest of the hospital reduces delays from critical care for patients admitted to wards. Reduce the risks of this situation not enabling admission of patients when they need to be, or being discharged too early in their care. Reduce the unacceptable number of patient discharges at night. Ensure staffing levels safely support all commissioned beds. Reduce occupancy levels in critical care to recommended levels.

Summary of findings

- Ensure that all patient's personalised end of life wishes are discussed and recorded. This should include their preferred place of dying and any spiritual needs. They should ensure that a patients unmet emotional needs are identified and discussions with patients and relatives around end of life wishes are appropriately recorded.
- Take further action to reduce the number of clinics that are cancelled for avoidable reasons
- Ensure critical care staff have sufficient understanding of the Deprivation of Liberty Safeguards so practice meets both the law in this regard and trust policy.
- Must take effective action to transform how midwives are supported and embed an open, honest, transparent and learning culture across the maternity services.
- Ensure that patients considered to be need of end of life care have the designated documentation completed.
- Ensure that Do Not Attempt Coronary Pulmonary Resuscitation part of the Treatment Escalation Plan is completed when required and is signed by the appropriate person and that assessments about patients mental capacity are completed when required and that the reasons for the decisions are accurately recorded.
- Ensure that patient records are stored securely. Patient confidentiality must be maintained in accordance with the Data Protection Act
- Ensure the effectiveness of the blood isolators used in nuclear medicine are monitored and that this equipment is maintained.
- Ensure that the environments where diagnostic testing takes place are adequately maintained so as to enable adequate decontamination to occur
- Ensure the outpatient improvement board is effective in addressing the challenges to ensure patients have timely access to first and follow up outpatient clinics for all specialities and that clinics are run and booked so as to reduce cancellations.

In addition the trust should:

- Ensure action plans following serious incidents occurring in the emergency department are monitored to ensure their effectiveness
- Ensure nursing staff have access to patient group directions in the emergency department
- Ensure immediate access to major incident equipment in the emergency department
- Ensure regular checks take placein the emergency department so that patients are comfortable, hydrated and adequately nourished,
- Ensure effective escalation processes when the hospital is approaching full capacity
- Ensure a cohesive leadership team which is focussed on the needs of patients and staff in the emergency department
- Continue to monitor and improve compliance with systems designed to ensure that premises, equipment and medicines are maintained and used in a safe way.
- Continue to monitor and improve compliance with record keeping standards.
- Consider whether the operational capacity and the range of care and treatment provided by the ambulatory emergency care unit can be increased to support admission avoidance.
- Continue to work with partners in the wider health and social care community to reduce the number of delayed transfers of care.

Summary of findings

- Continue to work with staff to encourage efficient discharge processes occur to facilitate patient flow seven days a week.
- Ensure feedback and learning from complaints is available for all levels and grades of staff
- Engage staff in developing a strategy and objectives which drive quality and improvement in the medical division.
- Work with specialties within the medical division to ensure that relationships with acute medicine are cooperative and supportive particularly where patients in MAU require decisions on transfer to other wards.
- Improve mortality reviews within surgery and critical care services so they demonstrate the implementation of actions, their monitoring, and lead to improvements in patient care.
- Ensure the cleaning of the floors is carried out to an acceptable standard at all times (particularly in the Surgical Assessment Unit) taking account of the raised levels of activity in some areas.
- Have all staff follow infection prevention and control protocols at all times and be bare below the elbow when in clinical areas.
- Review the cleaning checklists in surgery wards to ensure they have some meaning and used for their intended purpose.
- Relocate the flammable product cupboard away from a patient waiting area in the Tower Block theatres.
- Improve antibiotic stewardship on surgery wards to become compliant with the management of these medicines at all times.
- Ensure any patient records or information is confidential at all times on surgery wards and units.
- Be compliant with the use of the National Early Warning Score system on all surgery wards.
- Review elective readmission rates for surgical specialties so staff understand and report within governance how and why they exceed national averages. There should be plans developed to bring them in line with national averages.
- Ensure surgical services recognises and takes action to comply with the standards for emergency laparotomy surgery.
- Ensure there is an effective pain tool available to ward staff and used to help with patients who are not able to articulate how they are feeling.
- Review the competency training for newly recruited staff to ensure they are fast-tracked and able to use the skills they have brought with them.
- Ensure patients are not being accommodated in the corridor in chairs in the evening due to a lack of a bed after the closure of the Surgical Receiving Unit.
- Improve the use of the mental capacity assessments and associated forms used on surgery wards to capture consent decisions in line with trust policy. All patients subject to a Deprivation of Liberty Safeguards' authorisation should have a care plan.
- Ensure there are enough pillows in the recovery areas at all times.
- Improve the trust website to ensure people can get access to appropriate helpful information online.
- Produce a strategic plan for surgery services showing how it will achieve its objectives.

Summary of findings

- Review the risk register in surgery services to ensure action plans are delivering the intended changes. The service should ensure actions are realistic to achieve objectives.
- Ensure staff are clear about what constitutes a reportable incident, and these should be reported at all times. Make improvements to the incident management system so critical care incidents can be categorised, graded and able to be analysed at local level to determine proactively any risks or developing trends.
- Return to displaying results on avoidable patient harm within the critical care unit.
- Ensure security of trolleys for resuscitation equipment in critical care to highlight if, between daily checks, they had been opened, used, or tampered with.
- Review critical care discharge paperwork to provide ward staff with a comprehensive uncomplicated summary that meets the requirements of NICE Guidance 50.
- Review and risk-assess the provision of the critical care outreach team service which was not being provided, as recommended in best-practice, for 24 hours a day.
- Ensure allied health professional staff are used or employed to meet the needs of patients at all times.
- Review all procedures and protocols within critical care so they are up-to-date and reflect current and best practice.
- Routinely screen for delirium for patients admitted to critical care.
- Revisit the National Confidential Enquiry for Patient Outcome and Death 'On the Right Trach': A review of the care received by patients who underwent a tracheostomy (2014). This should include a review of skills and experience of other wards in the hospital for supporting patients with a tracheostomy.
- Ensure there is a review of equipment competence for nursing staff in critical care and training of approved numbers of staff.
- Provide clarity around the use of restraint for critical care staff.
- Review bereavement information in critical care services and look to improve the support provided to people faced with the death or a relative or friend on the unit.
- Look to provide an assessment for patients in critical care for any poor psychological outcomes or acute psychological symptoms, and provide support in line with National Institute for Care Excellence (NICE) guidance CG83. Provide patients with rehabilitation regimes when they leave the unit, in line with this guidance.
- Ensure critical care strategies and future plans are part of the overarching vision of the surgery, theatres and anaesthetics division.
- Review the risk register in critical care to ensure action plans are used to effectively deliver intended changes. Undertake audits of the physical environment under the Department of Health Building Note HBN04-02 2013 and include any shortcomings in the risk register. Include any gaps emerging from the audit of the service under the Faculty of Intensive Care Medicine Core Standards in the risk register.
- Ensure there is an effective review of acts of violence and aggression committed on critical care staff to look for learning and ways to prevent future occurrences.
- Look to return to regular unit or team meetings within critical care
- Should ensure all serious incidents identified prior to the newly revised monitoring system have evidenced that all necessary actions and learning has been completed.

Summary of findings

- Should promote the use of antibacterial hand sanitiser on ward and clinical areas to prevent the risk of spreading infections.
- Should ensure the privacy of patients at all times on the ante natal ward (Wheal Fortune) at all times.
- Should ensure the delivery trolley is stored safely on the ante natal ward at all times.
- Should ensure all necessary daily safety checks of required of resuscitation equipment in the maternity and gynaecology service is completed.
- Should ensure there is a range of supplementary equipment available to support pain and labour.
- Should ensure the community midwifery teams have local base rooms at all times in order to provide services to meet the needs of women living throughout the wide geographical area covered by the trust.
- Should ensure there is sufficient safe storage in the community for nitrous oxide.
- Should ensure any vehicle used to transport nitrous oxide has safety notifications in the event the vehicle is involved in an accident.
- Should review if the older and non-standard resuscitaire on the ante natal ward remains appropriate for use.
- Should review the storage of the resuscitaire on the ante natal ward so that it is easily accessible in the event of an emergency.
- Should ensure systems are followed to ensure medicines are not stocked for use beyond the stated dates.
- Should ensure there are beds available on the gynaecology ward for emergency gynaecology admissions.
- Should ensure all policies and guidelines are updated appropriately.
- Should ensure there is ongoing evidence of compliance with the WHO surgical checklist within the obstetric theatres.
- Should ensure the minimum standards in the National Neonatal Audit programme (NNAP) are met for women who require antenatal steroids as a result of premature birth.
- Should ensure all gynaecology cancer patients receive appointments in line with national standards.
- Should prevent the cancelation of elective gynaecology admissions and prevent gynaecology patients being admitted to other specialty wards.
- Ensure there are the correct protocols, guidance and a policy in place for the use of syringe driving equipment and that all staff receive updates on this.
- Ensure that all wards that require syringe driving equipment can access this without undue delay
- Ensure that all staff have training around end of life care, including training on the TEP form and the Symptom Observation Chart.
- Review the current provision of palliative care medical cover and consider whether it would be appropriate to increase this in line with national guidance.
- Ensure that the medical cover arrangements for palliative care are robust and clearly understood throughout the hospital.
- Ensure there is guidance and a policy in place for starting a patient on a symptom observation chart.
- Ensure there is a consistent approach for making referrals to the palliative care team.

Summary of findings

- Provide training for nursing staff in the use of a pain management tool.
- Ensure that staff designated as the ward end of life link nurse have received training in end of life care.
- Ensure that nutritional and hydration assessments for patients are completed consistently and are routinely monitored.
- Ensure that all wards are aware of how to access portable beds to accommodate the relatives of end of life patients and review its provision of facilities and accommodation for relatives of end of life patients to ensure a consistent approach from staff.
- Audit the number of patients who achieve their preferred place of dying.
- Ensure that the pastoral care service is more pro-active in ensuring that all end of life patients have the opportunity of receiving support from the chaplains or volunteers.
- Engage more with bereaved families to gain feedback on their experience.
- Ensure that the End of Life Care group is fully supported by senior staff and the board and is quorate in order to be effective. That the governance arrangements for end of life care laid out in the strategy are in place and the required reporting completed.
- Ensure that the layout of the blood labelling facilities in the nuclear medicine department to is arranged to minimise risk of contamination
- Ensure that soft furnishings, such as waiting room chairs, in outpatient clinics can be easily and adequately cleaned and decontaminated
- Ensure that staff understand the requirements of the local rules to protect staff and patients from risk of accidental irradiation, and ensure that staff compliance with this requirement is regularly audited.
- Ensure that staff are provided with opportunities for protected one to one time with their supervisor
- Ensure that patients in outpatients are routinely provided with a copies of correspondence written about them
- Ensure that membership of the radiation protection committee includes representation from the executive team and from 'shop floor' clinical staff
- Ensure FP10 prescription pad records are specific to individual pads in outpatient areas.
- Should raise awareness amongst staff of the 'flagging' system to identify additional needs of patients attending the outpatients and diagnostics services
- Address the delays for initial outpatient appointments in some specialist therapy services such as women's health physiotherapy and paediatric musculoskeletal therapy.
- Ensure that the environments where staff work and carry out testing are fit for purpose, in particular this recommendation refers to the accommodation of the nuclear physics team
- Ensure information systems provide adequate data to inform and improve management of outpatient clinics
- Ensure there is an audit trail of the medicines which have been taken out of The Hub by staff and returned if unused at the clinic.
- Ensure staff in sexual health services are provided with appropriate protective clothing in accordance with the trust policy and procedure when dealing with canisters of medicinal gases from the main externally stored supply.

Summary of findings

- Review the separate electronic patient record systems used by the chlamydia screening staff and the sexual health staff to record patient information to reduce the risk of important information being missed at future appointments.
- Review the way in which patients attending sexual health services are welcomed to reception and asked their name in order to protect their confidentiality.
- Review the action plan in place to support the chlamydia screening programme trajectory targets being met.
- Ensure signage around the hospital is clear in assisting patients in finding their way to The Hub.
- Review the main entrance to The Hub so it is fully accessible to patients with some disabilities.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating
Urgent and emergency services	Inadequate

Why have we given this rating?

We rated urgent and emergency care services as inadequate overall. Safety and well led were rated inadequate, caring as good and effective and responsive as requires improvement because:

- Safety was not a sufficient priority. There had been ten serious incidents in the year ending October 2015. Learning from them, or action taken to improve safety, was limited.
- The national early warning score (NEWS) had been implemented but the scores were not always calculated correctly. Action that should have been taken as a result of a high NEWS score did not always take place.
- A rapid assessment and treatment system had been implemented and this had improved the initial assessment of ambulance patients. However, there were deficiencies in the handover of clinical details between staff which sometimes put patients at risk.
- When there were long delays for treatment it was apparent that some people were encouraged to seek help from primary care services rather than wait in the emergency department. The staff giving this advice were not always qualified to do so.
- Nurse staffing levels had improved in the last year but at times there were not enough nurses in the clinical decision unit and the children's emergency department.
- All staff, including temporary staff, had been trained in the use of the electronic prescribing system. However, the continued use of paper records meant that there was a risk of duplicate doses being given in error.
- The requirements for safeguarding of children, young people and vulnerable adults were understood by staff and appropriate action was taken.
- Staff had attended major incident training but access to major incident equipment was delayed by 15 minutes due to a faulty lock.

Summary of findings

- Implementation of evidence-based guidelines was variable. We saw poor compliance with guidelines for fracture neck of femur (broken hips) and sepsis. There were effective clinical pathways for stroke and myocardial infarction (heart attacks).
- Pain relief, drinks and food were not always given in a timely manner.
- Patient outcomes varied and the results of audits were not always used to improve treatment techniques.
- There was a comprehensive training programme for medical staff but junior doctors were not always able to attend.
- A competency framework for nursing staff had recently been developed but had not yet been implemented.
- Access to radiology and pharmacy was available 24 hours a day, seven days a week. Access to mental health services was limited out of hours.
- The impact of a lack of available beds in the hospital had resulted in poor patient flow through the emergency department. It meant that the department was often full and could not immediately treat new patients.
- The number of ambulances waiting more than an hour to hand over patients had reduced significantly since the introduction of a rapid assessment and treatment system but still averaged five per month.
- Achievement of the national standard to admit, transfer or discharge 95% patients within four hours had varied from 90% to 61%. This compared badly to a national average of 92% in the same time period.
- Staff were aware of the hospital escalation policy but there were doubts about its effectiveness. Senior staff were reviewing the plan but did not know when improvements would be implemented.
- The leadership of the department was in transition and the sustainability of current arrangements was unclear. Nursing leadership was due to be shared with other departments leaving limited time for clinical engagement in the emergency department.

Summary of findings

- Governance and quality monitoring processes did not operate effectively. Poor results from clinical audits did not always result in a change in practice that improved patient safety. Performance data was collected and discussed at consultants' meetings but not at governance meetings.

However, caring was rated as good because:

- Staff provided compassionate care and worked hard to ensure that patients were treated with dignity and respect. People's social needs were understood.
- There were positive comments from patients about the care received, and the attitude of motivated and considerate staff.
- There were good results from the national emergency department patient survey.
- Staff engagement had improved in recent months. There was a good sense of teamwork and staff felt supported by their colleagues.
- Improvements in children's services and patient assessment had been made in order to enhance the treatment of patients. An improvement plan had been drawn up in 2015 but implementation had been slow.

Medical care (including older people's care)

Requires improvement

We rated this service as requires improvement because:

- There were insufficient numbers of staff and a heavy reliance on temporary staff and we could not be assured that they were appropriately skilled and experienced.
- Premises were mostly fit for purpose; however, we had continuing concerns about the unsuitable environment on Phoenix ward, which may have contributed to the high incidence of falls on this ward.
- We found wards and departments were visibly clean; however, environmental audits had identified that remedial works were required on some wards in order to reduce the risk of infection.

Summary of findings

- There were systems in place to ensure that premises, equipment and medicines were maintained and used to keep people safe; however compliance with safe practice was not consistent in some areas.
- Compliance with mandatory training was variable so we could not be assured that staff were up-to-date with safe systems and practices.
- There was a 'safety aware' culture within the division and a focus on reducing risk. Although there was evidence that the medical division was taking action to reduce the incidence of patient falls, this was an on going concern and still needed to improve.
- Actions had also been taken to improve record keeping, particularly in respect of patient observations. However, further work was required to ensure improvements were sustained and embedded.

- Performance against national standards in relation to stroke care had made significant improvements; however, the service was still not meeting standards in relation to patients receiving prompt and appropriate care on a stroke unit. Key performance standards in cardiology were also not met.
- The trust's mortality rate was above the national average. Reviews of chronic renal failure deaths and deaths from weekend admissions were in progress at the time of our inspection

- Nursing staff were not well supported, with an unstructured approach to training, development and clinical supervision. Appraisal rates across the division were poor, with only 56% of staff appraised as at December 2015.
- Bed capacity and patient flow were constant challenges. Patients did not always receive care and treatment in the most appropriate clinical setting. This meant inequitable standards of care were provided, with some patients having to wait longer for specialist support.

Summary of findings

- Some patients waited too long for diagnostic cardiology procedures; investigations were sometimes cancelled at short notice and sometimes more than once.
- Some patients were moved several times during their inpatient stay, sometimes at night.
- Patients were not always discharged in a timely manner, partly due to staffing issues resulting in delayed assessment and treatment, but mainly due to difficulties arranging suitable care packages in the non-acute NHS sector.
- The service was not meeting referral to treatment targets in cardiology and respiratory medicine.
- The divisional management team was very focused on patient flow and was taking steps to improve efficiency and reduce delays and length of stay; however, the pace of change and progress was too slow. The ambulatory emergency care unit was a positive admission avoidance initiative but its effectiveness was limited by its operational capacity and the range of care and treatment it was able to offer.
- The service took account of patients' individual needs. We observed that nursing staff were attentive and responsive. Patients were given assistance when they needed it, whether this be assistance with personal care, mobility or support to eat and drink. The service had access to specialist support for people with complex needs, including older people; however, this was a limited resource and, given that older people represented a large proportion of the inpatient population, we judged that there was insufficient specialist training in dementia care.
- There were no overarching strategy or well-defined objectives for the medical division which set out how the service's vision was to be achieved. The approach to service delivery and improvement was sometimes reactive and, at times, counter-productive.
- The divisional leadership had suffered from instability and a lack of cohesiveness. This was

Summary of findings

changing but the management team had more to do to ensure that clinicians were fully engaged, supported and working together as a team.

- Staff morale was mixed, with staffing levels frequently cited by staff as having a negative impact on their working lives. Staff turnover and sickness levels, although improving, remained high. There was more to do to improve staff recruitment and retention and reduce reliance on bank agency and locum staff, for which expenditure was rising month on month.

However:

- Care and treatment was mostly provided in accordance with evidence-based guidance and good practice but there was a risk that some people may not receive effective care and treatment.
- The service participated in national clinical audits. Performance was variable, although there was evidence that improvements were made in response to these.
- **We saw excellent multi-disciplinary team work at ward level, with a focussed and cohesive approach to care planning and discharge. Regular multidisciplinary "board" rounds took place and all relevant staff worked together to plan and deliver care to meet the range and complexity of people's needs. .Junior medical staff felt well supported with regular teaching and supervision.**

- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. Comments included: "Staff are amazing - it's absolutely brilliant!"
- Patients told us they were treated with compassion, kindness, dignity and respect. They told us staff provided comfort and reassurance when they were anxious or distressed. One patient described their doctor as "the most caring doctor I have ever known."
- **We observed that staff were polite and welcoming, greeting them and introducing themselves to patients. We saw that they were**

attentive and sensitive to people's different needs. Patients and those close to them were involved as partners in their care. Patients felt well informed about their condition, care and treatment. They told us that staff took time to explain things to patients and their families in a way that could understand.

- There was a comprehensive assurance system which provided a holistic understanding of performance from ward to board. Risks were understood but were not always effectively or promptly managed.

Surgery

Good

We rated this service as good because:

- Surgery safety, using checklists and briefings, was good.
- The majority of incidents were reported and investigated. The surgery teams assessed and responded well to deteriorating patients. There was good completion of patients' records, although some areas of patient confidentiality needed to improve.
- Surgery wards, operating theatres and equipment appeared clean and well maintained. There was good management of medicines.
- The high vacancies in nursing staff were of concern, but most were covered by experienced bank and agency staff. There was safe cover from the medical teams and a commitment to patient care.
- There was a good review by surgery teams of hospital deaths, but the demonstration of actions taken and learning shared needed improvement.
- Pain, nutrition, hydration management and patient assessments were undertaken well.
- There was a good understanding of the need for valid patient consent, which was obtained as required, although the documentation needed to improve.
- Care was good for patients coming in hospital who needed extra support, such as patients with a learning disability.
- Feedback from patients and their families had been almost entirely positive. Patients we met spoke without criticism of the service they

Summary of findings

received and of the compassion, kindness and caring of all staff. Staff ensured patients experienced dignified and respectful care, and worked hard to promote patients' individuality and human rights.

- Patients and their family or friends were involved with their care and included in decision-making.
- There had been investment and improvement to the pre-operative assessment service and patients were getting safely booked into the system.
- There was an effective governance structure to assess quality and safety and investment in the surgical services.
- There was committed and experienced leadership of surgery services, although the team needing strengthening in numbers.
- All the staff we met showed dedication to their patients, the place they worked, their responsibilities and one another. There was recognition of staff for positive efforts and achievements in surgery services.

However:

- There were improvements needed to the incident reporting system as it did not allow for quick analysis or incident grading.
- There were insufficient physiotherapist sessions to ensure patients having trauma or orthopaedic surgery had an enhanced recovery to get quickly back on their feet. The hospital was not operating on all those patients who needed hip surgery for a fractured neck of femur, within 36 hours.
- Not enough staff had an annual performance reviews (excluding medical staff, as these were now mandatory). In terms of training, staff were not meeting trust targets for updating their knowledge in mandatory subjects and safeguarding.
- There had been some good but also some poor performance against the standards expected for patients having emergency abdominal surgery.
- There had been no improvement to shortcomings in the audits around patient consent documentation.

Summary of findings

- Medical patients were often accommodated on surgical wards due to trust-wide pressures for medical beds. This reduced the number of beds available for surgical patients.
- Due to pressure on beds, too many planned operations were cancelled and some not rebooked within the required standard of 28 days. In addition, patients were looked after in recovery areas after their operation for too long, or moved to another part of the hospital to recover. Before being admitted to a ward, some surgery patients were waiting in chairs in the evening for a bed to become available. This was not providing patients with the best quality care and adding to the pressures on the staff and their morale.
- There needed to be an improvement in recognition and signposting to ongoing care for patients living with dementia, and their carers. Staff were helpful but there were limited facilities on the surgery wards to provide therapy or reduce confusion for patients living with dementia.
- Avoidable patient harm was slightly above (worse than) average in some areas.
- There was a strategic plan for the future of surgery services, but it did not provide any plans for delivering the objectives.
- Staff morale was affected by the high vacancy rates and constant pressure on surgery teams.

Critical care

Good

We rated this service as good because:

- Patients were protected from abuse and avoidable harm.
- There was a good record on safety with lessons learned from incidents and improvements made when things went wrong. Staff were aware of their duties to explain and apologise on the rare occasion when things went wrong. Staff were actively encouraged within the unit to raise concerns through an open, transparent and no-blame culture.
- There was safe monitoring of patients and staff responded to changes. Patient records were comprehensive, well maintained, clear, and contemporaneous.

Summary of findings

- There was a safe environment and the right equipment and the unit was clean with low rates of infection. There was good management, storage and safe used of medicines and consumable stocks.
- Nurse staffing levels were safe, but they were too dependent upon the use of temporary staff. There was wide-ranging experience and skills among the teams of nursing staff and a strong commitment from the experienced consultant intensivists.
- The provision of pharmacist and physiotherapist services did not wholly meet recommended staffing levels, but the dedicated teams prioritised critical care patients and provided a safe service.
- Patients had good outcomes as they received effective care and treatment to meet their needs. There was good provision of treatment and care in accordance with best practice and recognised national guidelines. Patients' needs in relation to pain, nutrition and hydration were well managed.
- There was a strong multidisciplinary approach to assessing and planning care and treatment for patients.
- Mortality rates were better than expected.
- Most services required to meet patient needs were available across all seven days of the week.
- There was good support to new nursing/ healthcare staff and junior and trainee doctors.
- There was valued support to patients and their families. They were treated with dignity and respect, and involved as partners in their care. Staff treated patients with kindness and warmth.
- People's feedback about the service had been entirely positive. Patients said staff were caring and compassionate, treated them with dignity and respect, and made them feel safe. The unit was busy and staff were professional, but they had time to provide individualised care.
- Relatives were able to ask questions and raise anxieties and concerns, and given answers and information they could understand.
- Consultants and nurses reviewed patients in good time.

Summary of findings

- Patients were treated as individuals and equalities, diversities, and patients with different needs were supported. There were no barriers to people to complain.
- There was an example of outstanding care delivered to a long-stay patient enabled, by the work of a team of professionals, to go home.
- The regular reviews of safety and quality through governance meetings promoted the delivery of safe patient care. The staff in critical care were committed to their patients, their staff and their unit.
- The unit participated in the national audit programme through the Intensive Care National Audit and Research Centre (ICNARC). Data returned by ICNARC was adjusted for patient risk factors, and the unit could benchmark itself against other similar units to judge performance.

However:

- The service did not always meet patients' needs. There were bed pressures in the rest of the hospital that meant too many patients were delayed in their discharge from critical care to a ward, or discharged at night. Not all patients were able to get a bed in critical care when they needed one.
- There was a good review of mortality and morbidity, but actions and learning were not evident within reporting.
- Not all targets were reached for mandatory training and staff updating their knowledge. Appraisal, training and development were not delivered to planned targets due to staff shortages. Not all staff were being trained for using specialist equipment.
- There was insufficient security of resuscitation trolleys to show they had not been tampered with between checks.
- Written protocols and procedures for the service required updating.
- The unit had not contributed to a tracheostomy self-assessment study or assessed the skills and experience in tracheostomy care when transferring patients elsewhere in the hospital.

Summary of findings

- There was a lack of recognition of Deprivation of Liberty Safeguards.
- Critical care did not have a clear vision and strategy. Some risks in the unit had not been captured within the risk register and the document needed clearer written actions.
- The trust needed to resolve the long-standing issues with the sustainability and capacity of the service and the effect on staff morale from bed and staffing pressures.

Maternity and gynaecology

Requires improvement

We rated this service as requires improvement because:

- The maternity services required improvements to safety.
- The security of equipment and privacy of patients was compromised on Wheal Rose (antenatal) ward with open access and limited staff availability to direct or advise visitors.
- The consultant staffing levels on the delivery suite did not comply with the Health and Social Care Act (2008) Code of Practice on staffing.
- Improvements were required to the access and flow through both the gynaecology and maternity services. Trust wide service pressures on beds had affected the gynaecology inpatient service. This had resulted in cancelled surgeries and clinics.
- Increased service demands, combined with a lack of capacity had affected the delivery suite. This had resulted in a low, but consistent number of patients who delivered their babies on the antenatal ward.
- Improvements were required in the maternity services to address the negative culture experienced by some midwives.

However:

- Junior medical staff were well supported to learn and develop. There was evidence of good multidisciplinary working which extended to other clinical specialties. Staff were proud of the patient care they provided.

Summary of findings

- Care in the gynaecology and maternity wards and central delivery suite was consultant led and able to support patients with high risks and/or complex health needs.
- Systems were used to appropriately assess and respond to patient risks, which were reviewed regularly.
- Effective processes were in place to report and monitor incidents and there was evidence the Duty of Candour regulations were followed.
- Staff understood safeguarding responsibilities and processes. Records in clinical areas were stored safely.
- The availability and quality of simulation training provided to staff for the management of emergency situations was outstanding.
- Patient feedback was encouraged. This had identified the majority of patients were satisfied with the care and treatment they received and would recommend services.
- Records documented patients' choices and preferences and these were followed when possible.
- The maternity services had achieved full accreditation with UNICEF UK breast feeding standards.
- Both the maternity and gynaecology services had regular audit programmes. These provided assurance that treatment and care was provided in line with national standards. Counselling was available to patients as required.
- There were effective, risk, quality and governance structures in place. Incidents, audits and other risk and quality measures were reviewed for service improvements and appropriate actions were taken.
- The gynaecology and maternity services maintained an overview of clinical and governance performance with the use of dashboards, which ranked a range of measures and their outcomes. These were regularly reviewed to look for ways to improve.
- Systems were in place to effectively share information and learning.

- There was good evidence of learning from complaints

Services for children and young people

Good

We rated this service as good because:

- Processes were in place to report incidents with details of full investigations having been completed where appropriate. Staff were aware of the process although some staff told us they did not always receive feedback on progress of the investigations.
- Systems were in place to monitor medicines management and infection prevention and control with action plans identified.
- There were adequate numbers of appropriately qualified staff on the ward areas we visited. Staffing levels were monitored using an acuity tool and adjusted across the unit as the needs of the children changed.
- Records were kept securely to maintain confidentiality for the patient but were available for staff to view when required.
- Safeguarding training was not compliant with the trust target. The safeguarding leads had taken action to raise awareness of safeguarding for children, as well as having other plans in place to meet this target by April 2016.
- Mandatory training did not meet the trust target of 100% compliance although staff we spoke with were aware of when and how to update their training.
- Risk assessments were available to help staff in paediatric areas to recognise when a child or young person was becoming unwell and needed further clinical intervention. This was not available to staff caring for children in the adult critical care unit.
- Processes were in place to use available evidence to achieve good outcomes for children and young people.
- Guidelines were based on national standards of best practice and audits were undertaken to identify compliance with action plans for improvements.

Summary of findings

- Services were provided seven days a week with busy periods identified and staff put in place to meet the demand.
- Systems were in place to ensure children and young people were cared for appropriately by competent staff in paediatric areas of the trust. Some areas where children shared areas with adult patients did not have staff trained in paediatric care.
- Specialist staff were available to provide advice and support for children and young people in a timely fashion. Professionals worked together from a variety of disciplines such as learning disability team, physiotherapy, child and adolescent mental health services and school staff. There was a limited availability of mental health beds for children and young people. The impact was that a child or young person would remain on an acute general ward when they were clinically fit to be discharged, with staff who were not mental health specialists.
- Staff were kind and compassionate in their communications with parents and their children. They were given information in a way they could understand.
- Children and young people felt informed and involved in their treatment options. Regard was given to emotional health and support was provided to promote independence when the child was discharged.
- Feedback from children and young people who used the service and their families was positive with quotes of “staff are fantastic”.
- Views of children, young people and their families was actively sought and responded to with changes made where possible and appropriate.
- Individual needs were considered and needs met wherever possible in a way that did not single people out as different.
- There were strong links with community resources to provide seamless care for patients when they were discharged from hospital.

Summary of findings

- Individual needs were taken into account in all areas we visited. Children were prioritised above adults on surgical lists, areas were dedicated to children where possible and actions were taken to improve the environment for children.
- Senior staff were represented at trust board level and felt children's services were listened to and action taken.
- Senior managers had no clear vision for the future of the service but they demonstrated how they worked to improve the services delivered. There was an atmosphere of openness and learning from experiences.
- Partnership working and engaging with patients and staff was a priority for the management team.

End of life care

Inadequate

We have judged the overall end of life service as inadequate.

- We found that a combination of inconsistent provision of training and guidance to staff had led to varied understanding and implementation of the trusts end of life strategy and guidance.
- We found that the safety of patients was potentially compromised by the non-completion of patients records in relation to mental capacity assessments and the decision making documentation around resuscitation. We found that records had not been completed and some were incorrectly signed. This meant patient safety and well-being were compromised as plans were not fully understood. There was limited recording of a patient or their relatives involvement in the making of these decisions.
- There had not been regular and consistent training for staff with regards to the introduction of new documentation and procedures that were rolled out across the trust for patients deemed to be at end of life. An end of life care facilitator post had been funded for twelve months until July 2014 but then not renewed. This had led to inconsistent practice and understanding from ward staff, many of whom had received no training about the new guidance and forms to be

used. There had been insufficient support and training to ensure that the trust wide strategy on end of life implemented in 2014 could become embedded into practice.
- There was limited advance care planning in place for patients. There was very limited recording of a patients personalised end of life wishes, for example a patients preferred place of dying.
- The End of Life Care group, which was chaired by the end of life lead and had some oversight responsibilities for the trust strategy, was not effective. This was due to limited attendance from senior medical staff and a lack of trust board representation and support.

However.

- We found the palliative care team responded quickly to referrals and provided good support to ward staff. The team and the palliative care consultant were highly regarded for the expertise and support they provided.
- Anticipatory medicines were always available and patients being discharged home had their medications provided promptly.

Outpatients and diagnostic imaging

Requires improvement

We rated outpatient and diagnostic services to require improvement overall because:

- In some clinics, intravenous fluids were not stored safely.
- Some facilities, particularly in diagnostics, were not adequately maintained and this posed a risk to staff and patient safety from radiation exposure.
- Staff were not consistently following local rules to protect other staff andthe publicfrom accidental irradiation
- We saw in several clinics that patient records were not stored securely.
- Best practice in hand hygiene was not consistently applied in outpatient and diagnostic services and risks of cross infection were not always well controlled.
- Teams were competent regarding safeguarding procedures. However, not all staff had received

adequate training in safeguarding children at level three as recommended by the guidelines published by the Royal College of Paediatrics and Child Health in March 2014.

- Some specialties within the outpatients and diagnostics service collected outcome data but this was not used to benchmark the performance of the service against similar providers or to monitor performance over time.
- There was not a reliable system in place for the supervision or mentoring of staff.
- Patients did not always have timely access to appointments. There were long waits for some specialist therapies.
- A new system to reduce the impact of cancelled clinics had been introduced but significant numbers of clinics were still being cancelled.
- Teams described feeling well supported in their immediate teams. However, both in the outpatients' service and the diagnostics service we saw there were examples of a disconnection between the senior management of the services and the day to day operational running of the clinics.
- The safety and well-being of some teams was not always prioritised, as seen in the inadequate accommodation for the staff of the medical physics team.

However caring was rated as good and we found:

- Staff reported incidents and these were investigated and they were aware of lessons that were learnt as a result of incidents. However, this learning was not always shared beyond the affected teams.
- The imaging service had improved staff compliance with completion of the World Health Organisation five steps to safer surgery.
- Audits were completed and these led to changes in practice that benefitted patients.
- There were good examples of multidisciplinary team working and staff had good access to the information they needed to provide effective care.
- Staff understood their responsibilities under the Mental Capacity Act 2005.

Summary of findings

- We saw that staff in outpatients and diagnostics services did everything possible to maintain patient's dignity and privacy within the busy clinic environment.
- Some clinic facilities were better designed than others to meet patient's individual needs. The learning disability service completed preliminary assessments of outpatients in order to identify requirements for reasonable adjustments.
- The trust had implemented a programme of on going improvement in the outpatient service. There was also a separation of administrative management and clinical leadership within the outpatient services. This meant that understanding of key risks was not well integrated. Data and administration systems did not give clear oversight of the factors causing clinic cancellations and this had not been adequately addressed.
- We saw examples of good practice regarding the promotion of a safety culture for staff. Staff told us they felt valued, respected, and proud to work for the trust.
- When staff raised concerns, leaders acted upon this, although we were told of examples when this action was delayed.
- Immediate action was taken by the trust following concerns raised during our inspection.
- Teams used surveys and other forums to engage with patients views.
- We saw good examples of innovative practice.

Sexual health services

Good

We judged sexual health services as good overall because:

- Patients were protected from avoidable harm. Openness and transparency about safety was encouraged. Staff understood their responsibilities and were encouraged to report incidents and near misses.
- Safeguarding vulnerable adults, children and young people was managed proactively and effectively by staff trained to recognise early signs of abuse.

Summary of findings

- Staff were employed in sufficient numbers to run the service effectively. A daily briefing ensured all staff were aware of any potential risks or concerns regarding the operation of the clinics.
- Patients' care and treatment was planned and delivered in line with current national recommendations and legislation.
- The service participated in local and national audits and used the outcomes to inform,develop and improve care pathways and patients' care and treatment.
- Staff worked well together as part of a multidisciplinary team to coordinate and deliver patients' care and treatment effectively.
- Patients were provided with sufficient information regarding their care and treatment needs to be able to give consent prior to procedures or treatments being carried out.
- The sexual health service provided a caring service to patients.
- The privacy, dignity and confidentiality of patients' was protected and they were treated respectfully by the staff.
- Patients we spoke with provided us with positive feedback regarding their experience of using the sexual health service.
- The service was planned and delivered in various locations and at different times of day times, in order to meet the needs of the local population.
- The facilities and premises we visited were fit for purpose.
- The booking system for appointments was easy to use and supported patients to attend an appropriate clinic to meet their care and treatment needs.
- Patients were advised on how to make a complaint, were listened and responded to and action was taken in response to complaints and suggestions received.
- Staff were aware of a clear vision and strategy for the service in that the aim was to become a

Summary of findings

fully integrated sexual health service. However, this was dependent on future commissioning arrangements which lay with an external organisation.

- There were effective governance systems within the service and the wider trust. The service was able to identify current and future risks and the actions required to address these issues.

Royal Cornwall Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging, sexual health services; Sexual health services

Detailed findings

Contents

Background to Royal Cornwall Hospital

Royal Cornwall Hospitals NHS Trust provides care to 450, 000 people across Cornwall. This includes general and acute services at Royal Cornwall Hospital, elective surgery at St Michael's Hospital, day surgery, medicine and renal services at West Cornwall Hospital and maternity services at Penrice unit at St Austell Hospital.

The Trust has 743 beds of which 74 are maternity and is staffed by approximately 4,383 members of staff.

At the time of the inspection there had been a significant period of instability at board level. Since the last inspection in January 2014 there had been three chief executives in post, two of those on an interim basis. Interviews for a permanent chief executive were taking place in the week following the inspection. Both the director of nursing and director of human resources and organisational development posts were interim appointments with the nursing director having been in place for five weeks at the time of the inspection. A new and experienced chair was appointed in 2015. The director of operations had joined the trust in September 2015. The director of finance was the longest standing of the team having been in post for five years.

We inspected the trust because the findings of our follow up inspection in June 2015 showed services had not improved since our first comprehensive inspection in January 2014.

CQC uses an intelligent monitoring model to identify priority inspection bands. This model 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. Against this the trust was judged as a high risk, at level one (the highest risk level) which it had been at since May 2015.

Our inspection team

Our inspection team was led by:

Chair: Professor Edward Baker, Deputy Chief Inspector of Hospitals, Care Quality Commission

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Emergency department consultant, Professor of vascular surgery, critical care consultant, paediatric consultant, consultant surgeon, obstetrician, consultant renal physician, Chief executive of an NHS Trust,

respiratory matron, a midwife, palliative care specialist nurse, director of nursing, care of the elderly nurse, specialist pain nurse, children's nurse and a senior radiographer.

The team was also supported by two experts by experience, analysts and an inspection planner.

How we carried out this inspection

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

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

The inspection team inspected eight core services as well as an additional service, sexual health

Royal Cornwall Hospital

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children's and young people
- End of life care
- Outpatients and diagnostic imaging
- Sexual health services
- St Michael's Hospital - Surgery
- West Cornwall Hospital - Medicine (including care of the elderly)

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Royal Cornwall Hospital. These included the local commissioning group, the Trust Development Authority (TDA), the local council, Cornwall Healthwatch, the General Medical Council, the Nursing and Midwifery Council and the Royal Colleges.

We held a listening event for the public on 11 January 2016 where some people came and told us about their experience of using services at the trust. We used this information during our inspection. People also contacted us via our website and contact centre to share their experience.

We carried out an announced inspection on 12,13,14,15 January and an unannounced inspection on 19, 20 and 26 January 2016. We held focus groups and drop-in sessions with a range of staff in the three hospitals we visited, including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and maintenance staff. We also spoke with staff individually as requested.

We talked with patients and staff from across the hospitals we visited. We observed how people were being cared for, talked with carers and family members, and reviewed patients' records of their care and treatment.

Facts and data about Royal Cornwall Hospital

According to the 2011 Census, Cornwall's population was 98.1% white. Twenty-three per cent of the population were aged 65 and over.

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

Detailed findings

In the 2015 Indices of Multiple Deprivation, Cornwall was in the second-to-worse quintile for deprivation.

During 2014-15 the trust activity was as follows:

- 64,794 inpatient admissions
- 449.167 outpatient total attendances
- 78,692 accident and emergency attendances

In the 2015 staff survey the trust scored better when compared to the England average for the percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell, which had fallen to 55 % from 64% in 2014. They scored worse than the England average for staff satisfaction with the quality of work and patient care they are able to deliver with a score of 3.63 against the national score of 3.93. There was a slight improvement when compared to 2014 for staff recommending the organisation as a place to work or receive treatment up from 3.0 in 2014 to 3.30 but this was overall a worse score than the England average for all trusts. Other areas where the trust scored worse than 2014 survey when compared to other trusts, included good communication with senior management and staff and the percentage of staff agreeing that their role makes a difference to patients.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Inadequate	Inadequate	Good	Good	Requires improvement	Inadequate
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Sexual health services	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

The ratings for the sexual health service have been taken into account for the overall location ratings. The findings

Detailed findings

for sexual health services run from Royal Cornwall Hospital have been reported in a separate report. The ratings were good for safe, effective, caring responsive and well led.

Urgent and emergency services

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

Information about the service

The emergency department (ED) at the Royal Cornwall Hospital is open twenty-four hours a day, seven days a week. It treats people with serious and life threatening emergencies and those with minor injuries which need prompt treatment such as lacerations and suspected broken bones. It is the only emergency department in the county of Cornwall, supported by an urgent care department at the West Cornwall Hospital in Penzance.

The department has a three bay resuscitation area. One resuscitation bay contains equipment for children. There are two major treatment areas. Major treatment one had room for 13 patients and major treatment two had space for nine patients. Both had rooms with doors for patients who required greater privacy or for those with infectious diseases. Less seriously ill or injured patients are seen in the minor treatment area which had space for six patients. There is a separate children's emergency area with four rooms and a separate waiting room. Patients who need further investigation or observation are cared for in an eight bedded clinical decision unit. There is a dedicated imaging suite providing plain X-ray and ultrasound. The emergency department last year (2014/ 2015) saw approximately 79,000 patients. Almost 12,000 of these were children.

We visited between 12 and 15 January 2016 and undertook an unannounced inspection during the evening of 19 January 2016. During this inspection we observed care and treatment of patients, looked at 14 treatment records and reviewed performance information about the department. We spoke with approximately 30 members of staff including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews.

Urgent and emergency services

Summary of findings

We rated urgent and emergency care services as inadequate overall. Safety and Well-led was rated inadequate, effective and responsive as requires improvement because:

- Safety was not a sufficient priority. There had been ten serious incidents in the year ending October 2015. Learning from them, or action taken to improve safety, was limited. There had been four more serious incidents between November 2015 and the end of our inspection. A repeated theme throughout these incidents was the inability to recognise and treat deteriorating patients and/or those with sepsis. Appropriate action had not been taken to improve patient safety and we witnessed similar situations during our inspection.
- There appeared to be a routine disregard of some safety procedures. Although the national early warning system(NEWS) had been implemented the scores were not always calculated correctly. Action that should have been taken as a result of a high early warning score did not always take place.
- A rapid assessment and treatment system had been implemented and this had improved the initial assessment of ambulance patients. However, there were deficiencies in the handover of clinical details between staff which sometimes put patients at risk.
- When there were long delays for treatment it was apparent that some people were encouraged to seek help from primary care services rather than wait in the emergency department. The staff giving this advice were not always qualified to do so.
- Nurse staffing levels had improved in the last year but at times there were not enough nurses in the clinical decision unit and the children's emergency department.
- All staff, including temporary staff, had been trained in the use of the electronic prescribing system. However, the continued use of paper records meant that there was a risk of duplicate doses being given in error.
- Staff had attended major incident training but access to major incident equipment was delayed by 15 minutes due to a faulty lock.
- Implementation of evidence-based guidelines was variable. We found poor knowledge of, and compliance with, guidelines for fracture neck of femur (broken hips) and sepsis. There were effective clinical pathways for stroke and myocardial infarction (heart attacks).
- Pain relief, drinks and food were not always given in a timely manner.
- Patient outcomes varied and the results of audits were not always used to improve treatment techniques.
- There was a comprehensive training programme for medical staff but junior doctors were not always able to attend.
- A competency framework for nursing staff had recently been developed but had not yet been implemented.
- Access to radiology and pharmacy was available 24 hours a day, seven days a week. Access to mental health services was limited out of hours.
- The impact of a lack of available beds in the hospital had resulted in poor patient flow through the emergency department. It meant that the department was often full and could not immediately treat new patients.
- The number of ambulances waiting more than an hour to hand over patients had reduced significantly since the introduction of a rapid assessment and treatment systembut still averaged five per month.
- Achievement of the national standard to admit, transfer or discharge 95% patients within four hours had varied from 90% to 61%. The average for the year ending November 2015 was 82%. This compared badly to a national average of 92% in the same time period.

Urgent and emergency services

- Staff were aware of the hospital escalation policy but there were doubts about its effectiveness. Senior staff were reviewing the plan but did not know when improvements would be implemented.
- The leadership of the department was in transition and the sustainability of current arrangements was unclear. Two senior nursing positions had recently commenced in post with a further one commencing shortly after our inspection. Nursing leadership was due to be shared with other departments leaving limited time for clinical engagement in the emergency department.
- Governance and quality monitoring processes did not operate effectively.Poor results from clinical audits did not always result in a change in practice that improved patient safety. Performance data was collected and discussed at consultants' meetings but not at governance meetings.

However, caring was rated as good because:

- Staff provided compassionate care and worked hard to ensure that patients were treated with dignity and respect. People's social needs were understood.
- There were positive comments from patients about the care received, and the attitude of motivated and considerate staff.
- There were good results from the national emergency department patient survey.
- Staff engagement had improved in recent months. There was a good sense of teamwork and staff felt supported by their colleagues.
- Improvements in children's services and patient assessment had been made in order to enhance the treatment of patients
- The requirements for safeguarding of children, young people and vulnerable adults were understood by staff and appropriate action was taken.

Are urgent and emergency services safe?

Inadequate

We rated urgent and emergency services as inadequate for safety because:

- Although incidents were reported and investigated in a timely manner, learning from incidents was not always embedded in practice. There had been ten serious incidents in the year ending October 2015. Learning from them, or action taken to improve safety, was limited. There had been four more serious incidents between November 2015 and the end of our inspection. A repeated theme throughout these incidents was the inability to recognise and treat deteriorating patients and/or those with sepsis. Appropriate action had not been taken to improve patient safety and we witnessed similar situations during our inspection.
- Although the national early warning system (NEWS) had been implemented the early warning scores were not always calculated correctly. Action that should have been taken as a result of a high early warning score did not always take place. We saw delays in patient treatment as a result.
- A rapid assessment and treatment system had been implemented and this had improved the initial assessment of ambulance patients. Triage of patients who brought themselves to the department was thorough and effective. However there were sometimes delays of up to 30 minutes at night Triage priorities were often not followed. There were deficiencies in the handover of clinical details between staff which sometimes put patients at risk.
- When there were long delays for treatment it was apparent that some people were encouraged to seek help from primary care services rather than wait in the emergency department. The staff giving this advice were not always qualified to do so.
- There was a shortage of consultants and they were not present in the department for 16 hours a day as recommended by the Royal College of Emergency Medicine.
- Nurse staffing levels had improved in the last year and active recruitment was continuing. At times, there were not enough nurses in the clinical decision unit and the

children's emergency department. Temporary nurses worked regularly in the department and were familiar with local working practices. There was a lead children's nurse and a qualified children's nurse on each shift.

- Medicines were stored correctly and all staff in the department had been trained in the use of the electronic prescribing system. Paper records were still in use for the prescribing and administration of some medicines leading to the risk of duplicate doses being given. Nurses used patient group directiions to administer some medicines. These could not be located during the inspection to confirm that they were being used correctly.

However.

- The requirements for safeguarding of children, young people and vulnerable adults were understood by staff. Training had been provided but staff had not always been able to attend.
- The department was visible clean and tidy. . Staff spoke confidently about hospital infection prevention policies and the actions they would take to prevent cross-infection. Monthly audits of hand washing showed that compliance with good practice had gradually improved in the last year.

Incidents

- Incidents and accidents were reported using a trust wide electronic system. All staff had access to this and knew which incidents required reporting. We looked at incident reports from July to October 2015. They had been logged appropriately with a detailed description of the incidents. However, the incident log did not allow the severity of the incident to be recorded. This made it difficult to assess the significance of the incidents or to identify any trends.
- There were 10 serious incidents in the emergency department in the year ending October 2015. We looked at three examples of the investigations that had followed and found these to have been carried out in an open and honest way. However comprehensive learning from these incidents was sometimes lacking. For example, an investigation into a patient whose condition deteriorated rapidly found that triage had been superficial and that a serious early warning score had been ignored. Learning regarding triage was described but no action was taken regarding early warning scores. (A system for identifying the early signs of a serious illness). We identified similar weaknesses in learning from incidents during our inspection in June 2015.
- There had been four more serious incidents in the months leading up to, and during our inspection. Although the route cause analysis had not been completed for all of them, there were similarities with the previous ten incidents. A repeated theme was the inability to recognise and treat deteriorating patients and/or those with sepsis. Appropriate action had not been taken to improve patient safety and we witnessed similar situations during our inspection.
- Sharing of lessons learnt from incidents was limited. Minutes from emergency department governance meetings between June and October 2015 showed that serious incidents were only discussed in July. There was no analysis of trends from other incidents. Minutes showed that learning from incidents was not discussed at Sisters meetings or nurses meetings. One nurse told us that incidents were discussed at daily safety briefings but that these were not documented.
- We asked the hospital to supply us with examples of learning from incidents in the emergency department. They supplied a governance newsletter dated December 2015. Although it contained details of a number of incidents none of them had taken place in the emergency department.
- Mortality reviews were carried out by the lead consultant and it was intended that mortality and morbidity discussions would be incorporated into monthly governance meetings. We looked at minutes of governance meetings between June 2015 and October 2015 and found that no mortality reviews were discussed. In June 2015 it was announced that there would be a review of out-of-hospital cardiac arrests. However, no mention was made of this in later minutes.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new 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."

- All staff that we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour. Senior staff demonstrated detailed knowledge of the practical application of this responsibility. They described discussions that had taken place with the patients concerned and their families and it was clear that they had fulfilled the requirements of the legislation.

Cleanliness, infection control and hygiene

- The ED was visibly clean and tidy. We observed support staff cleaning the department throughout the day.
- There were daily cleaning checklists but they were only partially completed. For example, on week beginning 4 January 2016 there were only signatures for the cleaning of the portable oxygen equipment on 7 and 10 January. A nurse told us that some equipment was cleaned by porters and they did not always have access to the checklists. All the equipment that we looked at was clean and ready for use.
- The major treatment area and children's areas had room with doors so that patients with infectious conditions could be isolated. Staff spoke confidently about hospital infection prevention policies and the actions they would take to prevent cross-infection.
- Hand washing facilities were readily available and we observed staff wash their hands and use hand gel before and after patient contact. This helped to prevent the spread of infection.
- We were shown audits of infection prevention and control practices which included monthly audits of hand washing. These showed that compliance with good practice had gradually improved and was 92% in November 2015.
- The sluice was clean and well organised and clinical waste was handled and disposed of safely.

Environment and equipment

- The majority of the department was light, spacious and well-ventilated having been rebuilt in 2013.
- The resuscitation room was small. The three cubicles were often full during our inspection and at times there was not enough room for all the staff needed to look after three very sick patients. We observed one occasion when there was no room for a fourth patient to receive treatment in a resuscitation cubicle. They were treated in the major treatment area for 20 minutes until space became available but this meant that there was limited access to resuscitation equipment.
- There was a dedicated ambulance entrance which allowed easy access to the major treatment and resuscitation areas.
- The helipad was situated close to the ED and there was good access. There was a helicopter landing policy to ensure the safe arrival and departure of patients and staff. We checked a range of specialist equipment including resuscitation equipment. It was clean, well maintained and ready for use. However, on the second day one of the oxygen cylinders on a patient trolley in the resuscitation room was empty. This delayed the transfer of a patient to a specialist ward.
- The main x-ray department was adjacent to emergency department to enable easy access for patients.
- The difficulties in accessing critical equipment such as syringe pumps, which we had found at our previous inspections, had been remedied. The critical care outreach team monitored the use of this equipment and ensured that there were sufficient available in the resuscitation room.
- Electrical sockets in the children's ED were covered in order to reduce the risk of electrical injury.

Medicines

- There was a section of the emergency department patient record document designated for the prescribing and administration of single dose medicines. This had been left blank on most of the records because, although medicine had been given, it had been prescribed using the computer system. Because two systems were in use there was a risk that a second dose of medicine could be given in error as there was no link between paper and computer prescribing.
- Nurses used patient group directions (PGD) in order to administer a number of different medicines such as painkillers, nebulisers and some antibiotics. We asked to look at the PGDs but they could not be found in the department. This meant they were not easily accessible to staff to be referred to if there was any doubt about the dose or type of medicine that could be given. There was also no evidence that nurses had read the PGDs and understood them. We asked the hospital to supply us with copies but, at the time of writing, these had not been received.

- Intravenous antibiotics were not always administered according to hospital policy. We saw three patients with sepsis that had not been given antibiotics within an hour of diagnosis. Although this problem had been identified during a clinical audit, effective action had not been taken to improve the practice.
- The computerised prescribing system ensured that medicines could not be prescribed or administered unless allergy details had been recorded.
- Medicines were stored correctly in locked cupboards or fridges. Controlled drugs and fridge temperatures were regularly checked by staff working in the department and seen to be within required parameters.
- Unused medicines were disposed of in accordance with hospital policy.
- We observed staff administer intravenous fluids safely and correctly. They accurately completed details on the medicines chart.
- Allergies were clearly documented on medicines charts and antibiotics were prescribed according to local protocols.

Records

- When a patient was registered their details were entered onto a computer system that showed how long people had been waiting and the investigations they had received. Patient records and information stored on computer was protected by passwords and backed-up to keep it secure.
- The system produced patient records in a paper format so that nurses could record care given. Doctors used a document entitled “Inpatient admission record” even if the patient was not admitted.
- When not in use all paper documents were held in a file which was securely stored in a locked cabinet.
- When patients left the department the paper record was scanned on to the computer system to allow access to records for patients who have previously attended the department. Paper records were disposed of using a secure shredding service that ensured patients information was kept safe.
- There was no space in the patient record document for risk assessments for pressure ulcers or falls. A separate document had to be used. Nurses that we spoke with could not give a clear answer regarding the criteria for carrying out these risk assessments and they were often not carried out
- We looked at the records of 14 patients. All entries by staff were legible and clearly signed and dated.
- During our unannounced inspection, two patients, who had been in the department for a number of hours, with intravenous infusions and urinary catheters had no fluid balance charts completed.
- We asked to see copies of record-keeping audits to see if this was a long-standing problem. We were told that the department did not currently audit their records to check that they were completed correctly. There were plans to do this in future.

Safeguarding

- The department had dedicated link nurses for patients who were at risk of abuse, including specific domestic violence link nurses. These link nurses were available to assist with patients in the department if required, attended multiagency meetings and ensured the department was kept up to date with any developments from these meeting.
- Of the nursing staff in the department required to complete level 2 child protection training, 82% had completed it. Only 66% of those who required level 3 training had completed it. Nurses told us that previous staff shortages had made it difficult to be released for training.
- Of the medical staff in the department required to complete level 2 child protection training, 83% had completed it. 33% had completed level 3. Although training levels were low, doctors that we spoke with were knowledgeable about identifying possible child abuse and how to protect children.
- Children’s records contained a checklist for assessing the risk of abuse. This was completed correctly in the three sets of notes that we looked at.
- We were shown a new protocol to guide staff on what to do should a child leave the department before being seen. Nursing staff were familiar with this. We were told that all children who left without being seen were logged on to the incident reporting system and a letter was sent to the child’s GP. We looked at all 130 incidents recorded in October 2015 (the last complete month available to us) and could find no reports relating to children leaving without being seen. However, we did find an example of a letter being sent to a GP.
- There was a manual process to ensure letters were sent to health visitors, GPs and school nurses when a child attended the department.

- In January 2015 the emergency department was included in a CQC review of looked after children and safeguarding arrangements in Cornwall. There were three recommendations for the emergency department and we found that these had been actioned. They related to ensuring that a record is made at reception of the person accompanying a child; ensuring that documentation prompts staff to identify any children in the household of adults who present as a result of risk taking behaviours; and ensuring a sufficiency of paediatric expertise in the emergency department at all times.

Mandatory training

- Mandatory training included essential topics such as fire training, health and safety, infection control, information governance and conflict resolution. This was delivered by the hospital's education team. The senior nurse had identified that arrangements for attending this training did not always suit the activity of an emergency department. As a result, uptake of the training was less than satisfactory. She was arranging for the training to be delivered in a single one day session which would make it easier to release staff.
- Training records supplied to us showed that nurses rates of attendance varied from 63% for manual handling of patients to 85% for conflict resolution. The hospital's target was 100%.
- Doctors' attendance was as low as 4%for manual handling of patients to 68% for health and safety and fire training.
- Training and assessment of resuscitation skills was poor. Hospital records showed that only 18.5 % of nurses had undertaken immediate life support training and 23 % had a current advanced life support (ALS) qualification. 84% of doctors had an ALS qualification.

Assessing and responding to patient risk

- Patients that arrived by ambulance or helicopter as a priority (blue light) call were taken immediately to the resuscitation area. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for the arrival of the patient. We observed these calls being taken quickly and calmly with details being recorded on an ambulance record sheet.
- From 8am-8pm other adult patients arriving by ambulance were taken to the rapid assessment and treatment (RAT) area. This consisted of three cubicles in the major treatment area. A team consisting of a nurse and two support staff measured vital signs, undertook diagnostic tests and allocated a triage category. This determined the priority to be seen by a doctor or nurse practitioner. S3 meant the patient should be seen within 10 minutes; S2 - to be seen within 20 minutes; S1- to be seen within one hour. Once the patient's condition had been assessed they were transferred to another treatment area within the department.
- However, one experienced nurse told us "We don't take any notice of S2". The reason for this was not clear but did seem to be common practice. We saw two patients with an S2 priority, one with a severe infection and one with shortness of breath, who were not seen by a doctor for two hours and one hour and 40 minutes respectively.
- In addition to triage categories the national early warning score (NEWS) was used to identify patients whose condition was at risk of deteriorating. Points are allocated to a patient's vital signs such as heart rate, temperature and blood pressure. The points are added up to achieve a total score which then determines further action. For example, actions following a score of five should include "assessment by a clinician with core competencies to assess acutely ill patients within 15 minutes", a minimum of hourly observations of NEWS parameters and the commencement of a fluid balance chart.
- Although the NEWS was always calculated by staff in the RAT area we found several examples where the actions required were not acted upon. One patient with a NEWS which should have resulted in being seen by a doctor within 15 minutes and being cared for in an environment with clinical monitoring facilities was taken to another department for a scan. The patient was not seen by a doctor for one hour and 20 minutes after prompting by the CQC team. The patient's condition continued to deteriorate.
- Another patient was found to have a NEWS of six on arrival. The NEWS protocol stated that the patient should be seen by a doctor within 15 minutes, needed a minimum of hourly NEWS observations and the commencement of a fluid balance chart. After three hours no further observations had been recorded and there was no fluid balance chart. These were commenced after prompting by the CQC team. The patient was seen by a doctor after two hours and was found to have a severe infection requiring admission to a ward.

- A third patient arrived with a high respiratory rate and the NEWS score that was calculated in the rapid assessment and treatment area indicated that hourly observations were needed and to be seen by a doctor within 15 minutes. A second set of observations were done after two hours which showed that the patient's condition had worsened. No further observations were done for a further two and half hours when the patient was transferred to a ward. A doctor saw the patient after one hour and 42 minutes.
- After 8pm ambulance patients were assessed by the nurse in charge of the major treatment area. During our out of hours inspection no-one waited more than ten minutes to be assessed at night.
- The hospital monitored the number of ambulance patients who waited more than an hour to be handed over from the crew to clinical staff in the emergency department. A year ago (November 2014) an average of 55 patients a week waited over an hour to be handed over. Recently, in October and November 2015 this had reduced to an average of two or three a week. Clinical staff told us the improvement was due to the new RAT system.
- Staff told us that when long delays did occur there could be six or seven ambulance patients queuing in the corridor. Senior staff told us that, when this happened, they ensured the patients safety by allocating a nurse to the corridor to assess and monitor patients. However, ambulance crews that we spoke with were not able to confirm that this occurred.
- On the last day of our inspection we witnessed four ambulance patients queuing in the corridor. Although they had ambulance crews with them there was no emergency department nurse to assess or monitor the severity of their condition. A senior member of the nursing staff entered the corridor at one point but walked away from the patients towards an office. No attempt was made to find another nurse to ensure the safety of the waiting patients.
- Patients who walked into the department, or who were brought by friends or family were directed to a receptionist. Once initial details had been recorded the patient was asked to sit in the waiting room. They were told that they would be rapidly assessed by a senior nurse. This assessment was required in order to determine the seriousness of the patient's condition and to make plans for their on-going care. This is often known as triage.
- We observed the triage of three patients (with their consent) and found it to be thorough and effective. The nurse had completed special training in triage and had been assessed as competent before undertaking the role.
- During the day the majority of patients were assessed within 15 minutes. However, during our inspection patients at night were waiting up to 30 minutes for an initial assessment. There was a risk their condition could deteriorate during that time.
- The department had received complaints about patients being turned away by receptionists before being seen by clinical staff. The capacity management major incident plan stated that when the department was very busy "minors patients to be informed of pressures and potential delays and informed of alternative care pathways where appropriate". The plan did not state who will do this. Nursing staff told us this would only take place once patients had been triaged. However, if there were long delays for triage, reception staff said that they were sometimes asked to "filter" patients by the nurse in charge. In effect, this meant advising patients to see a GP rather than waiting to be seen in the emergency department.
- Reception staff are not qualified to decide the type of treatment that people require and there was a risk that people with a serious condition could be advised to leave. We spoke with the manager responsible for the reception service who told us that this risk had been recognised. An e-mail had been sent in November 2015 to all receptionists clarifying the situation and making it clear that no-one should be advised to leave before being seen by clinical staff.
- Nurse practitioners had been trained to assess and treat minor injuries and illnesses in children. However, it was departmental policy that any child under one was seen by a doctor initially. Two senior nurses told us that, if there was a long wait to see a doctor or nurse practitioner, children's nurses would assess children and advise them if their condition could be treated by a GP. We were concerned that relatively inexperienced band 5 and 6 nurses were expected to do this. Children with earache, "snuffles" or mild wheezes were most likely to be advised to see a GP if there was a long wait to see a doctor or nurse practitioner. There was no written protocol to guide nurses and no competency

assessments to ensure that they had the skills to make these decisions. This meant there was risk that treatment could be delayed for children with a serious illness.

Nursing staffing

- At our last inspection we had found that there were not enough registered nurses to provide safe care for the number of patients attending the department. Since then the new senior nurse had used an acuity tool to calculate the number of registered nurses required, by monitoring the number of patients that normally attend and the seriousness of their illnesses or injuries. In addition, nurse to patient ratios were checked against guidance issued by the National Institute of Health and Clinical Excellence (NICE)
- We looked at nurse staffing for the month prior to our inspection and found that, when the department was regarded , in its entirety, there were sufficient registered nurses to satisfy NICE guidance. This was an improvement compared to our previous inspections.
- However, because one registered nurse was required for the three patients in the rapid assessment and treatment area, it left one registered nurse looking after five patients in major treatment 1. The same ratio applied in major treatment 2. This is less than the 1:4 ratio recommended by NICE. There were not enough band 7 sisters to take charge of the department on each shift. This particularly applied at night when a band 7 nurse was usually only in charge for two nights out of seven.
- There was only one registered nurse looking after eight patients in the clinical decision unit rather than two recommended by NICE.
- We observed the registered nurse leave the unit to ask a doctor to prescribe some intra venous fluids. She was away for ten minutes leaving a health care assistant caring for the patients.
- The senior nurse explained that, there had been a review of staffing and several new nurses, at all levels had been recruited, but they had not all commenced employment. It was expected that all vacant posts would be filled by the end of February 2016. Until that time temporary nurses from an agency were used to ensure adequate staffing levels. We spoke with three agency nurses and found that they had been working in the department for over a month. They were familiar with local working practices and had been trained on the computerised pharmacy system.
- Additional children's nurses had been employed, including a lead children's nurse. There was at least one registered children's nurse on duty at all times in the children's area. However, those nurses worked alone. When we first visited, the children's nurse was looking after a baby with breathing difficulties, a child with post-operative complications and a patient who had just been transferred from another hospital with a spinal injury. We were concerned one nurse was not enough to look after three children with significant illnesses.
- When two of the children needed admitting to a ward the children's nurse needed to accompany them and asked a nurse from the minor treatment area to look after the third child. We were told if children remaining in the department were not giving cause for concern, another nurse would not be called to look after them. Instead, children and their parents would be left in the children's waiting area and told to go into the adjacent minor treatment area if they needed help. There was a risk that a child may deteriorate while the nurse was away and that parents could not find help quickly enough.
- We visited the children's area on subsequent days and always found a single children's nurse with no other members of staff to support her.
- There were two main nursing handovers each day where essential patient information was discussed in a structured format. The morning handover included a safety briefing. Staffing information was not discussed. On three occasions nurses could not tell us who was in charge of each treatment area. One health care assistant could not tell us the name of the nurse in charge of the department. This had previously been identified as a problem and there was now a whiteboard in the main corridor displaying the name of the nurse in charge. The healthcare assistant told us that she rarely walked past the board and was not aware of the information on it.
- Handover of individual patients was not effective. A nurse in the resuscitation room was not aware of the treatment plan for a seriously ill patient who had been handed over to her 20 minutes previously. We spoke to

two nurses on night duty who were not aware that their patients needed hourly observations of pulse, blood pressure and respirations. They told us the information had not been handed over by day staff.

Medical staffing

- There were four vacancies for consultant posts and one consultant was on long-term sick leave. This left 5.5 full time equivalent consultants working in the department which meant it was not possible to comply with the recommendations of the Royal College of Emergency Medicine to have a consultant present in the department for 16 hours a day. Instead, consultants commenced work at 8am and finished at 10pm during the week and from 8am to 8pm at weekends. Consultants were on-call from home after these hours.
- We saw consultants working clinically in the department. They advised junior doctors about the diagnosis and treatment of complex patients and led the thrice daily clinical handover of patients. Some consultants expressed frustration that there was not time to gain knowledge of all the patients in the department. They were worried that they could not always see very sick patients quickly enough.
- The interim lead consultant told us that the vacant posts had been advertised twice in the last six months but no applications had been received. There was a possibility of recruiting in Australia but a final decision had not yet been made.
- Locum consultants were occasionally employed to cover annual leave. Medical staff told us that locums worked with permanent consultants until they were familiar with the working practices of the department.
- Junior doctors spoke positively about working in the department. They told us that the consultants were supportive and accessible, but at night and weekends, when there were no consultants, senior advice was more difficult to obtain. In-house teaching was well-organised and comprehensive and teamwork was good. The rota did not provide protected time for learning and so it was not possible to attend all the teaching session provided.
- There were two handovers per day where all doctors were involved. These were at 8am and 10 pm. The handover that we witnessed was brief and unstructured. No reference was made to early warning scores and opportunities for clinical teaching were missed, despite that fact that there was a patient whose treatment had not complied with RCEM standards. No mention was made of waiting times for admission even though four patients had been in the department for over four hours.
- The handover took place around one of the computers in major treatment area one. This was a busy, noisy environment and it was not possible for all doctors to hear what was being said.

Major incident awareness and training

- The hospital had a major incident plan, which was up-to-date and detailed. The plan provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries. These included injuries caused by burns, blasts or chemical contamination. It also described how to contact support staff, voluntary services and chaplains to provide additional support for the large numbers of people who may attend the hospital enquiring about family and friends.
- Staff in the department told us that training for major incidents was provided by an annual table top exercise. They were able to describe the arrangements to deal with casualties contaminated with chemical, biological or radiological material (HAZMAT).
- Equipment and documentation was kept in two large locked cupboards. The keys were kept in reception but one was found not to work when staff tried to open the cupboard for us. It took a phone call to a member of staff at home to establish the whereabouts of another key that would open the cupboard. This resulted in a delay of 15 minutes in accessing vital equipment needed to treat patients during a major incident.
- Nursing staff told us that security staff responded promptly when called. They had been trained in conflict resolution and the safe restraint of violent individuals.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated effective as requires improvement because:

- Although there were evidence-based guidelines for the care and treatment of patients they were not always followed. We found poor knowledge and compliance with guidelines for fractured neck of femur and sepsis. There were effective clinical pathways for stroke and myocardial infarction (heart attacks).
- Pain relief, drinks and food were not always given in a timely manner.
- Patient outcomes varied and the results of audits were not always used to improve treatment techniques. The action to be taken following a disappointing sepsis audit was further staff training and encouragement to use sepsis alert stickers on patient records. Training records showed that only thirteen out of seventy nurses had received sepsis training and only sixteen out of thirty doctors. We reviewed the records of four patients with sepsis and only one had an alert sticker attached.
- There was a comprehensive training programme for medical staff but junior doctors were not always able to attend. A competency framework for staff had recently been developed but had not yet been implemented.

However:

- Access to radiology and pharmacy was available 24 hours a day, seven days a week. Access to mental health services was limited out of hours.
- There was good access to information via the departmental computer system. Staff had a good understanding of consent and the Mental Capacity Act (2005).

Evidence-based care and treatment

- The department used a combination of NICE and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment that was provided.
- A range of clinical care pathways and proformas had been developed in accordance with guidance produced by NICE and the RCEM. These were easily accessible via the departmental computer system. They included fractured neck of femur (broken hip), sepsis and head injuries.
- An internal audit showed that compliance with the head injury pathway was satisfactory.
- The department satisfied the requirements of the national 'Standards for children and young people in Emergency Care settings'.
- There had been improvements in the management of patients with acute stroke since the introduction of a specialist stroke team at the hospital. After a brief initial assessment patients were taken immediately for a CT scan to determine the type and severity of the stroke.
- There was an effective clinical pathway for patients who had suffered a heart attack (Myocardial infarction). As soon as this was diagnosed patients were taken directly to the cardiac catheter laboratory for immediate treatment.
- Staff did not always follow national guidance for the treatment of sepsis (a life-threatening condition resulting from a severe infection). This had been identified in previous clinical audits and, in October 2015, the hospital had appointed a sepsis nurse specialist. This role was focussed on practice in the emergency department and medical assessment unit. The nurse specialist told us that much of her time was spent auditing records but that she visited the emergency department most mornings to review patient care.
- Although we found some evidence of good practice we found at least four patients where sepsis protocols had not been followed. The majority of these were during the evening. For example, an elderly gentleman with signs of sepsis on arrival was not placed on the sepsis pathway. This required "that senior medical input (consultant/registrar) is requested immediately", that arterial blood samples are taken within an hour and that intravenous antibiotics and high flow oxygen are commenced. The patient's clinical condition needed to be monitored hourly, including urine output. After three hours we noted that no monitoring of the clinical condition had taken place, and we could find no record of any medical input. The nurse looking after the patient was unable to tell us whether this had taken place.
- A lady who arrived in the morning with signs of sepsis was not seen by a doctor for one hour and 25 minutes. Her clinical condition was reviewed only once in four hours and there was no monitoring of urine output. She was later admitted to a ward with severe sepsis.
- The department has been involved in the trust-wide project to improve blood transfusion practice. This has resulted in better compliance with best practice and safer blood transfusions.

Pain relief

- We observed that nurses administered rapid pain relief when they assessed patients who had walked into the department. During our inspection all patients had their pain assessed on arrival but pain relief was sometimes delayed for patients arriving by ambulance. One patient with a broken hip and a pain score of seven out of ten waited three hours for pain relief. Pain was rarely reassessed in adults to ensure that pain relief had been effective.
- During our inspection we observed timely pain relief administered to children. The results of the pain relief were monitored and additional treatment given if necessary.
- The trust scored similar to other trusts in the A&E Survey 2014 for questions on pain relief

Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed, administered and recorded when clinically indicated.
- Although we saw staff offering refreshments during the course of our visit this was not done on a regular basis and was not always recorded in the patient record. A system of hourly care rounds had been recently introduced aimed at ensuring that patients felt comfortable and had been offered food and drink. We found the implementation of care rounds was intermittent. A number of patients who had been in the department for up to five hours had only been involved in a care round once, if at all.
- The trust scored similar to other trusts in the A&E Survey 2014 for the question on nutrition and hydration.

Patient outcomes

- The department took part in national audits in order to compare patient outcomes with other hospitals in England.
- An RCEM audit that took place in 2014 showed that outcomes for patients with sepsis (a life-threatening condition resulting from severe infection) were worse than most other hospitals in England. A re-audit was completed in February 2015 which showed that fewer patients than previously received intravenous antibiotics within the first vital hour (although more received the antibiotics before leaving the department). No improvement had taken place in the other sepsis standards. The action taken as a result of this was further nurse training and encouragement to use sepsis alert stickers on patient records. Training records showed that only 13 out of 70 nurses had received sepsis training since February 2015 (and only 16 out of 30 doctors). We reviewed the records of four patients with sepsis and only one had had an alert sticker attached.
- Results from four other national clinical audits showed that outcomes were the same as, or better than, most other hospitals in England. These were the initial management of the fitting child, asthma in children, paracetamol overdose and the management of mental health issues.
- There was an internal audit programme. This included topics such as management of patients with low risk chest pain, management of pain in children, diagnosis and treatment of pulmonary embolus and CT scanning in head injuries.
- There had been a re-audit of the diagnosis and treatment of patients with a fractured neck of femur (broken hip). Results (published in November 2015) were compared to the national audit that had taken place in 2012/13. They showed that pain relief had improved since the last audit and that severe pain was treated more quickly than most hospitals in England. X-rays were performed more quickly than in many hospitals. However, only 62% of patients were admitted to a ward within four hours. The RCEM standard is 98%.
- We observed the treatment of a patient with a broken hip. Although the initial assessment was good, it took two hours for the patient to be seen by a doctor. This delayed the pain relief for the moderate pain that had been described on arrival. We spoke with two experienced nurses and neither was aware of the RCEM standard that states 98% of patients with moderate pain should be given pain relief within 60 minutes of arrival.
- The rate of unplanned re-attendances within seven days is often used as an indicator of good patient outcomes. At the Royal Cornwall hospital it had varied between 4.5 and 6.5% since November 2014. This was better than the national average of 7.5%.

Competent staff

- Trust data on appraisal rates showed that all doctors who were permanently employed in the department had been appraised in the last year.
- The new senior nurse had recognised that a lack of training in appraisal techniques had led to a very low

nursing appraisal rate. Only 37 % of nursing staff had received an appraisal in year ending March 2015. Training had been introduced and by October 2015 52% of nurses had received an annual appraisal.

- 88% of consultant and middle-grade doctors had had their registration successfully re-validated and nurses were aware of the new revalidation process that was about to start.
- Nurses told us that, in the past, their specialist training and education had been fragmented and poorly organised. It had recently been given greater priority and as a result a new Band 7 post of Practice Educator had been created. The post holder had created a competency framework for all nurses and support staff. She was now working with hospitals training directorate to implement it.
- Nurses that we spoke with told us that they had undertaken the Resuscitation Council's Immediate Life Support (ILS) course, and others had also attended paediatric resuscitation training. Hospital records showed that only 18.5 % had undertaken ILS and 23 % had a current ALS qualification. 84% of doctors had an ALS qualification.
- Junior doctors described a comprehensive induction programme and told us they received regular supervision from the emergency department consultants, as well as weekly teaching sessions. Some doctors told us that they were not always able to attend the teaching sessions when the department was busy.
- The Trust lead Sepsis nurse attends the daily safety briefing, providing briefings as necessary.
- There were training sessions focussed on treating patients with sepsis which included use of simulation suite. Data provided showed low numbers of staff had attended. demonstrate.

Multidisciplinary working

- There was effective multidisciplinary working within the emergency department. This included good working relations with speciality doctors and nurses, therapists and GPs.
- Medical and nursing staff and support workers worked well together as a team. We observed them constantly updating each other on changes to patients' treatment.
- There were good working relationships with the child safeguarding team and with the community paediatric teams.
- Staff in the department reported effective links with the psychiatric liaison service. However, during our inspection we witnessed poor response times from the psychiatric team at night. These services were run by another NHS provider. There was no separate alcohol or substance misuse liaison team.

Seven-day services

- The ED consultants were not present in the department 24 hours a day. However they did provide senior clinical advice 24 hours per day, seven days per week, either directly within the department or on-call from home.
- The department had access to radiology support 24 hours each day, with rapid access to CT scanning when needed.
- There was an effective pharmacy on-call service. Staff told us that pharmacists responded quickly when called.
- There was variable support from mental health services at nights and weekends. During our inspection there were invariably one or two patients in the clinical decision unit who had been waiting overnight to be assessed and supported by the mental health team.

Access to information

- All paper patient records generated during an episode of care were scanned onto an electronic record when the patient was discharged or transferred out of the department. This meant that there was immediate access to records for any patients re-attending the ED.
- Information about previous hospital admissions was available in paper and electronic formats.
- Access to all electronic records was protected with passwords.
- Treatment protocols and clinical guidelines were on the trust intranet and we observed staff referring to them when necessary

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children they were responsible for.
- The staff we spoke with had sound knowledge about consent and the Mental Capacity Act (2005).

Urgent and emergency services

Are urgent and emergency services caring?

Good

We rated caring in the urgent and emergency care services as good because:

- Staff provided compassionate care and worked hard to ensure that patients were treated with dignity and respect.
- Feedback from patients and those close to them and was positive about the way staff treat people. There were good results from the national emergency department patient survey.
- There were positive comments from patients about the care received, and the attitude of motivated and considerate staff. They told us they felt supported and said staff cared about them.
- Patients were kept informed of on-going plans and treatment. Some family members told us that staff did not always keep them informed. Most told us they felt involved in the decision-making process and had been given clear information about treatment options.
- Their privacy and confidentiality was protected.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.

Compassionate care

- We saw several examples of patients being treated with compassion, dignity and respect. Staff spoke in a respectful but friendly manner and maintained people's confidentiality. We observed a healthcare assistant gently placing a call bell into someone's hand and explaining how it worked. She encouraged the patient to use it as soon as they needed anything.
- Communication with children was well thought out and effective. Nurses took time to distract and comfort them during injections and wound cleaning. Parents were involved in the assessment and treatment of their children and clear explanations were given.
- We spoke with fourteen patients and three family members. On the whole they reported a positive experience. One said "As far as I'm concerned, they're all marvellous". Another said "I am happy with all aspects of the care here".
- We heard staff updating relatives about patients' progress whilst maintaining confidentiality
- The questions related to caring in the 2014 national A&E survey indicated that staff in the Royal Cornwall hospital were as good as most others in England.

Understanding and involvement of patients and those close to them

- Current waiting times were not displayed in the waiting room. Receptionists said that they would tell people about any delays if asked. However, we observed triage nurses discussing waiting times and reassuring people that they would be on hand to help if anything was needed. They checked the waiting room on a regular basis and responded quickly if anyone seemed to be distressed.
- Some patients were confused about the identity of staff and expressed anxiety about this. Several of the staff did not wear name badges and so it was difficult to know who they were. Most of the name badges that were worn did not describe the role of the member of staff, only their first name. Staff uniforms were also confusing. Doctors, charges nurses and a male support worker were all wearing dark blue tunics and it was difficult to know who to approach in particular circumstances.
- We observed staff introducing themselves by name and explaining treatment plans in terms that were easily understood. One patient told us that staff who had looked after him were "all very impressive".
- Patients that we spoke with all said that they had been involved in the planning of their care and had understood what had been said to them.
- Privacy was maintained in the CDU by means of separate bays for men and women and two side rooms.
- Feedback from relatives was mixed. We spoke to the wife of a patient brought by ambulance with a head injury. She had been asked to sit in the waiting room and it was 30 minutes before a nurse came to collect her. She described being anxious and worried during that time. The son of an elderly patient who had been to the department on four occasions in the last year described the staff as "lovely". He said "They look after us very well."

Emotional support

Urgent and emergency services

- We observed staff giving emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible.
- There was a quiet sitting room where distressed relatives could sit in a private space. This was large enough to accommodate several people and was furnished comfortably. In the past people had experienced difficulty using mobile phones in the quiet room and were unable to contact other family members. They had found this distressing. In order to alleviate this distress staff had arranged the installation of a landline telephone so that people could be in contact with family and friends at all times.
- Multi-faith chaplaincy services were available day and night for people who would benefit from spiritual support.
- Specific support and counselling was available for victims of domestic violence.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We rated the urgent and emergency services as requires improvement for responsive because:

- The impact of a lack of available beds in the hospital had resulted in poor patient flow through the department and delays in treatment for patients. This meant that the emergency department was often full and could not immediately treat new patients.
- The number of ambulances waiting more than an hour to hand over patients had reduced significantly since the introduction of a rapid assessment and treatment system but still averaged five per month.
- The national standard which requires that 95% of patients in emergency departments wait less than four hours to be admitted, transferred or discharged had only been achieved for one week in the year ending November 2015. During the rest of the year performance had varied from 90% to 61%, with an average of 82%
- The trust had developed an ambulatory emergency centre aimed at reducing the number of people who needed to be admitted from the emergency department However, there was little evidence that it had produced a reduction in emergency admissions.
- Staff were aware of the hospital escalation policy but there were doubts about its effectiveness. Senior staff were reviewing the plan but did not know when improvements would be implemented.

However,

- There had been improvements in learning from complaints. Nursing staff pro-actively used the learning to enhance the care that they gave to patients.

Service planning and delivery to meet the needs of local people

- An enlarged and modernised department was completed in 2014 to provide more space for major treatment patients and a dedicated children's emergency department.
- Links have been established with local homelessness organisations so improve the support given to homeless patients.

Meeting people's individual needs

- Staff had received training in responding to the needs of people living with dementia. They described the care needed in a knowledgeable and sympathetic fashion.
- Frail elderly patients with complex needs were referred to occupational therapists before going home. This ensured that that appropriate support was in place before patients were discharged. The skills and knowledge of the occupational therapists were appreciated by the ED team. Elderly patients were not discharged home after 10pm. Instead they were admitted to a bed in the clinical decision unit (CDU) until morning.
- We were told that patients with complex needs would be treated by a senior doctor who had the experience necessary to meet their requirements
- Children's needs were met by the provision of age appropriate toys and activities, a separate spacious waiting area and specific pain scoring tools.
- There was a clear pathway in place for the admission of children aged 16 or 17 years.

- The appointment of a trust-wide learning disabilities team had improved awareness and staff felt able to contact them for advice. Nurses told us that they encouraged the involvement of families and carers so that they could understand someone's specific needs.
- There was a quiet sitting room where distressed relatives could sit in a private space. This was large enough to accommodate several people and was appropriately equipped.
- Translators could be accessed via the telephone translation system provided by the hospital. However they were not always available at short notice and so a list of languages spoken by staff in the department was also used.

Access and flow

- The lack of available beds in the hospital had resulted in poor patient flow through the department and delays in treatment for patients.
- Several patients that we spoke with told us that they had experienced delays. One said "Everything seems so slow". A relative who had accompanied his mother four times in the last year said "The staff are always good to us, but there are always very long waits". A mother who told us that she attended often with her three children said that there was always a long wait because serious illnesses took priority over minor injuries.
- NHS England has set a national standard which requires that 95% of patients in emergency departments wait less than four hours to be admitted, transferred or discharged. Royal Cornwall Hospital had met this target only once during a week in June 2015. Throughout the rest of the year ending November 2015 performance had varied from had varied between 90% to 61%. The average for the year ending November 2015 was 82%.This compared badly to a national average of 92% in the same time period.
- The average time to see a doctor or nurse practitioner varied between 41 minutes and 60 minutes in the year ending November 2015.
- The hospital had a high number of patients ready for discharge that were delayed due to lack of provision for their onward care needs and this impacted on patient flow in the emergency department. At times some patients were waiting in the department for 4-12 hours before being admitted to a ward. The numbers had varied in the last year (ending November 2015) from 13% of emergency admissions in June 2015 to 40% in November 2015. On average two patients a month spent more than 12 hours in the department waiting to be admitted to a ward.
- Nurses told us that one of the barriers to smooth patient flow was that empty beds often became available in "batches" and it was not possible to find enough nurses and porters to take them to the wards in a short space of time. We observed this one evening when there were five patients waiting for empty beds, three of them for several hours. At 9pm the site practitioner arrived in the department with the news that there were six empty beds in the hospital. It was not clear for how long they had been available.
- The hospital had developed an ambulatory emergency clinic which aimed to treat people without them being admitted to a ward. Conditions such as non-cardiac chest pain, cellulitis and blood clots could be treated there. However, there were no clinical protocols in place to identify patients who could be transferred to the ambulatory emergency clinic .In practice, this unit was used to assess and treat all urgent patients referred to the hospital by GPs, a large proportion of whom needed to be admitted. This meant that there was limited space for ambulatory patients. Nursing staff told us that they only transferred a few patients each week. The trust was unable to tell us exactly how many were transferred to the clinic from the ED.
- Black breaches occur when an ambulance has arrived with a patient but it is not possible to handover care to the emergency department staff for over an hour. Although the number of black breaches had reduced since the introduction of the rapid assessment and treatment processes there had still been an average of five per month between September and November 2015. A lack of available beds and the impact of this on flow in the hospital was again the main reported reason for this.
- There were a significant number of other delays in the handover of patients brought by ambulance. For year ending November 2015 an average of 32 patients a day waited between 15 and 30 minutes. Four patients a day waited between 30 and 60 minutes.
- The average length of time that patients spent in the department varied from 174 minutes in November 2015 to 156 minutes in September 2015. These times were worse than the England average of 135 minutes.

- Despite these delays only 2 % of patients left the department without being seen which was less than the England average.
- Staff were familiar with the hospital's capacity management escalation plan but had doubts about its effectiveness. The deficiencies in the plan had been recognised by the Emergency Care Intensive Support Team (ECIST) from NHS England when they visited the hospital in July 2015. They had provided a plan that had been successful in another hospital. We were told that this was currently being considered but no date had been set for implementation.
- During one of the evenings of our inspection the department fulfilled the criteria for an amber alert within the escalation plan. This meant "Persistent excess pressure requiring significant additional action". However, the additional action described in the plan could only be taken during normal working hours. For example, asking acute GPs to review patients in the department and arranging transport to take ward patients home. Due to a lack of significant action the department remained under persistent excess pressure for most of the rest of the night.
- A nurse from the department attended the bed management meeting twice a day. This was to update hospital managers on the capacity of the emergency department and to understand bed availability across the hospital. During our inspection there were a number of delays in admitting patients from the department but discussions at the bed management meeting were not able to provide any solution to the delays. Hospital managers used a computerised bed management system to supply details of the numbers of patients due for admission and those due to go home. During a midday bed meeting that we attended it became apparent that the figures on the computer system were not accurate. There were less empty beds in the hospital than was first thought. We were told the discrepancy was due to difficulties experienced by ward staff when updating the computer system.

Learning from complaints **and concerns**

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service (PALS), which would formally log their complaint and attempt to resolve their issue within a set period of time. PALS information was displayed on noticeboards throughout the department.
- Formal complaints were investigated by a consultant or the emergency department matron and replies were sent to the complainant in an agreed timeframe. Replies that we saw were detailed and considerate.
- We saw that learning from complaints was discussed at Sister/Charge Nurse meetings and that time was set aside during Sunday handover meetings to discuss learning from at least one complaint. Learning from complaints was not discussed at governance meetings.

Are urgent and emergency services well-led?

Inadequate 

We rated urgent and emergency services as inadequate because:

- The leadership of the department was in transition and the sustainability of current arrangements was unclear. Three new senior positions had been recruited just prior to our inspection. Nursing leadership was due to be shared with other departments leaving limited time for clinical engagement in the emergency department.
- There was no credible statement of vision or guiding values. Senior staff were unable to describe a vision or strategy for the department, although a meeting had been planned in order to formulate a nursing strategy.
- Governance and quality monitoring processes were not effective in identifying and managing issues and risks. Poor results from clinical audits had not resulted in an effective change in practice. The departmental improvement plan was not regularly monitored at governance meetings. A full capacity protocol, as advised by the national emergency care intensive support team (ECIST), had not yet been agreed.
- The risk register did not reflect all of the concerns described to us by staff. There was a focus on loss of reputation rather than patient safety risks. Performance data was collected and discussed at consultants' meetings but not at governance meetings.

However:

- Nursing staff engagement had improved in recent months. There was a good sense of teamwork and staff felt supported by their colleagues.
- Improvements in children's services and nurse-led patient assessment had been made in order to enhance the treatment of patients.

Vision and strategy for this service

- The leadership team were unable to describe a specific strategy for the emergency department. There was an expectation that it would be linked to the divisional business plan and the urgent care strategy for the south-west.
- A meeting had been planned for the end of January to formulate a nursing strategy for the department.
- The Emergency Care Intensive Support Team (ECIST) had visited the department in July and August 2015. Following their report an action plan had been drawn up but implementation had not always been as anticipated. For example, the improvement plan was not always monitored at department governance meetings and a full capacity protocol and internal escalation plan had not yet been agreed. Although bespoke leadership programmes had been completed by band 6 and 7 nurses, senior doctors had not yet taken part.

Governance, risk management and quality measurement

- The governance framework was not effective in identifying issues and risks that compromised patient safety in the emergency department The emergency department service level document (January 2016) stated that the governance structure was currently under review although the reasons for this review were not made clear.
- We were shown the departmental risk register but found that it included risks for medical wards. It was not specific to the emergency department. For example, the second highest risk was described as "Almost 100 unfilled nursing and HCA vacancies across the division". There were no details of the vacancies within the emergency department or the actions to be taken to address them.
- The highest risk was described as "Overall operational pressures and reduction in flow negatively influences the Trust 4 hour standard. This is a risk to RCHT reputation locally and nationally". Risk to patient safety due to long delays in assessment and treatment was a lesser consideration. The risk was first identified in February 2011.
- The risks described did not reflect the concerns described by staff in the department. These included a crowded department and not enough consultants.
- There was a lack of quality control measures. For example, there was no audit of patient records to determine whether risk assessments and clinical protocols were being carried out correctly. This meant that deficiencies in the use of the NEWS system, sepsis protocols and falls risk assessments had not been identified.
- Waiting times for most ambulance patients were not monitored. We asked for this information and were supplied with a large amount of raw data. Our own calculations revealed that the department is not meeting professional standards in this respect.
- The emergency department quality improvement plan stated that weekly NEWS audits will provide vigour in the monitoring of NEWS compliance. Audits had not been carried out weekly and the results had been variable. The most recent (6 January 2015) supplied to us showed a compliance of 87%. The quality improvement plan does not provide any outcome measure for the successful implementation of NEWS and we found consistent deficiencies in its use during our inspection.
- Other performance data such as the number of patients spending more than four hours in the department, time to triage and the number of patients leaving without being seen was collected monthly. This was discussed at consultants meetings but not at governance meetings.
- Governance meetings were not always held monthly as planned. For example none took place in August and September 2015. Agenda items were sometimes ignored. For example, clinical performance was not discussed between July and October and feedback from patients was not discussed between June and October.
- Actions agreed were not followed up. In July 2015 an audit of clinical handovers was presented and it was agreed that further work was needed in order to move forward. The topic was not discussed again at later meetings. A discussion following a serious incident identified the need to audit the quick triage tool. No audit or results appeared in subsequent minutes.

Urgent and emergency services

Leadership of service

- Leadership of the emergency department was not well established.
- There had been an interim senior nurse for the previous six months. Although she was described as "a force for good" and had been instrumental in making changes she was due to leave a week after our inspection. Her replacement had been appointed but also had responsibility for the medical assessment unit and ambulatory emergency clinic. This would leave limited time for visible leadership within the emergency department.
- A consultant nurse and an advanced practitioner had been recruited and were about to commence in post at the time of our visit.
- The general manager had been seconded from another department three months previously.
- The lead consultant described himself as "interim". He had been appointed to the senior role of divisional director three years previously and it had not been possible to recruit a replacement to his lead role in the emergency department. He therefore continued to undertake both roles. The trust was undertaking a review of clinical service management with a view to appointing a designated clinical director for the service. We have been advised that since the inspection this position has been filled.
- The leadership team were not visible in the department during our inspection. Nurses told us that the senior nurse was very approachable and that she was "the first port of call" if there was a problem. Her experience was appreciated.
- Day-to-day leadership was not effective. The nurse in charge of the department spent most of their time in major treatment one, rarely visiting other parts of the department. We found they often had no awareness of where the sickest patients were or what was happening to them. It sometimes left inexperienced nurses coping on their own in other treatment areas.

Culture within the service

- Staff told us that they felt respected and valued by their colleagues. Nurses told us that changes in nurses leadership in the last year had resulted in them feeling empowered to defend good patient care. They were optimistic that recent improvements would continue.
- Some doctors expressed resignation regarding the shortage of consultants in the department. It was regarded as a problem that was almost impossible to solve.
- Some staff told us that if they raised concerns they were regarded as "militant" and concerns were not always investigated in a sensitive way.
- Staff told us that the support that they received from their colleagues in the department helped them cope with the pressure which resulted when the department was very crowded.

Public engagement

- The matron of the department kept copies of patient feedback and letters of comment or complaint. Details of the friends and family test were available around the department.

Staff engagement

- Nurses told us that staff engagement had improved in recent months. Staff meetings were now being held and their concerns were listened to. They were kept informed of changes in the department and were consulted about future changes.

Innovation, improvement and sustainability

- We were shown an emergency department quality improvement plan for 2015. There were 21 key areas that needed to be addressed. One, adequate nurse staffing, was shown as complete.
- The implementation of a nurse-led rapid assessment and treatment system had reduced delays in the handover of ambulance patients.
- Recruitment of experienced children's nurses had improved children's services and has ensured that they meet national standards.

Medical care (including older people's care)

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

Information about the service

Medical care at the Royal Cornwall Hospital Treliske (RCHT) is delivered by the medicine division. Within this division there are 10 clinical specialties. These are acute medicine, cardiology, respiratory medicine, eldercare/ stroke medicine, gastroenterology/hepatology, endocrinology, neurology, nephrology (renal medicine), chronic fatigue service and clinical psychology. The trust provides a range of cancer services, which are managed by the clinical support services and cancer division, which, for the purpose of this inspection, are reported under medical care in this report.

The division has a budget allocation of £64.4 million and employs approximately 1,107 whole time equivalent staff.

There are 303 medical inpatient beds. The division also provides endoscopy, renal dialysis (the trust supports three renal dialysis units across the county) and outpatient clinics at multiple sites across Cornwall.

Inpatient care is provided as follows:

- Phoenix ward: stroke medicine
- Wheal Prosper ward: infectious diseases
- Roskear ward: cardiology
- Wellington ward: respiratory medicine with a six-bedded higher level care bay for patients who require additional care and support which may include non-invasive ventilation
- Kerensa ward: care of the elderly
- Grenville ward: renal medicine and endocrinology
- Carnkie ward: gastroenterology and care of the elderly
- Tintagel ward: Care of the elderly and neurology
- Coronary care unit: Cardiology
- Cardiac investigation unit: Inpatient and day case cardiology
- Lowen ward: clinical oncology
- Medical admission units: two wards (MAU 1 and MAU 2) which receive emergency medical patients (the medical take) who have been referred either by their GP or by the emergency department.

There is an ambulatory emergency care unit located adjacent to the emergency department which provides urgent assessment and treatment to patients who are unlikely to require an overnight stay. Where possible, medical acute patients referred by their GP are directed through the ambulatory emergency care unit where they are triaged to determine the most appropriate clinical pathway. Patients who meet the ambulatory criteria are managed by acute GPs and nurse practitioners, supported by acute physicians. The ambulatory emergency care unit operates between 8.30 am and 11pm Monday to Friday.

There is a chemotherapy day case centre (Headland Unit) and a medical day care unit, both of which operate from Monday to Friday.

There is a discharge lounge which operates Monday to Friday, from 7.30 am to 10pm, excluding bank holidays.

Medical care (including older people's care)

The unit can accommodate up to eight seated patients and six patients requiring a bed and aims to improve patient flow in the hospital by freeing up beds once a patient is ready to be discharged.

We previously undertook a comprehensive inspection at this hospital in January 2014. In June 2015 we carried out a focused follow-up inspection, where we identified the following concerns:

- Lack of sufficiently skilled staff in the high care bay on Wellington ward, which accommodated patients who required higher levels of care, including non-invasive ventilation. We took enforcement action with regard to this.
- Record keeping was not consistently maintained.
- Care and treatment for patients diagnosed with a new stroke were not responsive. Delays in discharging patients from the stroke ward, Phoenix ward, meant that patients were often cared for on other wards, affecting their access to therapeutic care.
- Outlying patients (medical patients who were accommodated on a non- medical ward) did not always receive timely and appropriate care.
- Cardiology procedures were frequently cancelled due to lack of cardiology beds.
- Discharge arrangements were not responsive.

We undertook a further follow-up visit in October 2015 to review the higher care bay on Wellington ward. We were satisfied at this time that necessary steps had been taken to improve staffing levels.

We visited the hospital between 12 and 15 January 2016 as part of the announced inspection and returned unannounced on the afternoon and evening of 25 January 2016. We spent time on Wellington, Phoenix, Roskear, Kerensa and Carnkie wards, the Cardiac Investigations Unit, Coronary Care Unit, Medical Admissions Units, Ambulatory Emergency Care, the Headland Unit and the discharge lounge. We also visited surgical wards (Eden ward, and the Surgical Admissions Lounge) where medical patients were accommodated. We spoke with 18 patients. We spoke with a wide range of staff, including ward-based medical and nursing staff, therapists and support staff, specialist nurses, bed coordinators, matrons and members of the divisional management team. We also attended a hospital-wide bed meeting. We observed care and treatment and looked at care records. We received information from our listening event and from people who contacted us to tell us about their experiences. Prior to and following our inspection, we reviewed performance information about the trust and a range of data provided by the trust.

Medical care (including older people's care)

Summary of findings

We rated this service as requires improvement overall because:

- There were insufficient numbers of staff and there was a heavy reliance on temporary staff and we could not be assured that they were appropriately skilled and experienced.
- Premises were mostly fit for purpose; however, we had continuing concerns about the unsuitable environment on Phoenix ward, which may have contributed to the high incidence of falls on this ward.
- We found wards and departments were visibly clean; however, environmental audits had identified that remedial works were required on some wards in order to reduce the risk of infection.
- There were systems in place to ensure that premises, equipment and medicines were maintained and used to protect people from avoidable harm ; however compliance with safe practice was not consistent in some areas. Compliance with mandatory training was variable so we could not be assured that staff were up-to-date with safe systems and practices.
- There was a 'safety aware' culture within the division and a focus on reducing risk. Although there was evidence that the medical division was taking action to reduce the incidence of patient falls, this was an ongoing concern and still needed to improve.
- Actions had also been taken to improve record keeping, particularly in respect of patient observations. However, further work was required to ensure improvements were sustained and embedded.
- The trust's mortality rate was above the national average. Reviews of chronic renal failure deaths and deaths from weekend admissions were in progress at the time of our inspection.
- Performance against national standards in relation to stroke care had made significant improvements; however, the service was still not meeting standards in relation to patients receiving prompt and appropriate care on a stroke unit. Key performance standards in cardiology were also not met.
- Nursing staff were not well supported, with an unstructured approach to training, development and clinical supervision. Appraisal rates across the division were poor, with only 56% of staff appraised as at December 2015.
- Bed capacity and patient flow were constant challenges. Patients did not always receive care and treatment in the most appropriate clinical setting. This meant inequitable standards of care were provided, with some patients having to wait longer for specialist support.
- Some patients waited too long for diagnostic cardiology procedures; investigations were sometimes cancelled at short notice and sometimes more than once.
- Some patients were moved several times during their inpatient stay, sometimes at night.
- Patients were not always discharged in a timely manner, partly due to staffing issues resulting in delayed assessment and treatment, but mainly due to difficulties arranging suitable care packages in the non-acute NHS sector.
- The service was not meeting referral to treatment targets in cardiology and respiratory medicine.
- The divisional management team was very focused on patient flow and was taking steps to improve efficiency and reduce delays and length of stay; however, the pace of change and progress was too slow. The ambulatory emergency care unit was a positive admission avoidance initiative but its effectiveness was limited by its operational capacity and the range of care and treatment it was able to offer.
- The service took account of patients' individual needs. We observed that nursing staff were attentive and responsive. Patients were given assistance when they needed it, whether this be assistance with personal care, mobility or support to eat and drink. The service had access to specialist support for people with complex needs, including older people; however, this was a limited resource and, given that older people represented a large proportion of the inpatient population, we judged that there was insufficient specialist training in dementia care.

Medical care (including older people's care)

- There were no overarching strategy or well-defined objectives for the medical division which set out how the service's vision was to be achieved. The approach to service delivery and improvement was sometimes reactive and, at times, counter-productive.
- The divisional leadership had suffered from instability and a lack of cohesiveness. This was changing but the management team had more to do to ensure that clinicians were fully engaged, supported and working together as a team.
- Staff morale was mixed, with staffing levels frequently cited by staff as having a negative impact on their working lives. Staff turnover and sickness levels, although improving, remained high. There was more to do to improve staff recruitment and retention and reduce reliance on bank agency and locum staff, for which expenditure was rising month on month.

However:

- Care and treatment was mostly provided in accordance with evidence-based guidance and good practice but there was a risk that some people may not receive effective care and treatment.
- The service participated in national clinical audits. Performance was variable, although there was evidence that improvements were made in response to these.
- We saw excellent multi-disciplinary team work at ward level, with a focussed and cohesive approach to care planning and discharge. Regular multidisciplinary "board" rounds took place and all relevant staff worked together to plan and deliver care to meet the range and complexity of people's needs. Junior medical staff felt well supported with regular teaching and supervision.
- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. Comments included: "Staff are amazing - it's absolutely brilliant!" This positive feedback was consistent with the results of patient surveys which were overwhelmingly positive.
- Patients told us they were treated with compassion, kindness, dignity and respect. They told us staff provided comfort and reassurance when they were anxious or distressed. A number of patients told us about acts of kindness where they considered that staff had gone 'above and beyond the call of duty'. One patient described their doctor as "the most caring doctor I have ever known."
- We observed that staff were polite and welcoming, greeting them and introducing themselves to patients. We saw that they were attentive and sensitive to people's different needs. Patients and those close to them were involved as partners in their care. Patients felt well informed about their condition, care and treatment. They told us that staff took time to explain things to patients and their families in a way that could understand.
- There was a comprehensive assurance system which provided a holistic understanding of performance from ward to board. Risks were understood but were not always effectively or promptly managed.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated this service as requires improvement for safety because:

- There were insufficient numbers of suitably qualified and experienced staff employed consistently to keep people safe. There was heavy reliance on temporary staff and we could not be assured that they were appropriately skilled and experienced.
- Premises were mostly fit for purpose; however, we had continuing concerns about the unsuitable environment on Phoenix ward, which may have contributed to the high incidence of falls on this ward.
- We found wards and departments were visibly clean; however, environmental audits had identified that remedial works were required on some wards in order to reduce the risk of infection.
- There were systems in place to ensure that premises, equipment and medicines were maintained and used to keep people safe; however compliance with safe practice was not consistent in some areas.
- Compliance with mandatory training was variable so we could not be assured that staff were up-to-date with safe systems and practices.
- Although there was evidence that the medical division was taking action to reduce the incidence of patient falls, this was an ongoing concern and still needed to improve.
- Actions had also been taken to improve record keeping, particularly in respect of patient observations. However, further work was required to ensure improvements were sustained and embedded.

However,

• There was a 'safety aware' culture within the division and a focus on reducing risk.

Incidents

- There were 1441 incidents reported by the medical division between July and September 2015, of which 818 were categorised as patient safety incidents. Eleven of these incidents were categorised as serious incidents. The top two categories of patient safety incidents were:
  - Pressure ulcers (319)
  - Slips, trips and falls (266)
- Pressure ulcers were the most commonly reported patient safety incident within the medical division, although these included pressure ulcers acquired before admission to hospital. There was a relatively low incidence of hospital-acquired pressure ulcers which caused moderate or serious harm. There were three grade 3 pressure ulcers reported in this period. There was a trust-wide pressure ulcer prevention group which monitored the incidence of pressure ulcers and oversaw the pressure ulcer prevention plan. The plan was last updated in October 2015. There was slippage on a number of identified actions and meetings had not been taking place regularly.
- There were 266 falls reported across the medical division from July to September 2015, equating to an average of 88 per month. Six falls reported during this period were categorised as serious incidents. Two occurred at West Cornwall Hospital and the emergency department (not reported in this inspection report). The remaining four incidents occurred on medical wards at the Royal Cornwall Hospital and resulted in serious harm to patients. Two patients sustained a fracture, one patient suffered a subdural bleed and one patient sustained a head injury and subsequently died. Although the trust was taking steps to mitigate the risk of falls, there was no indication that the incidence of falls was reducing over time. There was a trust-wide falls prevention group which had developed a falls action plan. The group met every two months to review progress against this plan. Actions included the identification and training of falls link nurses, the completion of ward environment audits and the roll out of focussed ward-based falls prevention training. The action plan demonstrated progress in these areas but some actions were not proceeding with pace.
- The incidence of venous thromboembolism (VTEs) was monitored monthly via the ward performance assurance framework. VTEs occur when a blood clot breaks loose and travels in the blood. In October 2015 there were two cases of hospital acquired thrombosis reported. These occurred on Wellington ward and the Medical Assessment Unit. All other wards were compliant.
- Staff received instruction on incident reporting as part of their induction training. Staff we spoke with understood their responsibilities to raise concerns and report incidents and they told us they were encouraged

to do so. They confirmed that they received feedback when they reported concerns, although they did not always believe that raising concerns made a difference. In the 2014 NHS staff survey the trust scored worse than the England average in response to the question which asked about the fairness and effectiveness of procedures for reporting errors, near misses and incidents.

- Regular mortality and morbidity (M&M) reviews were undertaken and reviewed within specialties at least every two months and reviewed quarterly by the divisional quality and governance board. This was to ensure that learning and improved practice resulted from reviews of clinical complications or unexpected outcomes. All serious incidents within the division were shared at specialty governance meetings to ensure share learning. For example, in October 2015 learning was shared arising from a patient death from sepsis, associated with intravenous therapy (cannula). Issues and themes were escalated to the trust-wide mortality review committee. The mortality review committee produced a monthly bulletin which was circulated medical staff to ensure shared learning.

Duty of Candour

- There was variable understanding amongst staff with regard to the duty of candour regulation, however, all staff understood and expressed commitment to the values of openness, honesty and transparency. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a new 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."

Safety thermometer

- Data was collected using the NHS safety thermometer. This is a national measurement tool used to record patient harms. Safety thermometer performance was monitored through the performance assurance framework which was produced and reported on at ward, specialty and divisional level.
- Data was collected on a single day each month and recorded the presence or absence of four areas of harm:
- Pressure ulcers: There were 65 pressure ulcers reported between November 2014 and October 2015, with no discernible trends identified. This includes both existing and hospital acquired pressure ulcers.
- Falls: There were 18 falls reported over the same period. Again, there were not any discernible trends in prevalence.
- Urinary tract infections in patients with a catheter (CAUTIs): there were 12 CAUTIs reported over the same period. Again, there were no discernible trends in prevalence.
- There were 16 venous thromboembolism (VTEs) reported between October 2014 and September 2015.

Cleanliness, infection control and hygiene

- There were 10 cases of Clostridium difficile reported in the division between April and October 2015.
- There were no reported cases of methicillin resistant Staphylococcus aureus (MRSA) bacteraemia between April and October 2015.
- We observed that wards and departments were visibly clean, tidy and free from offensive odours. We saw regular cleaning took place and staff disposed of waste appropriately. We saw staff use appropriate protective equipment, including gloves and aprons.
- Staff mostly observed standard hand hygiene precautions. We saw staff regularly washed their hands and patients told us that they witnessed this also. We noticed however that there were insufficient hand gel dispensers at the entrance to some wards. Most staff observed the 'bare below the elbow' policy. However, on Roskear ward we witnessed two junior medical staff who entered the ward without washing their hands. One doctor continued to wear a coat during a ward white board round. This was not challenged by other staff.
- There were side rooms on each ward where patients with confirmed or suspected infections could be isolated and barrier nursed to prevent the spread of infection. Notices were displayed to prevent unauthorised persons from entering these isolation areas.
- Several patients commented on the cleanliness of the environment. One patient on Wellington ward told us "It is spotlessly clean here."
- There were monthly audits of infection control and a range of performance indicators were reported upon, including hand hygiene and compliance with aseptic non-touch technique (ANTT) - to minimise the risk of

infection which could occur during preparation, administration and delivery of intravenous therapy. Results for October 2015 showed mostly good levels of compliance for hand hygiene, although room for improvement was identified on Carnkie ward and the Coronary Care Unit. Compliance was generally good for ANTT, with the exception of MAU, Grenville and Kerensa wards.

- In the 2015 patient-led assessment of the care environment (PLACE) cleanliness scored 100% compared with the England average of 98%. However, ward based environmental audits undertaken by infection control nurses to assess the condition of facilities and equipment in relation to cleanliness showed less positive results. Audits undertaken in March, April and May 2015 showed scores of between 47% and 91% (85% and above was classed as compliant). Non-compliant wards included the Cardiac Investigations unit, Carnkie ward, Coronary Care unit, Grenville ward, Phoenix ward, and Wheal Prosper ward. We asked the trust to provide more recent audits so that we could see that actions had been taken to improve environmental standards. We did not receive this assurance. For example, audits supplied for Carnkie ward showed that concerns had been identified in August 2015 in relation to cleaning standards (scoring 59%), kitchen (66%) and store room environments (40%). No evidence was provided to show that recommended actions had been completed or the areas re-audited since.
- Compliance rates for staff training in infection control variable, with junior medical staff being the worst performing group. There were also particularly poor levels of compliance for nursing staff in endoscopy (32%) and on CCU (47%).

Environment and equipment

- Premises were mostly appropriately designed, laid out and equipped to keep people safe. Wards were well lit and there were appropriate floor finishes to reduce the risk of slips, trips and falls. Toilets and bathrooms were large enough to allow people to be assisted with personal care and could accommodate equipment, such as lifting aids.
- When we inspected this service in June 2015 we found that the environment on Phoenix ward was poor. The ward corridors were cluttered with equipment which presented a risk of trips and falls. One of the showers on Phoenix ward was not suitable for patients with a physical impairment. A high step had to be negotiated to access the area and the space was limited for staff to support patients who may not be able to stand alone. This bathroom had now been refurbished and access improved. However, the ward corridors continued to be cluttered with equipment. We were concerned also that some of the bays were not clearly visible to staff so patients could not be easily observed, thereby increasing the risk of falls.
- In the 2015 patient-led assessment of the care environment (PLACE) the trust's facilities scored 94%, compared with the England average of 90%.
- Wards were appropriately equipped. We checked a range of equipment and found it to be well maintained and clean. There were systems in place to ensure that resuscitation equipment was regularly checked. Checks took place daily with seals intact (this was to ensure that the equipment was tamper-evident) and once a week the seals were broken and a full check took place. We found that checks had mostly take place consistently; however, we identified some gaps in recording on Kerensa, Wellington and Tintagel wards.
- There was a daily safety checklist completed in higher care bay on Wellington ward to ensure that all equipment was clean and fit for purpose.

Medicines

- Medicines were mostly appropriately and securely stored and we saw that appropriate checks had been undertaken daily, including those for fridge temperatures and controlled drugs. However, on Kerensa ward we found numerous gaps in recording of fridge temperatures. On Roskear Ward we found that although fridge temperatures had been regularly checked, there were numerous occasions recorded when the minimum and or maximum temperatures had been outside of the acceptable range. Staff had not recorded a second reading when this occurred or taken advice from pharmacy. The nurse in charge did not know how to reset the fridge temperatures.
- Pharmacists were employed to support medical wards and this support was felt to be adequate. Responsibilities included stock checking and top up, monitoring medicines administration charts and medicines reconciliation. This is the process by which

pharmacists check that they have the correct information about patients' medicines to make sure they continue to be given correctly during their hospital stay.

Records

- When we inspected this service in June 2015 we found that records of nursing care and observations were not completed consistently throughout the wards and departments. Omissions included pressure area checks, position changes, continence checks and fluid balance charts. We also had concerns that patients' records were not stored securely.
- Improvements had taken place. Records were stored securely in steel cabinets which were kept locked. Nursing documentation was better organised, with folders divided to allow for easy location of documents. Observation charts were kept at the end of patients' beds to make them more accessible. Regular audits of documentation were taking place, although these highlighted there was still room for improvement. There was a record keeping improvement project ongoing on the cardiology and respiratory wards. On Wellington ward a checklist had been developed which was available in each patient bay and highlighted progress on completion of each patient's records, highlighting sections still to be completed.
- We checked a sample of nursing care records on the wards we visited and found that these were improved. Observation charts, care rounding records and fluid balance charts were mostly consistently completed. However, we found a number of records where nurses had not timed, dated and signed entries in patients' notes and not all pages had patient identifier labels in place. This meant there was a risk that records could be mislaid or misfiled because they were not identifiable to individual patients.
- There were regular audits of medical staff record keeping. In March 2015 an audit of medical notes on MAU identified the following areas for improvement: handwriting, identification of the ward and responsible clinician on each page and checking results on the electronic patient records system. In June 2015 an audit of doctors' clerking notes showed good compliance in relation to the presence of patient labels, recording of presenting complaint, history of present illness, drug history and management plan. Improvements were needed in recording national early warning scores (NEWS) - a tool to determine the degree of illness of a patient using physiological readings, consultants completing safety checklists and dementia scoring[SE1].

Safeguarding

- Staff we spoke with demonstrated a good understanding of their responsibilities to safeguard people from abuse and their responsibility to report concerns. Most staff had received mandatory safeguarding training; however some junior medical staff were not up-to-date with this training.
- People in vulnerable circumstances were identified on the ward-based electronic based information system using a recognised symbol. Staff told us they notified the trust's safeguarding team of such patients.

Mandatory training

- Not all staff were up-to-date with mandatory training in safe systems, processes and practices to keep people safe. Compliance rates with mandatory training were variable, showing some room for improvement. Within the medical division overall compliance with mandatory training was 78% in December 2015. Particular areas of concern were Kerensa ward (67.9%), Coronary Care Unit (77.5%), Grenville ward (75.3%), Phoenix ward (77.8%), Renal Unit 71.9%, Roskear ward (76.5%), Wellington ward (76.5%). Some staff on Kerensa ward expressed concern that they were expected to undertake mandatory training in their own time. A staff member on Phoenix ward also told us that scheduled training was sometimes cancelled at short notice and they had to re-arrange it in their own time and were not always able to get time off in lieu when this occurred.

Assessing and responding to patient risk

- The trust had developed quality care indicators, including a risk assessment pack to be completed within six hours of a patient's admission, and early warning scores, based on a range of physical observations. At our previous inspection we found that risk assessments were not consistently completed. Compliance with these indicators was now audited each quarter in each inpatient area. Compliance in quarter two (July to September 2015) was generally high (above 85%), with the exception of Carnkie ward (78%) and Grenville ward, where compliance had been consistently poor for the previous 12 months.

Medical care (including older people's care)

- There was a comprehensive risk assessment checklist completed for every patient on admission. This included assessments for the risk of falls, malnutrition and developing pressure ulcers. We found these were mostly fully completed on the wards we visited.
- Falls risk assessments were undertaken in accordance with guidance produced by the National Institute for Health and Care Excellence (NICE) in 2013. NICE recommends that the following groups of inpatients should be regarded as being at risk of falling in hospital and their care should be managed accordingly:

1. all patients aged 65 years or older
2. patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition.

- NICE recommends a multifactorial risk assessment be undertaken which includes assessment of continence and toileting, medicines, balance, blood pressure, vision and footwear. We looked at a sample of patients' records and saw these assessments were undertaken consistently, with the exception of blood pressure recording. Management plans set out measures in place to reduce the risk of falls. These included frequent care rounds, close observation by staff, and the provision of non-slip footwear and falls mats.
- The trust participated in the 2015 national audit of inpatient falls published by the Royal College of Physicians to assess and benchmark their performance against NICE standards. They performed poorly in relation to:
- medicines review and an assessment for medicines that increase risk of falls
- vision assessment
- oral and written information given about falls
- measurement of blood pressure
- an assessment for the presence of delirium and a delirium care plan in place
- an assessment of cognitive impairment and a care plan to support the patient with cognitive impairment
- a falls care plan in place
- a mobility care plan in place

Actions had been incorporated into the trust-wide falls prevention plan.

The trust score in the mid-range in relation to:

- assessment of urinary continence and a toileting plan in place
- a record of use of walking aids

The trust scored well in relation to:

- assessment of fear of falling
- appropriate mobility aid in reach
- environment free of clutter
- call bell in sight and in reach of patient
- a record of the level of mobility
- asked about a history of falls
- patient had safe footwear.

- Patients were assessed for the risk of developing a pressure ulcer within six hours of admission in accordance with NICE guidance. We checked a sample of patients' records on each of the wards we visited and saw that risk assessments had been completed.
- Patients were assessed for venous thromboembolism (VTE) and bleeding on admission and re-assessed after 24 hours in accordance with NICE guidance. Compliance with this standard was monitored via the ward performance assurance framework. In October 2015 all wards were compliant.
- Patients who were admitted urgently were assessed using the National Early Warning System (NEWS). This is a nationally recognised system which allows clinicians to quickly determine the degree of illness of a patient by monitoring their vital signs. The NEWS observation chart included clear 'RAG rated' guidance on the steps for staff to follow if observations highlighted a concern.

- There was a NEWS and Escalation of Care improvement Programme led by the matron for respiratory and cardiology wards. This had entailed education and training, implementing changes in recording and communication practices and weekly peer audit of documentation. The aim was to improve 95% compliance with this safety system. Results after one year showed progress, although with room for improvement, with yearly averages by ward ranging from 80% to 90%.The project report which published these results in December 2015 concluded that contributory factors to poor compliance included increased demand, patient acuity and dependency, sub optimal staffing levels and use of temporary staff.
- A system of escalating concerns had been introduced comprising communication prompts which were used to alert clinician colleagues of concerns that required

immediate attention. SBAR - Situation Background Assessment Recommendation, is a nationally recognised communication tool. This had been adapted to include 'Decision'. SBAR-D information was recorded on bright yellow 'escalation of care' labels, which were affixed in patients' notes.

Nursing staffing

- There was a significant shortfall of registered nurses and healthcare assistants throughout the medical division.
- The nurse staff establishment was set using guidance published by the National Institute for Health and Care Excellence (NICE) Safe staffing for nursing in adult inpatient wards.
- Staffing levels (staff in post versus the funded establishment) were monitored and reported in the monthly performance assurance framework. In September 2015 there was a vacancy rate of 23% for registered nurses. All but three medical wards had a deficit of over 10%. The vacancy rate for other clinical staff (excluding medical staff) was 19%. Of particular concern were Tintagel ward with a 62% deficit and Wellington ward with a 47% deficit. The sickness rate across the division was consistently high and was 4.7% in December 2015.
- Nurse staffing vacancy rates by medical specialty as at October 2015 were as follows:

- Cardiology: 5.9%
- Elder care: 23.3%
- Emergency medicine (MAU and ambulatory care) :7.5%
- Endocrine: 0%
- Gastroenterology: 2.2%
- Medical management: 8.2%
- Neurology: 0%
- Renal: 6.3%
- Respiratory:12.4%
- West Cornwall: 6.9%

- There was significant reliance on temporary staff to ensure that wards were staffed to planned levels. The number of shifts filled by ward each month was monitored and published. The Safe Staffing report for December 2015 showed staffing deficits on some wards by day and by night. Average day shift fill rates for registered nurses were below 90% on the cardiac investigations unit, Kerensa ward and Wheal Prosper ward. The average fill rate for healthcare assistants was also below 90% on Wheal Prosper ward. At night time the average fill rate for registered nurses was below 90% on the coronary care unit and for healthcare assistants on Wheal Prosper wards. Conversely, data showed that staffing levels were frequently increased above planned levels when patient acuity or dependency demanded this.
- There was a Safe and Supportive Observations Policy which set out criteria for requesting additional staff to provide close observation of vulnerable patients. Staff told us that they were mostly able to source additional temporary staff support when required.
- The Safe Staffing report included comments from senior nurses on each ward to support the data (assurance statements). Most areas summarised their staffing situation as satisfactory because risks were continually assessed and staffing used flexibly.
- Many staff, including senior staff, expressed concerns about the significant use of temporary staff. At the divisional governance and quality meeting in November 2015 it was noted that there had been some improvement in covering shifts across the division. However, it was further noted that "agency staff do not fulfil the full role and responsibility on the wards as substantive staff." In the Safer Staffing report for December 2015 it was recorded in relation to Wellington ward: "Due to vacancies staffing safety in advance continues to be a challenge. Other wards are currently supporting and shifts are being covered with bank and agency."
- Staff told us that, where possible, wards employed temporary staff who were known to them, although this was not always possible. They expressed concerns about the variable quality of temporary staff and frustration that permanent staff worked longer and harder because temporary staff were not familiar with the ward or did not have the necessary range of skills. One staff member told us "some temporary staff are brilliant; others don't have a clue." Another staff member told us that temporary healthcare assistants were not always trained to undertake observations which put pressure on existing staff. Another member of staff told us that temporary staff who were unfamiliar with the ward or the specialty "put a strain on existing staff. For example, not all temporary registered nurses were able to administer intravenous medicines or use the electronic prescribing and medicines administration system.

Medical care (including older people's care)

- There was a trust-wide wide generic induction checklist which temporary staff had to complete before beginning work. On the Headland unit a specific competency based assessment was undertaken of temporary staff before they started work on the unit. On Wellington ward a ward-based induction checklist had been drafted, although this was not yet in use.
- There was an ongoing programme of nurse recruitment, including overseas recruitment. There were a number of initiatives in place to improve recruitment and retention, including the employment of apprentices who may progress to healthcare assistants. There were also opportunities for healthcare assistants to acquire advanced skills to progress to the role of healthcare practitioner.
- In the 2014 national inpatient survey the trust scored 6.9 out of 10 in response to the question which asked patients if they felt there were enough nurses on duty to care for them. This was about the same as other trusts. In the 2014 national cancer experience survey the trust scored in the bottom 20% of trusts nationally in response to the question about staffing levels.
- In the 2014 national inpatient survey the trust scored 6 out of 10 in response to the question which asked patients if their call bell was answered quickly. This was about the same as other trusts. During our ward visits we observed that staff were visible in all patient areas and responsive to call bells. However, staff told us they were not always able to respond to patients' needs as quickly as they would like. On the MAU, where there was a significant shortfall of registered nurses and healthcare assistants, staff told us that the planned staffing level of one registered nurse and one HCA to each six-bedded bay was sometimes not achieved, with the ratio sometimes being one to nine.
- When we inspected this service in June 2015 we found that there were insufficient suitably skilled nurses employed on Wellington ward, particularly in the high care bay where level 2 patients (who required a higher level of care, monitoring, observation and intervention) were cared for.
- When we returned to inspect this service in October 2015 staffing levels had been increased so that there was a ratio of one registered nurse to two patients and there was always a minimum of one registered nurse in the high care bay when colleagues had to leave the bay. There were processes in place to ensure that the dependency and acuity levels of patients in this bay were continually assessed so that staffing could be adjusted as required. Although there was significant use of temporary staff to achieve the required staffing levels, we were assured that only nurses with the required competencies would be employed in this bay. All temporary staff were required to complete a trust wide induction checklist and the ward was in the process of developing a local induction checklist which focussed specifically on respiratory care competencies. The ward was continuing to recruit more staff in order to reduce its reliance on temporary staff.
- When we returned in January 2016 staffing levels continued to be a challenge, although there was an ongoing recruitment campaign, which included overseas recruitment. There were nine registered nurse vacancies on the ward and therefore significant reliance on temporary staff. Block booking of temporary staff was taking place to provide continuity of care. Staff told us that temporary staff were routinely deployed in the higher care bay because they were supervised there. We were told that experienced HCAs were sometimes used as a third member when there were insufficient registered nurses, although HCAs were never left on their own in the bay.
- The ward used an assessment tool to assess the acuity of patients in the higher care bay and the number of nurses required to provide the level of care required.
- The ward had developed a competency framework and nursing staff were being supported to acquire specific skills related to respiratory care. These ranged from foundation (essential skills), progressing to a level where nurses were competent to work in the higher care bay, to the 'gold standard' required of specialist nurses (band 6 and above). At the time of our visit three of the19 substantive nurses had achieved specialist nurse competencies and 12 out of 19 nurses had achieved the competencies to work in higher care. The ward sister told us that the aim was for all staff to complete these competencies within two years. Records did not provide evidence that this was proceeding with any pace (although a programme of internal staff training ('Mash up Mondays') had begun in September 2015) or that timeframes for completion had been agreed with individual staff members. Temporary staff who were regularly deployed on the ward were not required to achieve these competencies. We noted that the

competencies did not include arterial blood gas (ABG) interpretation as recommended by the British Thoracic Society. The ward sister was the only nurse who was able to complete this process.

- The trust risk register (January 2016) recorded an extreme risk relating to nurse staffing levels on Lowen Ward. It was recorded: "there are inadequate numbers of staff trained in the administration of chemotherapy on Lowen Ward to provide cover 24 hours a day and insufficient on Headland to meet continuing high demands placed on the service. Patients are therefore at risk of not being able to have their planned chemotherapy treatment on time and there is risk of a need for a waiting list. Patients' chemotherapy treatments being delayed which could have an impact on the prognosis of patients." At our listening event a relative told us that their family member's chemotherapy treatment had recently been delayed because of a lack of capacity in the department. Actions in place included ongoing recruitment of registered nurses and block booking of agency chemotherapy nurses.
- There were detailed and structured nurse handovers and safety briefings when shifts changed morning and night so that incoming staff were familiar with their patients' needs and any known safety risks.

Medical staffing

- There were a number of medical staff vacancies across the division.
- There was currently one whole time equivalent consultant vacancy in respiratory medicine, with a further anticipated vacancy. The specialty had advertised three times for substantive applicants without success and had been unable to source adequately qualified locums for several months. The service was currently being supported by a number of short term locums who primarily covered outpatient work and gaps in the on call rota. Concerns were expressed by both medical and nursing staff about poor consultant cover out of hours and at weekends, which was jointly covered by respiratory and endocrinology consultants.
- The gastroenterology service had seen a significant rise in referrals over the last 12 months and a business case was in the final stages of preparation, to increase the medical team. This was in order for them to deliver this increased activity and provide enhanced cover out of hours.
- Consultant vacancies and absences in elder care had impacted on the available consultant resources to support the ED by reviewing frail, elderly patients.
- The trust risk register recorded an extreme risk relating to insufficient oncology capacity. This meant that acute oncology inpatients were not reviewed by a consultant every day as required by cancer standards. The service was unable to provide rapid assessment clinics which would enable patients to be reviewed acutely and discharged, pending review at these clinics (also a requirement of cancer standards). In order to mitigate the risk, acute oncology patients were reviewed by oncology specialist nurses supported by a junior doctor and escalated to consultants for urgent review if they had concerns. A business case was being prepared for the recruitment of additional consultants.
- Junior medical staffing had recently been reduced on the stroke ward (Phoenix), with the transfer of one junior doctor to support the transfer of neurology beds to another ward. There was one junior doctor covering the ward and their workload was high, such that they frequently worked late and were unable to take breaks.
- Nursing staff on a number of wards expressed concerns about the level of medical cover out of hours and felt that junior doctors were too thinly spread". One staff member told us "It is sometimes scary when we have deteriorating patients". There was one junior doctor on duty to cover each of the ward blocks, supported by a medical registrar and a consultant on call. Staff felt that when the hospital was busy this was inadequate.
- There were senior medical staff (decision makers) available at all times in the MAU. This was in accordance with Quality Standards for Acute Medical Units (June 2012). There was consultant cover from 8am to 7.45pm Monday to Friday and at weekends from 8am to 5pm. Nights were covered by a consultant on call. Registrar cover was provided in the evening and at night the MAU was covered by junior doctors and a registrar from the hospital at night team.
- There was consultant cover provided on medical specialty wards from 8am to 5pm Monday to Friday. At weekends medical ward cover was provided by the general physician on call. Overnight cover was provided by a registrar as part of the hospital at night team.

Medical care (including older people's care)

- Consultant gastroenterologists provided a GI bleed service 24 hours a day, seven days a week. Dedicated lists were provided six days a week.
- Junior medical staff told us they had adequate access to and support from consultants. Consultant reviews took place regularly and junior doctors were not asked to perform tasks that they are not competent in or comfortable with.

Major incident awareness and training

- There was a trust-wide Capacity Management Escalation Plan (September 2014) which provided guidance on responsibilities in the event of surges in demand or incidents which disrupted normal service provision. Senior clinical staff were familiar with this policy and their responsibilities to take appropriate steps to minimise risks to patients. A divisional escalation plan was under development.
- Capacity status within the hospital was categorised as 'green' (business as usual) through 'amber' and 'red' to 'black' (significant internal incident) escalation status. There were a series of triggers within the medical division which if met, may result in escalation to a higher status. These included bed availability, expected and actual discharges and staffing.

Are medical care services effective?

Requires improvement

We rated this service as requires improvement for effectiveness because:

- Performance against national standards in relation to stroke care had made significant improvements; however, the service was still not meeting standards in relation to patients receiving prompt and appropriate care on a stroke unit. Key performance standards in cardiology were also not met.
- Nursing staff were less well supported, with an unstructured approach to training, development and clinical supervision. Appraisal rates across the division were poor, with only 56% of staff appraised as at December 2015.

However:

- Care and treatment was mostly provided in accordance with evidence-based guidance and good practice but there was a risk that some people may not receive effective care and treatment.
- The trust's mortality rate was above the national average. Reviews of chronic renal failure deaths and deaths from weekend admissions were in progress at the time of our inspection.
- The service participated in national clinical audits. Performance was variable, although there was evidence that improvements were made in response to these.
- We saw excellent multi-disciplinary team work at ward level, with a focussed and cohesive approach to care planning and discharge. Regular multidisciplinary "board" rounds took place and all relevant staff worked together to plan and deliver care to meet the range and complexity of people's needs.
- Junior medical staff felt well supported with regular teaching and supervision.

Evidence-based care and treatment

- Patients' needs were assessed and their care planned and delivered in line with evidence-based guidance, standards and good practice such as National Institute for Health and Care Excellence (NICE) guidelines.
- The respiratory multidisciplinary team used the British Thoracic Society care bundle for chronic obstructive pulmonary disease (COPD) and community acquired pneumonia (CAP). Care bundles are care pathways based on a series of protocols aimed at achieving specified outcomes.
- There were heart failure clinical management pathways for left ventricular systolic dysfunction (LVSD) and acute decompensated heart failure in accordance with NICE guidelines. There were heart failure symptom management plans in place using patient symptom diaries and guidance for patients on when to seek help.
- The chest pain service had developed a draft chest pain care bundle. There was a clear acute coronary syndrome assessment pathway in place and a chest pain pathway. A 'one stop' clinic for chest pain was provided where patients were reviewed by the chest pain specialist nurse, diagnostic tests performed and discussed with the consultant.
- Advanced nurse practitioners (ANPs) in acute oncology provided an effective 24 hour telephone advisory service for patients receiving chemotherapy treatment.

There was an established pathway for patients with suspected neutropenic sepsis, who were seen promptly by an ANP in the Acute Admissions Unit or the Ambulatory Emergency Care Unit.

- The trust was accredited with the Joint Advisory Group (JAG) on GI endoscopy in February 2015. This means they have been assessed as meeting a range of national quality and safety standards. The gastroenterology team had a well-established jaundice hotline clinical pathway. This enabled GPs to refer patients to the service using a proforma and patients were generally seen and given an endoscopic procedure within 48 hours.

Pain relief

- The trust used a care rounding tool which ensured that patients' levels of comfort were regularly assessed. This included asking patients if they were in pain. Completion of these rounds was regularly audited.
- In the 2014 inpatient survey the trust scored 8.1 out of 10 in response the question which asked patients whether hospital staff did all they could to help control their pain if they were ever in pain.
- Patients we spoke with told us their pain was managed promptly and effectively.

Nutrition and hydration

- Patients had nutritional assessments undertaken on admission. Where risks were identified their nutritional and fluid intake was monitored. We looked at a sample of records on each of the wards we visited and saw that this was managed well. Care rounds were documented and showed that patients were offered drinks at appropriate intervals.
- Patients who required assistance to eat and drink were identified on admission and their needs were documented (using a red tray symbol) on the ward electronic patient information board. These identified patients were served their meals on a red tray so that staff were alerted to the fact that assistance was required. Patients had access to drinking water at all times. There were regular drinks rounds and we saw staff offer assistance to those patients who needed it.
- There was a dietetic service which supported all medical wards and ensured patients were provided with appropriate dietary advice and support.

Patient outcomes

- The trust's mortality rate was higher than the national average. The trust's risk register (January 2016) identified specific areas of high mortality, which included acute stroke, pneumonia and post chemotherapy lung cancer. There were specialty-led mortality reviews, overseen by the medical division and the trust-wide mortality review committee.
- Stroke care:
- In the Sentinel Stroke National Audit Programme (SSNAP) the trust improved its performance significantly, scoring 'C' for the period April to June 2015, compared with 'E' in the period July to September 2014. Scores range from 'A' (highest) to 'E' (lowest). The trust scored 'A' for team-centred scanning for all four quarters. Performance was poor for most of the other indicators.
- In November 2015 the division reported positive results against key performance indicators:
- 71% of patients had CT scans within 60 minutes and 98% within 12 hours.
- 86% of patients received a swallow assessment within four hours
- 78% received a swallow assessment within 72 hours
- However, the aspects of the stroke pathway which were dependent on patient flow continued to be poor, with only 51% of stroke patients spending 90% of their time on the stroke unit (the contracted target was 92%). The number of patients directly admitted to the stroke unit within 4 hours was 38% against the contracted target of 67%.The trust told us about a number of initiatives to improve performance which included a protocol to protect stroke beds, moving neurology beds to another location to create a dedicated stroke unit and the provision of a stroke coordinator role on the stroke unit. There was also a review of the specialist nurse support with progression to seven-day working and succession planning. The trust had a detailed action plan which was monitored and reported through the stroke programme board. It was recognised that "further review of the pathway together with partners was also required to deliver sustainable improvement."
- The medical division's risk register recorded that haemorrhagic stroke patients did not receive care and treatment in accordance with national guidelines. Patients were currently cared for on the intensive care unit because there were insufficient specialist nurses

employed on the stroke unit to provide the level of care required. The risk register highlighted that this lack of specialist care could have a negative impact on patient outcomes.

- Cardiology:
- In the Myocardial Ischaemia National Audit Project (MINAP) (2013-14) there was mixed performance. A higher proportion of the trust's patients with non-ST segment elevated myocardial infarction (nSTEMI) was referred for or had angiography. A lower proportion was seen by a cardiologist or member of their team and a lower proportion were admitted to the cardiac unit or ward.
- In the Heart Failure Audit 2013/14 the trust performed worse than the England and Wales average for all but one of the indicators relating to in-hospital care. It scored worse than the average for all the indicators relating to discharge. The recommendations were incorporated into the cardiology action plan (see below).
- The service was not meeting NICE standard 3: Chronic heart failure in adults (June 2011) which states that patients with suspected heart failure should be seen by a specialist and have an echocardiogram within two weeks. The heart function nurse reported that they were currently working hours which were significantly in excess of their contracted hours. However, a second specialist nurse was to be appointed.
- The service was not meeting commissioned service key performance indicators relating to the nurse chest pain pathway. These related to length of inpatient stay and outpatient follow-up.
- An external MDT peer review was conducted by the South West Cardio-vascular Network and a report was published in November 2013. The report made a number of recommendations which formed the basis of a cardiology action plan:
  - Progress to date included the introduction of a telephone pre-assessment service for all elective cardiology inpatients,
  - eradication of the backlog of patients waiting for angiography (a diagnostic procedure used to assess the diagnosis of coronary heart disease),
  - agreement of a protected bed policy for the cardiac investigation unit,
  - improved throughput in the cardiac catheterisation laboratory
  - clearance of the backlog of patients waiting for 24 hour tape analysis (diagnostic procedure to monitor heart rhythm).

  The medical division reported to us that progress had stalled since mid-September 2015 due to operational pressures. The action plan was re-drafted in January 2016.

- Diabetes:
- The trust scored worse than the England and Wales median for 12 of the 20 scored indicators in the 2013 National Diabetes Inpatient Audit. Since the audit a number of actions had taken place to improve patient experience and outcomes. These included:
  - the appointment of an additional endocrine consultant (currently recruiting),
  - the introduction of a foot assessment for all diabetic patients,
  - the establishment of a weekly multidisciplinary foot team meeting to assess patients with active foot disease
  - the introduction of mandatory training for junior doctors and pharmacists in insulin administration and a monthly insulin errors group.
- Cancer care:
- All national cancer access standards were met as at October 2015.
- The trust participated in an external peer review of national cancer standards in March 2015.Results were variable across cancer sub-specialities but common issues highlighted were lack of oncologist resources (haematology, head and neck, thyroid, acute oncology and cancer of unknown primary), and attendance at network groups and MDT patient reviews.
- The trust's risk register (November 2015) recorded an extreme risk relating to failure to implement standards in relation to the management of patients with cancer of unknown primary or secondary cancer. The register stated there was a risk that patients with a cancer of unknown primary do not receive appropriate discussion and subsequent care in a timely fashion. This was because they were not complying with guidance set out in the Manual for Cancer Services: Cancer of Unknown Primary Measures published by the national peer review programme in 2014. We were told during our visit that these cases were reviewed by the upper gastrointestinal MDT and followed up by oncology advanced nurse practitioners.

- Another area of serious concern highlighted by the review was the lack of Clinical Nurse Specialist support provided to patients diagnosed with thyroid cancer.
- A work plan had been developed in response to the recommendations of the external peer review and these were monitored by the cancer steering group. Progress had been achieved in some areas but the appointment of a second specialist nurse to support patients with thyroid cancer was not likely to be achieved until December 2016.
- The risk of readmission was below the England average (better) for both elective and non-elective care overall at Royal Cornwall Hospital for the period August 2014 to July 2015. However, the risk of readmission was higher than average (worse) for elective gastroenterology and non-elective respiratory medicine.

Competent staff

- Patients had confidence in the doctors and nurses who treated them. In the 2014 inpatient survey the trust scored 8.9 out of 10 for having confidence in the doctors who treated them and nine out of 10 for confidence in the nurses treating them. This was about the same as other trusts.
- Junior doctors told us they felt well supported with protected time for formal teaching, including simulation training and a weekly presentation. In addition they told us they benefitted from informal teaching during ward rounds.
- Nurse education and supervision was less structured; staff told us they did not receive regular education and clinical supervision. On Wellington ward a competency framework had been developed which all nurses were required to complete. This set out a range of essential and desirable competencies specific to respiratory care. Teaching, including simulation training was provided at sessions known as 'Mash up Mondays'. All registered nurses who were on duty on this day were required to attend (facilitated by senior staff covering ward duties) and off duty staff were also encouraged to attend.
- Nursing staff did not receive regular formal supervision and their performance was appraised only once year at their annual appraisal. Group supervision was provided through staff meetings but these were infrequent and irregular on some wards. Appraisal rates across the division were poor, with only 56% of staff appraised in December 2015.
- There were link nurses allocated to support colleagues in specialist areas such as infection control and dementia care. However, on Wellington ward the ward sister told us that there were insufficient permanent staff to allow delegation of all identified roles.
- There were clinical nurse specialists who provided advice, support and training to staff trust-wide. These included nurse who specialised in the complex needs of older people and specialist learning disability nurses. Ward staff told us these services were supportive and responsive.

Multidisciplinary working

- Regular multidisciplinary patient reviews took place to ensure that all relevant services worked together to provide seamless care. Regular multidisciplinary "board" meetings took place on all wards. At the meetings we observed, staff demonstrated a holistic approach to assessing people's individual needs, including consideration of their physical, psychological and social needs. They worked together develop a coordinated plan to meet the range and complexity of needs.
- Staff and teams worked well together to deliver coordinated care and treatment. One patient on Wellington ward told us "The difference here compared with other hospitals I have been in is that they all work together as a team." Another patient told us "I am impressed by the treatment and their communication with each other."
- There were pathways in place for referrals between team and specialists, both within and outside of the hospital. The nephrology service reported good relationships with surgeons via multidisciplinary team meetings if patients required surgical intervention. They had also developed new ways of working with GP colleagues so that immediate advice could be given without the patient having to attend an outpatient clinic.
- There was an effective multidisciplinary stroke pathway, with a coordinated approach between the ED, stroke nurse, stroke consultants, radiologists, ITU and stroke ward staff, and outpatient TIA clinics. This ensured that stroke patients received prompt diagnosis.
- The MAU received specialist advice from elder care, respiratory, cardiology and gastroenterology

consultants. However, responsiveness of this support was reported by MAU staff to be variable. This meant there was a risk that patients' length of stay on MAU may be extended.
- Staff in respiratory and cardiology reported a shortage of physiotherapists (two whole time equivalent staff). They told us that this resulted in a limited service where they had to prioritise cardiology patients and patients awaiting discharge. They were unable to review patients who required rehabilitation.

Seven-day services

- Acute physicians had increased their weekend working commitment from one in six to one in three weekends in order to better manage flow in the department. Recruitment was underway to employ a further two acute physicians at the time of our visit.
- The ambulatory emergency care unit currently operated five days a week, although there were plans to increase to six-day working shortly, and a business case had been developed to extend to seven-day working.
- Pharmacy services were available seven days a week, with an on call service provided out of hours.
- Diagnostic imaging services were available seven days a week, with specialist imaging provided by on call clinicians.
- Endoscopy was available seven days a week for gastrointestinal bleeds.
- Pathology services were available seven days a week, although there was no consultant cover over the weekend for histopathology.
- Access to physiotherapy and occupational therapy services was available at weekend, albeit reduced. There was access to overnight respiratory physiotherapy. Concerns were expressed by staff on several wards, particularly the stroke ward, about the under-resourced speech and language therapy service, which was not available at weekends. There was no dietetic service provided at the weekend.
- Access to specialist nurses to support older people, people living with dementia and people with a learning disability were only available from Monday to Friday.
- The discharge lounge was open from Monday to Friday only.
- A business case for seven-day working within respiratory medicine was being developed. The case was for at least two additional consultants and up to four additional nurse specialists, in addition to administrative support, to meet current service demands and to support a seven-day "hot clinic" for respiratory ambulatory emergency care referrals.
- We were told about a patient on the respiratory ward who had been 'nil by mouth' over a weekend because specialist support was not available to insert a nasogastric (NG) tube. The patient required endoscopic guided NG tube insertion and this specialist support was not available at the weekend. An NG tube is a tube passed into the stomach via the nose to provide nutritional support for patients who are unable to take substances orally.

Access to information

- Patients' records were accessible to all members of the multidisciplinary team and staff reported no problems with access to information when patients moved between teams.
- There were electronic information boards on each ward which provided a convenient 'at a glance' overview of the ward and each patient. There was a range of symbols used as alerts to highlight specific needs or areas of risk, for example, patients who had been identified as being at risk of falls, patients living with dementia and patients who required assistance to eat and drink.
- Care summaries were sent promptly to GPs to ensure continuity of care within the community. The performance assurance framework for December 2015 showed that 75% of discharge summaries were sent within 24 hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good understanding of their responsibilities in relation to consent, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).
- Training in the Mental Capacity Act 2005 was provided as part of mandatory safeguarding training. As referred to under 'Safeguarding' (above), most staff had completed this training, with the exception of some junior medical staff.

Medical care (including older people's care)

- Where people lacked capacity, staff made best interests decisions in accordance with legislation. On Roskear ward we saw an appropriate DoLS application had been made, after ruling out possible medical reasons for incapacity.

Are medical care services caring?

Good

We rated this service as good because:

- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. Comments included: "Staff are amazing - it's absolutely brilliant!" This positive feedback was consistent with the results of patient surveys which were overwhelmingly positive.
- Patients told us they were treated with compassion, kindness, dignity and respect. They told us staff provided comfort and reassurance when they were anxious or distressed. A number of patients told us about acts of kindness where they considered that staff had gone 'above and beyond the call of duty'. One patient described their doctor as "the most caring doctor I have ever known."
- We observed that staff were polite and welcoming, greeting them and introducing themselves to patients. We saw that they were attentive and sensitive to people's different needs. Patients and those close to them were involved as partners in their care. Patients felt well informed about their condition, care and treatment. They told us that staff took time to explain things to patients and their families in a way that could understand.

Compassionate care

- Patients and their families were treated with dignity, respect and compassion. There was a strong sense of a culture in which staff felt passionately about the individuals they cared for. At a multidisciplinary meeting on Phoenix ward we heard staff discussing patients with affection and empathy.
- In the 2014 inpatient survey the trust scored 9.2 out of 10 in response to the question which asked if nurses did not talk in front of them as if they weren't there.
- We observed staff introducing themselves to patients. The trust had signed up to the 'Hello my name is…' campaign. This national campaign encouraged and reminded healthcare workers of the importance of introductions in the delivery of care.
- We saw that staff took the time to interact with patients and those close to them in a friendly, respectful and considerate manner. This included greeting patients when they first arrived on the ward and saying goodbye to them when they left. The ward sister interrupted a discussion with us so that they could go and say goodbye to a patient who was being discharged. One patient on Wellington ward told us "I feel at home here and my relatives feel welcome." Another patient told us "I feel amongst friends here." A patient on Carnkie ward described staff as "very well-mannered and respectful".
- A patient on Carnkie ward told us about an act of kindness shown to a fellow patient on the ward. They told us that this patient liked to occupy themselves with a colouring book. One day their coloured pens had run out and the following day a nurse brought the patient a new set of pens and refused payment for these.
- Another patient, who had undergone an invasive procedure, which caused them great anxiety, told us about the support they had received from a doctor, who had held their hand throughout the procedure. They told us "he is the most caring doctor I have ever known. He even took time out to come to the ward (following the procedure) to check on me."
- Staff took steps to protect people's privacy and dignity. This was not always easy as some ward areas were a little cramped. However, staff were very aware of the importance of privacy and dignity. They drew curtains when private conversations, physical examinations or care took place. In the 2014 inpatient survey the trust scored 8.6 out of 10 in response to the question which asked patients if they were given enough privacy when discussing their condition or treatment and 9.5 out of 10 for being given enough privacy when being examined or treated.
- Patients told us that when they experienced pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way.
- The trust used the friends and family test (FFT) to capture patient feedback and this showed high levels of

satisfaction (mostly above 90% of responses were positive). The FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family.

- The division also conducted "here and now" surveys which asked patients to rate their care overall and to comment on issues such as communication, privacy and dignity, assistance with personal care, pain management, assistance to eat, call bell being in easy reach and call bell response times. Responses were generally positive.

Understanding and involvement of patients and those close to them

- Patients and those close to them told us they were kept informed about their condition and their treatment. A patient told us that their family had been regularly updated and given advice.
- Care and treatment was explained in a way that patients could understand. In the 2014 inpatient survey the trust scored 8 out of 10 in response to the question which asked patients if doctors and nurses answered questions in a way that they could understand. One patient told us "I felt part of the team; they showed me my x-ray and explained everything to me."
- On Wellington ward there was a relatives' surgery held one day a week so that relatives could discuss their family member's ongoing care with senior nursing staff.
- In the 2014 cancer patient experience survey (for inpatients and day case patients with a primary diagnosis of cancer discharged between September and November 2013) 93% of respondents rated their care as 'excellent' or 'very good'. The trust scored in the top 20% nationally in 25 questions, in the middle range in 43 questions and in the bottom 20% for two questions.
- The high performing areas included: given easy to understand information about tests and test results, given choice of different types of treatment, patients' views taken into account by doctors and nurses discussing treatment, given information about side effects, patients involved in decisions about care and treatment, staff asked patients what name they preferred to be called by, patients got understandable answers to important questions, doctors did not talk in front of patients as if they weren't there, patients' family had opportunities to talk to the doctor. The low performing areas related to patients seeing information in the hospital about cancer research and having enough ward nurses on duty.

Emotional support

- During our visit patients told us they were given support to help them cope emotionally with their care, treatment or condition. One patient on Wellington ward told us "there is always someone there if I want them." Another patient told us they appreciated "regular checks on my wellbeing." A patient on Carnkie ward told us "Staff were very caring when I was upset about being here for a long time." Another patient told us that when they were anxious about receiving the results of tests, the doctor made them a priority, and helped to calm their nerves.
- Nurses completed a holistic assessment for each patient on admission. This included reference to the patient's psychological wellbeing. In the sample of records we checked, we noticed that this was not always recorded. We could not be assured therefore that people's needs in this respect had been fully considered.
- In the 2014 inpatient survey, the trust scored 5.6 out of 10 for finding someone on the hospital staff to talk to about any worries or fears and 7.2 out of 10 for receiving emotional support from hospital staff.

Are medical care services responsive?

Requires improvement

We rated this service as requires improvement for responsive because:

- Bed capacity and patient flow were constant challenges. Patients did not always receive care and treatment in the most appropriate clinical setting. This meant inequitable standards of care were provided, with some patients having to wait longer for specialist support.
- Some patients waited too long for diagnostic cardiology procedures; investigations were sometimes cancelled at short notice and sometimes more than once.
- Some patients were moved several times during their inpatient stay, sometimes at night.

- Patients were not always discharged in a timely manner, partly due to staffing issues resulting in delayed assessment and treatment, but mainly due to difficulties arranging suitable care packages in the non-acute NHS sector.
- The service was not meeting referral to treatment targets in cardiology and respiratory medicine.
- The divisional management team was very focused on patient flow and was taking steps to improve efficiency and reduce delays and length of stay; however, the pace of change and progress was too slow. The ambulatory emergency care unit was a positive admission avoidance initiative but its effectiveness was limited by its operational capacity and the range of care and treatment it was able to offer.
- The service took account of patients' individual needs. We observed that nursing staff were attentive and responsive. Patients were given assistance when they needed it, whether this be assistance with personal care, mobility or support to eat and drink. The service had access to specialist support for people with complex needs, including older people; however, this was a limited resource and, given that older people represented a large proportion of the inpatient population, we judged that there was insufficient specialist training in dementia care.

Service planning and delivery to meet the needs of local people

- Facilities and premises were mostly suitable for the services delivered. Royal Cornwall Hospital is the main acute hospital providing medical services in Cornwall.
- There was a new a new cardiology radial lounge for the provision of straightforward cardiology procedures which could be undertaken as a day case, thereby helping to reduce waiting lists and improve patient flow in cardiology. This was in the final stages of commissioning at the time of our visit.
- There was an ambulatory emergency care unit which provided urgent assessment and treatment for patients who may not require admission to hospital. The purpose of this unit, including referral criteria and exclusion criteria, and had been clearly set out in operational guidelines. This document described the purpose of the unit as to allow for "a timely and specific decision to be made in order to streamline care of patients referred by GPs or the emergency department) and avoid hospital admission where possible." The unit was currently operation from Monday to Friday, with plans to extend to a six-day service (anticipated February 2016) and eventually, a seven-day service. The ambulatory emergency care unit saw about 18 patients per day. The trust told us that the discharge rate, i.e. the proportion of patients who did not require admission to an inpatient bed was currently 60%. This indicated that the unit was being used appropriately and effectively and that extending its hours of operation would help to relieve pressure on hospital beds at the weekend.
- There were currently no rapid access clinics in ambulatory emergency care unit, although there were plans to develop these. This would support early discharge from MAU and admission avoidance by providing access to urgent specialist assessment in an ambulatory setting.
- The trust was not always able to provide single-sex accommodation for patients. It was reported in the integrated performance report to the trust board in November 2015 that there had been three non-clinically justified single sex accommodation breaches in October that affected four people. Two of these occurred on Wellington ward in the higher care bay, the other was a patient on the Coronary Care Unit (CCU). Staff told us they were very aware of the need to protect people's dignity and did all they could to overcome the challenges presented by the physical environment. They confirmed that no complaints had been received from patients who received care in mixed sex bays. There was a single sex log maintained in the higher care bay, completed twice daily. Patients who no longer required level 2 care (and did not therefore meet the criteria for a clinically justified breach) were immediately notified to the site manager so that an alternative bed could be found.
- The Endoscopy Unit at RCHT was in the process of a refurbishment in situ. The new unit had four endoscopy suites, as well as a seminar room and three recovery bays. New decontamination units were also in the process of being commissioned which would provide scope decontamination facilities for all specialities within RCHT.
- There was an elder care ward which was designated 'dementia friendly'. Kerensa ward had recently been re-designed, and refurbished to provide a safe and appropriate environment for patients living with

dementia. Design features included different coloured bays to help patients to orient themselves, matt floor finishes, appropriate lighting and seating and a reminiscence area.

Access and flow

- Patients did not always receive treatment in the right place at the right time due to increasing demand and poor patient flow.
- Patient flow was affected by delayed transfers of care. A significant number of patients remained in hospital after they had been assessed as fit for discharge. This had been a long-standing challenge for the trust. There were over 27,000 delayed transfers of care in the period April 2013 to August 2015. Of these, a significant proportion (and a significantly higher proportion than the national average) was attributed to waiting for further non-acute NHS care.
- The trust monitored its performance in relation to delayed transfers of care. This was reported monthly via the performance assurance framework from ward to board. It was reported to the trust board in January 2016 that delayed transfers of care accounted for 7.1% of total bed days (well above the 3.5% expected national maximum), with an average level of 62 patients per day being fit for discharge from acute wards.
- Although the average length of stay was slightly lower (better) than the England average for elective and non-elective care overall at RCH from September 2014 to August 2015, elective clinical oncology and cardiology, and non-elective cardiology and respiratory medicine had a higher than average length of stay. In December 2015 the average length of stay for elective patients was 2.8 days for elective patients and 4.7 days for non-elective patients. The division also monitored the daily average number of patients whose length of stay was more than 10 days and more than 30 days. This was showing a worsening trend, with a daily average of 125 patients with a length of stay over 10 days and 37 patients with a length of stay over 30 days.
- There was an Adult Discharge and Transfer Policy (2013) policy which set out standards based on best practice as outlined in the Department of Health's guide Ready to go? and the Ten essential steps to effective discharge (2010).
- The policy promoted effective discharge planning which began on admission and was regularly reviewed via the MDT board round process. Discharges were encouraged seven days a week and before 11am to aid patient flow. The division's performance framework monitored performance against these standards. It was reported that in December 2015 19.4% of discharges took place in the morning. Division-wide data was not available for weekend discharges but ward data showed that performance was well below the desired level. The policy did not make reference to the discharge lounge and how this could be used to help facilitate patient flow. Staff acknowledged that this facility was under-utilised, accommodating approximately 12 patients per day and it was not operational at weekends.
- Patients were frequently admitted to inappropriate wards because of issues of bed capacity and patient flow. The medical division's risk register (December 2015) recorded an extreme "red" risk as follows:

- "There is a risk of patients not receiving care in the right setting as a result of continuing high levels of delayed transfers of care for patients awaiting packages of care and /or care/nursing home availability. Patient impacts include an increased risk of acquiring a hospital acquired infection, an increased risk of falls due to poor mobility in an inappropriate environment and the potential for detriment to patients' wellbeing. This also impacts on the Trust's ability to manage flow through ED, potentially impacting on patient safety."
- The escalation ward, which had been used previously when there was extreme pressure on bed capacity, was no longer operational. There were four escalation beds on Tintagel ward but it had become the norm to accommodate additional medical patients on non-medical wards. The bed manager told us that at times of extreme pressure, patients had been accommodated on the Newlyn Unit, which was a day case unit. The trust confirmed that 117 inpatients were accommodated on this unit from 10 December 2015 to 9 February 2016.
- During our visit there were approximately 40 medical patients accommodated on non-medical wards, in addition to four patients on Tintagel ward. These were known as medical outliers. There was an Outlier Policy (August 2013) which set out the principles and criteria to be followed to ensure that only suitable patients were accommodated on non-medical wards. Patients were identified as suitable for outlying only if they met essential criteria; they were clinically stable, had a

diagnosis and/or treatment and discharge plan in place, had a known and documented resuscitation status, and were not undergoing treatment for MRSA bacteraemia. Medical specialities had linked non-medical wards where outlying patients would be accommodated and there was a named physician who was responsible for reviewing these patients.

- We visited two surgical wards where medical patients were being cared for: Eden ward and the surgical admissions lounge. Eden ward was a 28 bedded gynaecology ward. During our visit, between seven and 17 of these 28 beds were occupied by medical outlier patients. We were told this number had been as high as 22.
- Staff expressed frustration that patients were sometimes inappropriately referred to their wards, usually late in the day, and that their concerns were overruled by site managers. One staff member told us "this is a dumping ground for care of the elderly patients."
- Concerns were recorded in the minutes of the trust-wide falls prevention group meeting held in December 2015 about patients being transferred from the medical admissions unit to Eden ward out of hours and an associated increase in falls on the ward. It was recorded that there were sometimes 18 to 22 medical outliers on the ward and insufficient falls sensor mats were available to patients, who were at risk of falls.
- Staff on both of these wards confirmed that medical patients were appropriately reviewed by physicians and that this occurred daily, although it did not take place with the same regularity as reviews of the host ward's specialty patients. Some staff reported that at weekends they sometimes found it difficult to arrange medical reviews. One staff member told us, "we can be ringing all day to get a patient reviewed." They also expressed concerns that there was insufficient junior medical staff presence at the weekend and this sometimes led to delays in urgent reviews of patients when requested. A number of staff told us they did not report their concerns through the incident reporting process because they did not have time.
- Staff also reported that support from physiotherapy and occupational therapy was more difficult to access than on medical wards because they were less well resourced. They told us this sometimes led to delayed reviews, sometimes increasing patients' length of stay. We saw an example of this. A frail elderly patient had been admitted to the Eden ward following a fall because there were no care of the elderly beds available. It was recorded the day after admission that the plan was to discharge the patient within 24 to 48 hours. A physiotherapy assessment did not take place for two days and an occupational therapy assessment did not take place for four days. After five days the patient was still in hospital. A second elderly patient, also admitted following a fall waited four days for an occupational therapy assessment.
- Some patients were moved too often during their inpatient stay. The number of bed moves during a patient's stay and the number of bed moves at night was not currently monitored and there was no policy and guidance relating to this. During the period October 2014 to September 2015, 13% of patients moved wards twice or more during their admission. Patients were sometimes moved at night (after 10pm). This was a frequent occurrence on the medical admission units (MAUs). In September 2015 a total of 546 patients were moved at night. On average three patients a night were moved from a medical ward (excluding MAUs). An improvement plan had been developed by the medical division, which was to be informed by a review of data to understand where patients moved from and to, and the reasons for their move. There were plans to develop a policy for out of hours moves which would include criteria for any move agreed after 10pm. This was to become a performance indicator within the division.
- The trust was meeting the18 week referral to treatment time target (RTT) overall; however the target was not being met in cardiology and respiratory medicine. This standard requires that 90% of admitted patients start consultant-led treatment within18 weeks of referral.
- When we inspected the service in June 2015 we were concerned that some patients waited too long for cardiac procedures. The referral to treatment target for cardiology was not being met, with only 84.8% of patients receiving treatment within 18 weeks. Patients' procedures were frequently cancelled, sometimes at very short notice and after they had been admitted to hospital for their procedure. Some patients had experienced more than one cancellation. Cancellations and delays occurred because:
- Elective cardiac beds were being used to accommodate medical outliers. In January 2016 we found that, although steps had been taken to improve this performance, including the introduction of a protected

bed policy in the cardiac investigations unit, delays and cancellations continued to occur, due to the high numbers of acute medical admissions. At times of pressure on bed availability medical patients were admitted to the cardiology unit. This led to the beds not being vacated in time for the planned cardiology patients to be admitted to the unit for their procedure. Between 1 October 2015 and 22 January 2016 a total of 80 elective cardiac procedures were cancelled, of which 68 were cancelled on the day. Eleven patients had their procedure cancelled more than once. Six procedures were cancelled due to threatened industrial action by junior doctors on 1 December 2015. Two complaints were received between October 2015 and January 2016 in relation to cancelled procedures. Some additional short term capacity to undertake certain procedures had been sourced from private providers in order to keep waiting lists down. However, staff expressed frustration that patients continued to have procedures cancelled at short notice and that some patients, such as patients who required angiography, experienced delays more than once and up to three times. Staff told us that site managers continued to admit acute medical patients to elective inpatient and day case beds, resulting in elective procedures being cancelled. This included procedures such as the implantation of an implantable cardioverter defibrillator (ICD) which is a device that monitors heart rhythm and delivers electrical treatments when needed. Abnormal heart rhythms, if not corrected can cause death. Delays increased risks to patient safety, caused inconvenience and distress and also resulted in under-utilisation of the cardiac catheter laboratory and the health professionals employed there. In January 2016 the current waiting lists for diagnostic cardiac procedures was 82 patients. The situation had not improved since our inspection in June 2015.

- Patients were ill prepared for their cardiac procedures because they had not been adequately assessed prior to admission. In response to this the trust had introduced a pre-assessment service.
- When we inspected the service in June 2015 we were concerned that stroke patients did not receive a responsive service.
- Stroke patients did not always receive specialist care on a stroke ward. This was because of problems with patient flow which meant that specialist beds were blocked by outlier medical patients or patients whose discharge was delayed because they were not able to access rehabilitation packages of care in the community in a timely way. This was reflected in the Sentinel Stroke National Audit Programme (SSNAP) score of E (scores range from A to E, with E being the worst). In November 2015 the trust had introduced a policy which ensured that two beds (one for each gender) were 'protected'. This meant that medical outliers could not occupy these beds and increased the chance that a patient who had suffered a stroke would be admitted directly to a specialist stroke ward. As a result of this, the trust's overall performance against SSNAP standards had improved from E to C. Performance against the standards which require patients to be admitted directly to a stroke unit and spend most of their inpatient stay on a stroke unit had improved, although it remained well below the targets. In December 2015 neurology beds, previously located on Phoenix ward were moved. This meant that Phoenix ward became a dedicated stroke unit. However, when we visited the ward during our unannounced visit on 25 January 2016 we saw that medical outliers continued to occupy beds on this ward.
- In June 2015 we reported that patients who had received thrombolysis treatment were admitted to ICU for periods sometimes in excess of 24 hours because there were insufficient numbers of skilled staff for the required observation on the stroke ward. While this ensured patients received the required immediate treatment, they were not cared for in an appropriate therapeutic environment supported by appropriate nursing and therapy staff. This continued to be the case at the time of our inspection in January 2016.
- The trust was taking steps to reduce the risks associated with poor patient flow.
- There was regular dialogue with health and social care partners to facilitate and expedite appropriate packages of care in the community.
- There was joint working with the onward care team, run by the local community healthcare trust. The onward care team attended bed meetings and supported ward staff to facilitate packages of care in the community.
- There were bed meetings held three times daily to review hospital activity including bed occupancy, number of patients in ED, expected admissions, transfers and discharges and medical outliers.

- There were weekly meetings to review all patients whose length of stay was 10 days or more to investigate reasons for delay and to ensure that appropriate actions were initiated or escalated as appropriate.
- Daily multidisciplinary board rounds were held on each ward to review patients' plans of care, including discharge. We observed several of these meetings during our visit.
- The ambulatory emergency care unit, established in November 2014, was a positive admission avoidance initiative, although limited by its capacity.
- However,
- There was limited access to rapid access clinics to enable acute physicians to refer patients to attend outpatient clinics and avoid admission. There were irregular pleural effusion clinics and delays of up to two weeks were sometimes experienced for referral to the medical day care unit where conditions such as this could be treated without the need for admission.
- There was no admission prevention team or frailty service to support acute physicians to facilitate early discharge or prevent admission to the medical admissions unit (MAU).
- There was no data available to measure the effectiveness of the MAU's discharge and admission avoidance processes.

Meeting people's individual needs

- The service delivered care which took account of the needs of different people, including those in vulnerable circumstances or with complex needs. However, care for people living with dementia needed some improvement.
- We saw that staff were visible in ward bays and were attentive and responsive to patients' needs. Patients had call bells within their reach, although we rarely heard them sound. Regular care rounds took place to ensure patients' comfort. These included checking patients' toileting needs and that they had access to a drink. Care rounds were arranged with a frequency which was assessed according to patients' dependency.
- Patients told us they had enough to eat and drink and they were offered choice and alternatives. In the 2015 patient-led assessment of the care environment (PLACE) the trust scored 93% for the quality of food, compared with the England average of 88%. One patient commented to us about "really nice food." They told us "I was really surprised by the quality and selection." Another patient, who had spent time in the hospital before, commented that during his most recent stay, that the food was better presented and there was greater choice. A third patient told us "I like the food and I look forward to mealtimes."
- On Wellington and Roskear wards we observed a quiet hour after lunch when lights were dimmed, visitors discouraged and patients were able to rest.
- The trust had a Dementia Care Policy (January 2015) which set out objectives aligned to the national dementia strategy and the Quality Standards for Dementia Care published by the national Institute for Health and Care Excellence (NICE).
- The trust was monitored by commissioners against a national target, Commissioning for Quality and Innovation (CQUIN) in relation to the identification and care of patients with dementia and other forms of cognitive impairment. This was reported to the trust board each month and showed that the trust was consistently exceeding the 90% target, with a year-to-date performance of 99.48% in November 2015.
- The trust commissioned the Alzheimer's Society to conduct monthly surveys to capture feedback from patients living with dementia and their carers. Reports were provided twice yearly to the Trust Management Governance Committee. The most recent report (October 2015) reported on feedback received from April to September 2015. Findings were mainly positive:
- Patients were treated with dignity and respect. Staff were described as caring, they interacted well with patients and in a way that the patient understood.
- Patients and carers were positive about the environment which was felt to be appropriate for the needs of people living with dementia.
- Most patients/carers reported that adequate support was provided to support people who required assistance with eating and drinking.
- The use of 'This is me' was increasing, although it was still not universally used.
- Pain was managed well. This is a profile, often completed by family members or carers, which sets out patients' needs and preferences, which they may not be able to communicate themselves.
- Some areas for improvement were identified:

Medical care (including older people's care)

- Whilst some staff were reported to be very knowledgeable about dementia care, other staff, particularly agency staff, showed less awareness of the needs of people who were living with dementia.
- Some patients/ carers were unhappy about being moved to another ward at night, which they reported, caused anxiety and disorientation.
- Some carers felt that they were not involved in their relative's care.
- Some patients and carers were not sure who they should complain to if they were concerned about any aspect of care.
- Some patients reported being bored and said they would like someone to talk to.
- Some carers were not aware of the carers' information leaflet.

- Patients living with dementia were identified on the electronic ward information boards using a forget-me-not symbol (a nationally recognised symbol which helps staff recognise when someone is experiencing memory problems or confusion). We noted however that the symbol was not displayed on the white boards at each patient's bedside. This meant that some visiting staff, such as housekeepers, may not be alert to this status. One registered nurse we spoke with was not familiar with the forget-me-not symbol.
- We saw that some patients living with dementia, although not all, had a 'This is me' booklet within their patient records. The Dementia Care Policy stated that this profile should be completed for all patients living with dementia or with mild cognitive impairment. It stated that the documents should be visible in the bed space for all staff and volunteers to see, to support the person in all communications and interactions. This was not the case during our inspection.
- Most staff had received awareness training in dementia care as part of their mandatory training and annual clinical updates. This training was delivered through the provision of a leaflet. However, a number of staff we spoke with told us they had not received specialist training in dementia care, despite the fact that a significant proportion of patients in their care were living with dementia or experiencing memory issues. The Dementia Care Policy set out the trust's commitment that people living with dementia received care from staff appropriately trained in dementia care. It stated that dementia awareness training (tier 1) was provided as part of induction and annual mandatory training programmes. It stated that additional learning and development opportunities were available for various clinical staff groups but it was not clear which staff groups this referred to.
- We were told that there was a network of 'forget-me-not champions', with around 90 staff across the hospital who attended quarterly meetings and received training so that they could provide advice and support to their colleagues in relation to dementia care. We were not able to speak with any of these identified staff during our visits; however, we did speak with one of the trust's two older persons' specialist nurses. These specialists, who provided a service from Monday to Friday, worked closely with the elder care wards and supported the emergency department and the medical admissions unit, visiting these departments daily and liaising with care homes and community services and supporting discharge arrangements. They provided support and advice to staff in other areas of the hospital by referral and focussed particularly on dementia care and care for people with Parkinson's disease.
- The older people's specialist nurses had coordinated a number of initiatives to support older people with complex needs. These included the recruitment of volunteers. College students were employed on Kerensa and Tintagel wards providing befriending support and assistance with meals. There were campaigns to encourage staff and visitor donations of objects which could be used to create or renew memory boxes used on some of the elder care wards and to recruit volunteers to knit 'twiddle muffs'. These are knitted hand muffs with items such as ribbons and buttons attached. They are used to provide a source of visual, tactile and sensory stimulation for people living with dementia who have restless hands. The specialists had also successfully trialled the use of alarmed devices to remind staff to administer medication to patients with Parkinson's disease.
- Staff could also refer patients to the complex care and dementia liaison service, which was provided five days a week by a third party organisation.
- Patients with a learning disability were identified through the patient information system and staff told us that support could be sought from the trust's learning disability liaison service. Three specialist nurses provided a trust-wide service from Monday to Friday. Staff told us that patients with a learning disability

would often be cared for in a side room where carers could also be accommodated. The trust had set up a system to identify for people with a learning disability who were known to them and the local authority. With their permission, patients' names and details were shared and a flag added to the patient administration system. This meant that on arrival in the emergency department, patients were identified and an email alert would be sent to the learning disability liaison service. A member of the team would then visit the patient. Although this wasn't a seven-day service, the team would follow up any patients admitted to medical wards which occurred out of hours, even if they had been discharged.

- The national inpatient survey (2014) highlighted that there was room for improvement in relation to the information that patients received when they went home. Some patients, who had been given medicines to take home, reported that they had not been told about medication side effects to watch out for. Some patients said that they had not been told about any danger signs to watch for after going home and some patients reported that their family and friends had not been given information about how to help care for them if needed.
- A telephone translation service was available and staff knew how to access this if required.

Learning from complaints and concerns

- In the 2014 inpatient survey the trust scored only 2.6 out of 10 in response to the question which asked patients if they had seen or been given any information explaining how to complain to the hospital about care received.
- Staff were familiar with the complaints procedure. They told us that complaints and any learning arising from them were discussed at team meetings and safety briefings.
- Complaints were investigated and responded to in a timely way. Responsiveness was monitored as part of the monthly divisional performance assurance framework which showed the division performed well in December 2015.
- Themes and trends were discussed at specialty meetings and areas of concern were escalated to the divisional quality and governance board. Staff we spoke with in wards areas were not able to describe any changes that had been made as a result of complaints However, the divisional management team provided some examples of changes in practice following complaints:
- Relatives were offered an opportunity to speak with a doctor after a patient has passed away. This was now offered as standard practice.
- Leaflets issued to patients undergoing an endoscopy had been amended to clarify the requirement to stop medicines prior to the procedure.

Are medical care services well-led?

Requires improvement

We rated this service as requires improvement because:

- There were no overarching strategy or well-defined objectives for the medical division which set out how the service's vision was to be achieved. The approach to service delivery and improvement was sometimes reactive and, at times, counter-productive.
- The divisional leadership had suffered from instability and a lack of cohesiveness. This was changing but the management team had more to do to ensure that clinicians were fully engaged, supported and working together as a team.
- Staff morale was mixed, with staffing levels frequently cited by staff as having a negative impact on their working lives. Staff turnover and sickness levels, although improving, remained high. There was more to do to improve staff recruitment and retention and reduce reliance on bank agency and locum staff, for which expenditure was rising month on month.

However:

- There was a comprehensive assurance system which provided a holistic understanding of performance from ward to board. Risks were understood but were not always effectively or promptly managed.

Vision and strategy for this service

- The medical division's management team shared with us their goal which was "to be recognised for the quality, safety, innovation and productivity of the division's

services". Staff we spoke with were not familiar with this statement but they articulated a similar vision and commitment to shared values, which were very much focussed on safety and high quality patient care.
- There was no overarching strategy shared with us or articulated by staff, which set out how the division's goal was to be achieved. Many staff described a "reactive" or "fire-fighting" culture. There was a widely shared perception that improvements were made in response to regulatory action taken by organisations, such as the Care Quality Commission, or recommendations from other external bodies.

Governance, risk management and quality measurement

- There was a clear, well-structured governance system, informed by up-to-date and reliable management information. The division's performance was monitored and measured through the performance assurance framework which was published monthly and was discussed at ward, specialty and divisional management level. The divisional performance assurance framework formed the basis of performance reviews with the executive team each month, and in turn, the specialty performance assurance framework formed the basis of monthly reviews with the divisional management team. Ward performance assurance frameworks informed regular matrons' meetings with ward managers.
- There was a holistic understanding of performance. The performance assurance framework focussed on a number of domains: quality (patient experience and safety), operational (patient activity and flow issues), finance and workforce. In addition, specialty governance leads contributed to the monthly quality reports, sharing information on patient feedback, including complaints, incidents and risks.
- Risks to patient safety and quality were well understood but were not always mitigated effectively or promptly enough. Risk registers were maintained and monitored at specialty and divisional level. Risks were regularly discussed by the divisional quality and governance board and de-escalated to specialty level or escalated to trust level as appropriate. Poor patient flow was acknowledged as one of the biggest challenges facing the division and the trust. Steps had been taken to improve this but they were neither imaginative nor innovative and some steps were counter-productive. The failure to implement a bed protection policy in a sustained way until November 2015 had resulted in unresponsive care to stroke patients and considerable financial penalties for the trust because key national standards were not met. Cardiac waiting lists were being addressed by contracting elective work to the private sector because non-elective medical patients blocked beds.
- Regular matrons' rounds took place. In the respiratory and cardiology specialty the format of this had recently been changed and it was now structured around the Care Quality Commission's five domains; safe, effective, caring, responsive and well-led. Ward performance was 'RAG rated'. and there were reviews of actions take since the last round. We were also told that governance leads within the medical division were conducting ward visits, undertaking what were described as "mini friends and family tests".

Leadership of service

- The service was led by a divisional management team made up of a divisional director, divisional manager and divisional nurse. Each specialty was managed by a clinical lead, a matron and an operational service lead. The divisional nurse was an interim appointment and the divisional manager was a relatively new appointment. There had also been numerous staff changes at matron and ward manager level but it was felt by the management team that they were now a more stable and cohesive management team, with all key positions filled.
- In the 2014 NHS staff survey the trust scored worse than the England average in relation to support from immediate managers and the percentage of staff reporting good communication between senior management and staff. However, most staff told us they felt supported, valued and respected by managers.
- Ward sisters were visible and accessible. Matrons were regular visitors to the ward and were seen to be supportive. Staff views varied as to the visibility of the divisional senior nurse. However, they had regular meetings with matrons and ward sisters and this was felt to have improved communication and cohesiveness.
- Staff told us that the main source of information was via daily safety briefings. These meetings took place at staff handover times and their purpose was primarily to

communicate patient information and safety messages. Ward sisters held staff meetings and produced staff newsletters; however, these were neither frequent nor regular on some wards.

- Many staff commented positively about the chief executive who had earned the reputation of listening and engaging with staff. One staff member on MAU told us that the chief executive had visited the ward on Christmas day and this had boosted staff morale. The newly appointed director of nursing was not yet well known but had recently visited one ward during a night shift and this had been appreciated by staff.

Culture within the service

- Staff we spoke with told us they mostly enjoyed working at RCHT, although many commented that morale was impacted by inadequate staffing levels and the resulting pressure of work. Sickness levels and staff turnover, although improving, were still high. In the 2014 staff survey the trust's scores in relation to staff motivation at work and job satisfaction were worse than the England average.
- The trust scored worse than the England average in relation to the percentage of staff who had experienced harassment, bullying or abuse in the last 12 months and the percentage of staff who reported feeling pressure in the last three months to attend work when feeling unwell. Sickness absence rates were above the national average.
- New staff and temporary staff told us that ward staff were friendly and welcoming. However, there was some evidence of silo working, and inter-specialty tension, most acutely felt by acute physicians, some of whom felt unsupported by divisional management and other medical specialties. In the 2014 NHS staff survey the trust scored lower than the national average for 'effective team working'. Team working at ward and department level was frequently cited as one of the best things about working at RCHT.
- In the 2014 NHS staff survey the trust scored worse than the England average in relation to the percentage of staff who agreed that they would feel secure raising concerns about unsafe clinical practice. However, most of the staff we spoke with told us they felt comfortable to raise concerns and did so.

Public engagement

- In the 2014 NHS staff survey the trust scored worse than the England average in relation to the percentage of staff who agreed that feedback from patients was used to make informed decisions in their directorate/ department.
- In the 2014 inpatient survey the trust scored only 1.5 out of 10 in response to the question which asked patients if during their hospital stay, they had been asked to give their views about the quality of care.
- The trust used the friends and family test to capture patient feedback; however response rates were low. In December 2015 the response rate was 9.4%. We were provided with limited evidence of other forms of public engagement. On Wellington ward, staff wanted to introduce a more efficient beverage system and offer a wider range of snacks for patients. They worked with the catering contractor and introduced new beverage trolleys. They organised for suppliers to provide a range of snacks and patients took part in tasting sessions to inform the range of snacks now provided.

Staff engagement

- In the 2014 NHS staff survey the trust's score in relation to the overall level of staff engagement and the percentage of staff able to contribute towards improvement was worse than the England average.
- A number of staff referred positively to an initiative known as "listening into action" which was a regular interactive session provided by the previous interim chief executive where staff were invited to discuss concerns or suggest improvements. The initiative had continued to be supported by the current interim chief executive and the new chair of the trust. One staff member told us "things that have needed fixing for some time have been fixed." An example provided was the provision of a bank account for ward managers so that they could purchase small items needed on their wards, without having to place purchase orders.
- On Wellington ward an 'away day' had been planned for staff (two dates were offered to ensure maximum staff attendance). In addition to staff training, it was intended that these meetings would provide an opportunity for staff to reflect on ward performance and make suggestions for improvements.

Innovation, improvement and sustainability

- The ambulatory emergency care service, which was established in November 2014, was recognised by the

national Ambulatory Care Network for its early success in reducing ambulance delays in the emergency department and discharging 41% of patients the same day.

- The gastroenterology team had a well-established "jaundice hotline" clinical pathway. We were told that GPs were able to refer to the service using a referral proforma and patients were seen and generally had an ERCP (an endoscopic examination of the pancreas) within 48 hours of receipt of a referral.
- Progress had been made since June 2015 following the recommendations of the external MDT peer review of cardiology. The cardiology improvement plan was driven by a newly appointed specialty lead, supported by a dedicated project manager. The division had approached the south west cardio-vascular network to conduct a follow-up external review.
- There were a number of local quality improvement projects. These included the NEWS and escalation improvement plan and the nurse documentation improvement plan, both of which were being led by the respiratory/cardiology specialty. Practical measures had been implemented to improve documentation standards, such as the introduction of mobile workstations. Name stamps were issued to all staff so that they did not have to print their name and role every time they completed patient documentation. Progress against both of these improvement plans was being monitored through peer-led audit. Other projects included:
- the introduction of a 'hot' (rapid access) liver clinic set up weekly to identify potential cancer patients,
- the introduction of an alcohol liaison team
- A number of initiatives had been established to provide convenient care to people in or close to their homes. These included:
- a pilot for diabetic patients in Camborne and Redruth and surrounding areas to be monitored remotely in the community,
- an email service for renal patients to prevent them attending hospital,
- telephone clinics in neurology for patients with epilepsy.
- The cardiology team reconfigured premises to make more efficient use of the space available for staff and patients. Space previously used for staff accommodation was reconfigured to accommodate a new cardiology pre-assessment service and a radial lounge. A shared staff rest room was created for staff in cardiology and respiratory medicine. Staff were engaged in equipping the new rest room, which also had the benefit of bringing staff from different teams together and enhancing working relationships.

Surgery

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

Information about the service

Royal Cornwall Hospital, Truro, provided a range of surgery and associated services. Within the hospital, the surgery teams were part of the surgery, theatres and anaesthetics division. The service included surgery performed in West Cornwall Hospital, Penzance, and St Michael's Hospital, Hayle, as well as the critical care service (reported on separately in this report). Some of the data referred to in this surgery report, unless we have been able to exclude it, will therefore include some of these areas.

The Royal Cornwall Hospital had two main operating theatre units. One was located on the third floor of the Tower Block where there were five theatres for both inpatient and day-case surgery. This included one theatre for children, and a recovery area, which also included areas equipped for children. The other unit was located on the second floor of the Trelawny Wing where there were six operating theatres (six to 11) for both inpatient and day-case case procedures, and a recovery area with an area equipped for children. There was an ophthalmology service and ear, nose and throat and oral surgery on the Newlyn Unit located on the ground floor of the Trelawny Wing. Patients in Trelawny Wing were admitted for elective (planned) procedures though Theatre Direct, St Mawes Surgical Receiving Unit, the Newlyn Unit, or the Surgical Admissions Lounge in the Tower Block. Emergency surgical patients were admitted through the St Mawes Surgical Receiving Unit, the Trauma Unit, or the emergency department, all of which were located in Trelawny Wing.

The surgical services provided included urology, trauma and orthopaedic, vascular surgery, general surgery (incorporating breast, bariatric and gastro-intestinal), ophthalmology, oral, and ear, nose and throat (ENT).The hospital carried out interventional radiology within the Newlyn Unit: a process of using minimally invasive image-guided procedures to diagnose and treat diseases. Royal Cornwall Hospital carried out around 29,000 operations in 2015. Of these, 52% were day-case, 16% inpatient elective (planned), and 31% (9,000) inpatient emergency cases.

There were five surgical wards:

- The Trauma Unit – a 56-bed ward for patients predominantly having emergency or elective trauma and orthopaedic surgery.
- Pendennis – a 23-bed ward for patients predominantly having upper and lower gastro-intestinal or bariatric surgery.
- South Crofty – a 27-bed ward for patients having predominantly elective orthopaedic surgery.
- St Mawes – a 24-bed ward for general surgery patients.
- Wheal Coates – a 21-bed ward for patients having ENT, vascular and oral surgery.

During this inspection, we visited the surgery services on Wednesday 12, Thursday 13 and Friday 14 January 2016. We met and spoke with 35 patients and some of their relatives and friends. We visited all the surgery wards, operating theatre suites and recovery areas, the surgical admissions lounge, Theatre Direct, and the hospital sterilisation and decontamination services. We spoke with staff, including nurses, practitioners, and nursing assistants, the main theatres and day-case unit managers, and the

recovery teams. We met the senior management team for the division, senior ward staff, consultants, senior doctors, and junior doctors. We also talked with pharmacist staff, housekeepers, and therapists. We observed care and looked at 15 sets of patient's records and data.

Summary of findings

We rated this service as good because:

- Surgery safety, using checklists and briefings, was good.
- The majority of incidents were reported and investigated. The surgery teams assessed and responded well to deteriorating patients. There was good completion of patients' records, although some areas of patient confidentiality needed to improve.
- Surgery wards, operating theatres and equipment appeared clean and well maintained. There was good management of medicines.
- The high vacancies in nursing staff were of concern, but most were covered by experienced bank and agency staff. There was safe cover from the medical teams and a commitment to patient care.
- There was a good review by surgery teams of hospital deaths, but the demonstration of actions taken and learning shared needed improvement.
- Pain, nutrition, hydration management and patient assessments were undertaken well.
- There was a good understanding of the need for valid patient consent, which was obtained as required, although records needed to be improved.
- Care was good for patients coming in hospital who needed extra support, such as patients with a learning disability.
- Feedback from patients and their families had been almost entirely positive. Patients we met spoke without criticism of the service they received and of the compassion, kindness and caring of all staff. Staff ensured patients experienced dignified and respectful care, and worked hard to promote patients' individuality and human rights.
- Patients and their family or friends were involved with their care and included in decision-making.
- There had been investment and improvement to the pre-operative assessment service and patients were getting safely booked into the system.

Surgery

- There was an effective governance structure to assess quality and safety and investment in the surgical services.
- There was committed and experienced leadership of surgery services, although the team needing strengthening in numbers.
- All the staff we met showed dedication to their patients, the place they worked, their responsibilities and one another. There was recognition of staff for positive efforts and achievements in surgery services.

However:

- There were improvements needed to the incident reporting system as it did not allow for quick analysis or incident grading.
- There were insufficient physiotherapist sessions to ensure patients having trauma or orthopaedic surgery had an enhanced recovery to get quickly back on their feet. The hospital was not operating on all those patients who needed hip surgery for a fractured neck of femur, within 36 hours.
- Not enough staff had an annual performance reviews (excluding medical staff, as these were now mandatory). In terms of training, staff were not meeting trust targets for updating their knowledge in mandatory subjects and safeguarding.
- There had been some good but also some poor performance against the standards expected for patients having emergency abdominal surgery.
- Medical patients were often accommodated on surgical wards due to trust-wide pressures for medical beds. This reduced the number of beds available for surgical patients.
- Due to pressure on beds, too many planned operations were cancelled and some not rebooked within the required standard of 28 days. In addition, patients were looked after in recovery areas after their operation for too long, or moved to another part of the hospital to recover. Before being admitted to a ward, some surgery patients were waiting in chairs in the evening for a bed to become available. This was not providing patients with the best quality care and adding to the pressures on the staff and their morale.
- There needed to be an improvement in recognition and signposting to ongoing care for patients living with dementia, and their carers. Staff were helpful but there were limited facilities on the surgery wards to provide therapy or reduce confusion for patients living with dementia.
- Avoidable patient harm was slightly above (worse than) average in some areas.
- There was a strategic plan for the future of surgery services, but it did not provide any plans for delivering the objectives.
- Staff morale was affected by the high vacancy rates and constant pressure on surgery teams.

Surgery

Are surgery services safe?

Good

We rated safety as good because:

- Incidents and near misses were relatively well reported, although not in all areas, but actions and learning from investigations was shared with and reported back to staff. Serious incidents were investigated and reported to clinical governance teams for review and learning.
- The surgery wards, operating theatres and equipment appeared clean and well maintained. Almost all staff adhered to infection prevention and control principles and guidelines. Medicines were well managed. Most patient records were well completed and practical.
- The surgery teams assessed and responded well to deteriorating patients.
- The audits of the World Health Organisation surgical checklist showed this process designed to protect patients was undertaken safely and effectively. The use of the brief and debrief tools at the start and end of surgical lists had been successfully introduced.
- There were high levels of vacancies for nurses and operating-department practitioners. However, regular and experienced bank and agency staff were used to fill staffing gaps. There was safe cover from medical teams who provided person centred care.
- Measures put in place to improve the quality of the drapes and their storage had produced a satisfactory solution in almost all cases.

However:

- The incident system did not allow for quick analysis or incident grading.
- The demonstration of actions taken and learning shared from mortality reviews needed improvement.
- There was good security with most patient records, but some charts needed improved confidentiality.
- In terms of training, staff were not meeting trust targets for updating their knowledge in mandatory subjects and safeguarding.

Incidents

- The surgery division took appropriate action in response to significant incidents. The hospital had reported one Never Event in adult surgery services in the last 12 months (November 2015). A Never Event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death. This event related to a change in a planned operation on a patient's eye (at the patient's request). The procedure initially reverted to the original eye, before this was recognised and corrected. There was no enduring harm to the patient. The initial report into the event recognised the things that went wrong and listed a number of actions for the theatre team to put in place immediately. The root-cause analysis report, which would include a full investigation of the circumstances of the incident and a more detailed action plan, was being finalised at the time of our inspection.
- There were 12 serious incidents reported in the year from November 2014 to October 2015 (the latest available information). These included two falls and two pressure ulcers. These were reported at the divisional governance meeting and in the performance report. There was an investigation of each incident following NHS guidance for examining and reporting serious incidents. Actions were identified and these were followed until they were completed. We saw serious incident investigation and action plans reviewed at governance meetings where they were subject to constructive criticism.
- There was learning and development from serious and less serious incidents. For example, following two serious incidents and a near miss involving a prosthesis, changes were made to minimise similar risks by reducing the suppliers to two main providers. On Pendennis ward, analysis of two patient falls identified a lack of non-slip socks. Consequently, there was a new system developed to ensure they were always in stock.
- All staff we met said they were encouraged and expected to be open and honest about reporting incidents, even though we found some staff were not necessarily reporting some issues. Staff throughout the surgical services said there were no barriers to reporting incidents. All staff could use the electronic system or liaise with a manager to report an incident. However, those staff we asked said they were not aware of a 'trigger list' describing incidents that should be reported, and they would use their common sense. Some staff admitted they did not routinely report some day-to-day issues, such as staff shortages, or theatre disruptions. Other staff also said they did not routinely report near misses, although they recognised these

could help with learning and helping to avoid future incidents. The trust, overall, was below the NHS England average for reporting incidents. There were 7.2 incidents reported for every 100 patient admissions, against an NHS average of 8.4 incidents reported within the NHS. This could be an indicator of the need for the trust to improve the reporting culture among staff.

- Investigations into incidents were undertaken and actions for staff identified to limit repeats. Most staff said they received feedback on things they reported. The hospital had a department that received any incidents reported, put them into a category of the type of incident, and graded their seriousness by referring to national guidelines. This team provided support to any investigation, and decided whether the investigation required an element of independence from the incident itself, or passed back to the local team to look into.
- The system to report incidents did not enable staff reporting the incident, or their managers, to grade or categorise incidents by the seriousness of the issue, or to show it as a near miss. Staff relied upon the incident team if they needed more targeted information, but could not produce this type of analysis themselves.
- Surgery teams and a hospital-wide committee reviewed patient mortality and morbidity (M&M). The surgical-specialty team reviewed all patient deaths and any complications. A hospital-wide committee then reviewed a sample of 10% of all patient deaths at a review committee each month. Records of discussions held demonstrated reviews into patient deaths and any other concerns were carried out well. The surgical-specialty M&M meeting presentations demonstrated a clear audit of the patient's care and everything surrounding that. We looked through the colorectal data as an example of a review of death and complications. Classification and grading of surgery complications was undertaken using a ratified method. The statistics were carefully reviewed and presented, but there was no comparison against any national data to determine whether the results were within safe or effective levels.
- There was insufficient evidence to show how agreed actions or learning identified from the M&M reviews was followed and led to improvements. There were no minutes within the M&M review evidence to demonstrate if or how staff were accountable for any actions agreed from reviews to improve or change practice. In the hospital-wide review, although there was some recognition of areas for improvement, there were no clear actions with staff accountable to carry them through. In one report, we saw a number of reviews where there was no record of the cause of death in the patient notes. There was no action plan associated with these omissions and no action to resolve this issue of recording.

Duty of candour

- Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation, which was introduced in November 2014. This Regulation requires an NHS 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 that falls into defined thresholds. Duty of candour had been introduced to staff and recognised in surgery services. Those staff we talked with were aware of this relatively new regulation to be open, transparent and candid with patients and relatives when things went wrong, and apologise to them. The trust had produced a guide for staff to follow explaining the legal requirements upon them and the trust when things went wrong. We noted in the report on the Never Event as explained above, how the Duty of candour (although not described in that term) had been applied, and the patient involved had received an apology.

World Health Organisation Surgical Safety Checklist

- The hospital used the internationally recognised World Health Organisation surgical safety checklist in all surgical procedures. The use of the World Health Organisation surgical safety checklist was described in the Theatre Practice Standards – Generic policy.The checklist formed part of a procedure carried out to check all safety elements of a patient's operation before and after proceeding. This included, for example, checking it was the correct patient, the correct operating site, all the staff were clear in their roles and responsibilities. The review checked all equipment was present and functioning, and all instruments and swabs used accounted for. We observed good practice among theatre teams in using the checklist in the operating theatres, including the team brief at the start of the session. In the pre-operative checklist read-through, all staff involved were present and included in working through the checklist as required. There were no

distractions. We observed the way the checklist was respected and felt staff appeared 'natural', in that it was not being performed for our benefit, but was part of normal embedded practice.

- Surgery safety checks were extended to meet the guidance of the NHS National Patient Safety Agency 'Five Steps to Safer Surgery 2010' guidance. Practice now included a briefing at the beginning of a surgical list and a debriefing before members of the team left the theatre or department. This had been introduced to supplement the use of the checklist and this practice was now well embedded in the operating theatres. The value of the brief and debrief had been recognised following the introduction of and learning from Human Factors training at the trust.
- The hospital performed reasonably well in audits of the checklist, and when standards fell, improvements followed. There were audits of the completion of the paperwork used (quantitative) and audits of the quality (qualitative) of the checklist process. In the latest audit report available, covering July, August and September 2015, the quantitative results for compliance in July and August had dropped from good results in the previous three months. By September, this had improved and compliance was up at 93%. In quality terms, there was a relatively stable performance in the high 90s each month. Where there was non-compliance, staff were reminded to ensure there was respect for the process, and all staff were present when required.

Safety thermometer

- Avoidable patient harm data was collected and reported for all surgical areas and was similar overall to other acute hospitals when compared nationally. There was a slightly deteriorating trend in falls and pressure ulcers where the hospital was not performing as well as the England average. Results for avoidable harm were variable, but there was a slight decline in the delivery of harm-free care in the 12 months from August 2014 to July 2015 (the most recent data available). The best results had been in January 2015 with 95.30% of harm-free care delivered to patients, but this had dropped to 91.31% by July 2015. At surgical ward-level, there was a varied but not poor performance, and some results were excellent.
- South Crofty and St Mawes both had seven months out of 12 with 100% harm-free care.
- Pendennis and the Surgical Admissions Lounge had five months with 100% harm-free care.
- Although the Surgical Admissions Lounge had five excellent months, the other seven were less good with only one being above 90%. There were four months where patients (although a low number) had catheter or urinary tract infections.
- The wards performing less well in this snapshot of data were the Trauma Unit and Wheal Coates. There were numerous occasions in the twelve months where the Trauma Unit was below 90% with a prevalence of pressure ulcers and falls with harm, which, in the second half of the 12 months occurred almost every month.
- In terms of harm, falls causing harm were moderate overall in the surgical wards. There had been 21 reported across the surgical wards in the 12 months. This equated to 1.2% of the patients admitted at the time and was above (worse than) the England average of 0.5%. There had been 32 pressure ulcers. This equated to 1.8% of the patients admitted at the time and was above (worse than) that the England average of 0.9%. Although the trust was credited for assessment and avoidance of venous thromboembolism, there were still 10 incidences of this in 12 months.
- Although in some areas, harm-free care was not delivered at all times, there was good use of equipment and techniques to help patients at risk from avoidable harm. This included the use of pressure relieving mattresses, bed rails and anti-embolism stockings. Before using this equipment, assessments were made of its safety and effectiveness. Staff and patients said these resources were readily available when needed.

Cleanliness, infection control and hygiene

- Most of the ward areas of the hospital were visibly clean, tidy and well maintained. This included patient bed spaces, corridors, staff areas and equipment used both regularly and occasionally. Patient bed spaces were visibly clean in the easy and hard to reach areas such as beneath beds and on top of high equipment. Bed linen was in good condition, visibly clean and free from stains or damage to the material. Storage cupboards were well organised with most equipment on shelving units to prevent dust and dirt gathering around and beneath objects. One area where cleaning had not been effective were the floor areas of the large waiting rooms in the Surgical Assessment Lounge. This was a busy unit with many patients and staff coming through. Although the

floor was swept each morning, this was not effective. The floor was heavily scuffed, dusty, and grimy around the edges. The floor within the patient changing areas was also not effectively cleaned, being in a poorer state than the main seating area.

- Several patients we met on the wards said they regularly saw the cleaners who were dusting at height (such as curtain rails), cleaning floors, bathrooms, and under beds.
- The operating theatre units we visited were visibly clean, well-organised and maintained, although the staff changing areas in the Trelawny Wing were in a poor state of repair. We were told these were being refurbished in March 2016. The recovery areas in both units could be effectively cleaned at the start of the day, as they were empty of beds or trolleys. Members of staff knew who was responsible for the various cleaning roles within the operating theatres. This ensured complex machines, equipment and areas were maintained and cleaned by trained personnel.
- The surgery services had an exemplary result for levels of hospital-acquired infection. There were zero levels of methicillin resistant Staphylococcus aureus (MRSA) in the six months from April to October 2015. There were mostly good results in the audit of patient screening for MRSA, but one area stood out with poor results not otherwise explained. The concerns were with screening of emergency patients on Wheal Coates ward. The highest percentage of compliance was 67% in May 2015, but this had dropped since then to as low as 11% in October 2015. In the governance meeting minutes, we saw no evidence of this reported. The majority of wards or units scored over 90% in the period, although there were only two months reported for elective patients on South Crofty ward.
- There were good investigations into any incidence of hospital-acquired infection. We looked at incident investigations for four incidences of Clostridium difficile. The basis for the reviews focused upon which areas of the hospital/ward had been visited by the patient, any pressures on staff, and environmental issues such as problems with cleaning and hand hygiene around the time of the incident. We noted from a number of the reports into incidences on St Mawes ward how there was a recurring problem with the lack of a diarrhoea assessment which, however, continued to be an issue.
- Most staff we met and/or observed followed infection prevention and control protocols and wore clean well-maintained uniforms. Staff followed the rules around wearing minimal jewellery, having short and clean nails, and being 'bare below the elbow' to allow for effective hand washing. Staff not required to wear a uniform (such as doctors and pharmacists) followed trust policy in the same way. However, within surgical areas, we saw two pharmacy technicians a bed coordinator and a doctor who were not bare below the elbow.
- All the staff we observed washed their hands and used hand gel as required. Visitors were requested and encouraged to do the same. We saw staff wearing personal protective equipment (aprons and gloves) when required. There was sufficient stock of personal protective equipment and hand-wash sinks, soap, paper towels and hand gel in appropriate places. All those patients we asked said they had seen staff washing their hands and one patient said how they had been impressed with the cleaner on their ward who regularly stopped to wash their hands.
- There were mostly good results from hand-hygiene and 'bare below the elbow' audits. We reviewed the audits on the surgical wards and units from April to September 2015. Observations were made of ten staff each month. The average for compliance with hand hygiene for these six months was 93.5% and for staff being bare below the elbow was 97.6%. Theatre Direct staff scored 100% in both measures for the whole six-month period. St Mawes staff also scored 100% for being bare below the elbow for the six months.
- Some checklists for cleaning audits were not complete. We looked at the checklists on St Mawes as an example of cleaning, and those for 4 January and 11 January 2016 were incomplete in many areas.
- Patients recognised good cleaning, and results from patient-led surveys showed excellent results. The trust had scored the maximum score in cleanliness in the Patient-Led Assessment of the Care Environment (PLACE) surveys in 2015 of 100/100. The trust had always scored well in this area with 99/100 in both 2013 and 2014. The NHS England average for 2015 was 98/100.
- Clinical waste was well managed. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. None of the waste bins or containers we saw on the wards or within theatre units were unacceptably full. Nursing staff said they were emptied or removed and replaced regularly.

Surgery

Environment and equipment

- Arrangements for the delivery and removal of reusable surgical instruments and other equipment were good. In the operating theatres, clean instruments and equipment were stored outside of the theatres in storage areas or rooms off the main corridor. Sterile instruments and consumable items were in a designated storage area with instruments wrapped in surgical fabric. To prevent cross-contamination, used surgical instruments and equipment were taken from operating theatres through rear exits and along an area designated for this purpose. Equipment was deposited into lockable sealed trolleys for collection and processing by the on-site decontamination and sterile services unit.
- There had been a successful effort to reduce problems with holes in the surgical fabric wraps used to cover instrument sets. For safety, any set of surgical instruments would not be used if the wrapping were damaged. In our last comprehensive inspection in January 2014, this was a significant problem causing delays and cancellations to operations. However, staff in both theatre areas said this had now significantly improved. There was upgraded racking to store instruments in most areas, and sets were placed to reduce risk of damage. Heavy sets were placed on low shelves, and not stored on top of each other. Staff in the central sterile services division said the storage was, however, still not fully adequate in theatres 11 and 12. The fabric used to wrap the instruments had been changed to a better product. There were still occasional problems with holes in these wraps but the issue was much improved. Staff said the orthopaedic instruments sets were the main problem as they were heavier and often contained a high number of pieces. The trust had plans to obtain stainless steel boxes to store orthopaedic instrument sets in future to resolve this problem.
- There was safe provision of resuscitation equipment. They were easily accessible being well placed within wards and units so they stood out. Trolleys were locked with a breakable seal. This demonstrated the trolley had not been opened or equipment used or tampered with since it was last used. Daily checks were required for resuscitation trolleys and equipment including defibrillators on each ward, theatres and other surgical areas. Records we looked at showed completion on the vast majority of days in the last three months, although there were some days missing. There was no apparent responsibility among the staff for reporting when they found gaps in checking or raising this at the safety briefing, although it was one of the items listed on that briefing.
- There was emergency equipment supplied and fitted to surgery wards and areas. There was piped oxygen and suction equipment in each ward and recovery area at the bed space. Emergency call buttons were clearly marked.
- We observed an effective reaction by staff to a failure in a piece of equipment in an operating theatre. The situation did involve a patient being operated on at the time, but was handled with calmness and professionalism. The equipment was rapidly replaced and did not result in significant delays to the procedure.
- All consumables and equipment were within their expiry date in the areas we checked. The staff we met said the stocks, stores and trolleys were regularly checked by staff. This included checks for evidence of damage to packaging of consumable stock (damaged items were then disposed of) and for items approaching or past their expiry date. We saw consumables and equipment in the departments were kept to a minimum of those things used often in order to reduce waste and the risk of expired equipment.
- Equipment was stored safely. Flammable products were in locked steel cabinets. Products deemed as hazardous to health were in locked cupboards and often in sluice or clinical rooms that were also locked and only accessible to authorised staff. After our inspection in January 2014, we commented in our report how there was a cabinet storing flammable product close to the paediatric waiting area in the Tower Block operating theatre area. On this visit, the cabinet was still in the same place. The manager of the unit was unaware of the previous concern, as they were relatively new in the role. They did, however, say they would review the arrangement and look for a more appropriate site for the cabinet.
- To prevent unauthorised access, relevant areas of the surgery services we visited were locked and accessible only to staff who had swipe cards. After our inspection in January 2014, we commented on the security of the operating theatres in the Tower Block, which was unacceptable. This had been resolved. On this visit, we found the doors closed and secure. After announcing

who we were through the intercom, we were met by a receptionist who checked our identity and arranged for the manager to meet us. Now all visitors to the operating theatres were met by a receptionist who checked their identity and asked them to wait to be escorted any further into the unit. Patients able to walk into theatre prior to their procedure were accompanied by a member of the theatre staff.

Medicines

- Medicines were supplied and stored securely in all clinical areas. Medicines, including medical gases, IV fluids and liquids, were kept in locked cupboards with appropriate staff responsible for the keys. There were arrangements for the supply of regular medicines. An inpatient pharmacy service supplied medicines to all wards and departments and dispensed discharge medicines for patients to take home. There was an emergency supply of standard medicines. All staff we asked knew about this stock and knew how to access it out of hours. Medicines' refrigerators were available with temperatures recorded daily to show medicines requiring refrigeration had been stored at a safe temperature.
- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and its associated regulations. We checked a number of stocks and the registers and found them to be accurate. There were manageable levels of stocks to prevent medicines going out of date and reducing the risk of errors. In an example of good practice, checks of controlled drugs on the Trauma Unit were carried out at the nursing safety handover so any issues could be immediately investigated and resolved.
- There was a regular audit for the use of antibiotics, although the surgery division was not meeting targets for compliance. The audit was undertaken to improve the management of antibiotics by checking the duration of their use with patients, the route of administration, and how they were being used. The target for compliance was 95%, but the surgery division had not met this in the six months from May to October 2015 (although three of these months did not return results). Results had also not shown any improvement with June at 84%, July at 89% and September at 87%.

Records

- Records we reviewed were well completed, legible, timed and dated. We looked at 15 sets of patient notes. All those we saw were relatively well completed, although some held the reviewing doctor's name, but not their grade. The diagnosis and management plan for the patient, and ward round decisions, were documented in the notes. There was also good recording of input from the multi-disciplinary team and assessment of pressure ulcers, falls, and nutritional risks. All the consent forms we saw were appropriately completed and signed.
- There was an excellent system on surgical wards for keeping patient medical and nursing notes secure. However, in a few areas of wards, there was some inattention to patient record confidentiality or security. The majority of patient notes were stored in locked trolleys. This was a system that appeared to be well embedded and respected by nurses and doctors. However, there were some patient nursing charts stored in folders in pockets or on clipboards outside of patients' rooms or side rooms. The set of charts we saw on the Surgical Admission Lounge were hanging just outside a side room. They were not in a folder so there was no attempt to keep the patient's personal information confidential. On Pendennis ward, there were patients' charts in folders in an area where they were not visible from the nurses' station. They could therefore be easily read or removed. Although the information on these charts was limited, it was nevertheless, confidential or private information. On the Surgical Admission Lounge staff said these records were only stored in this way if a patient was being barrier-nursed due to an infection. However, there was no sign on the side room to say the patient in question was being barrier-nursed, and the charts did not indicate this. There were three notes trolleys on Couth Crofty ward that we saw were not locked after use and one on the Surgical Admissions Lounge. Staff admitted they sometimes forgot to turn the small switch back to the lock position.
- Some patient information recorded on the Surgical Admission Lounge white boards in the main corridor of that unit was confidential. This was a busy unit with many patients and visitors moving through. The boards were used for staff, who needed to have the most up-to-date information at all times about the constantly changing group of patients. However, the white boards had confidential information written on them in a

corridor. This included the medicine a patient was taking, and how another patient was required to have a review from the oncology department. The sister in charge recognised this when we mentioned the problem with how the information was displayed. Confidential information was removed and the sister said the department would find a way to manage this information without breaching patients' confidentiality or right to privacy.

Safeguarding

- Not all staff were up-to-date with their training to recognise and respond in order to safeguard a vulnerable person, although they were close to target for level one adult safeguarding training. The trust had set a target requiring 100% of staff to complete this mandatory training to update their knowledge (all staff were trained initially at induction). In all but safeguarding for children at level three, medical staff were further behind that nursing/support staff. Results, at 31 December 2015, for adult safeguarding training for surgery staff (which covers the whole division) were:
  - Level one training had been updated by 98.4% of staff.
  - Level two training had been updated by 70.2% of staff. Of these, 55.7% were medical staff and 75.8% nursing/support staff.

Results for child safeguarding training were:

- Level one training had been updated by 59.7% of staff. Of this, 54.5% were medical staff and 61.8% nursing/support staff.
- Level two training had been updated by 64.7% of staff. Of this, 59.3% were medical staff and 66.9% nursing/support staff.
- Level three training had been updated by 22.2% of staff. Of this, 100% were medical staff and 12.5% nursing/support staff.

- There were policies, systems and processes for reporting and recording abuse. The safeguarding adults' policy had been implemented in accordance with national guidelines. The policy had been updated in 2015 to take account of the statutory requirements of the Care Act (2014) which had superseded the government's 'No Secrets' paper of 2000. The policy referenced the local authorities' policies to ensure approved and recognised local safeguarding systems and processes were followed. There were listed definitions of forms of abuse and people who might be at risk. This linked with the provisions of the Mental Capacity Act 2005 in relation to deciding if a person was vulnerable due to their lack of mental capacity to make their own decisions. The policies (including the policy for child safeguarding) clearly described the responsibilities for staff in reporting concerns for both adults and children, whom, as required, were subject to different procedures. There were checklists for staff to follow to ensure relevant information was captured and the appropriate people informed.
- Staff we spoke with were clear about reporting safeguarding, allegations or suspicions of abuse of people in vulnerable circumstances. They understood their responsibilities and the trust's processes for making reports. Staff who had any uncertainty over their concerns said they would raise the matter with their manager or an appropriate member of staff to get guidance and advice. Staff told us there were no barriers to reporting any concerns. They said they would not be put off by reporting something which ended up with their concerns being unfounded. One member of staff rightly commented that no situation is ever the same, however similar it might appear on the outside.

Mandatory training

- Not all staff were meeting the trust target and up-to-date with the latest mandatory training refresher courses. Staff were trained at induction and then updated in a wide range of statutory and mandatory subjects at various intervals. The staff (in the whole surgery, theatres and anaesthetics division) were not meeting trust target levels overall for 100% having updated their training. The training included a wide range of topics such as conflict resolution, infection control, equality, diversity and human rights, and health and safety topics. Compliance with the mandatory training requirements at the end of December 2015 showed overall for the division, 76% of staff had updated their mandatory training. For medical and dental staff 68% had updated their training and 79% of nursing/support staff had met the target. In terms of subject matter, some results should be highlighted:
  - Of nursing/support staff, 100% had updated their equality and diversity training. Medical staff were just behind at 92%.

- Of nursing/support staff, 80% had updated their manual handling training, but this had been completed by only 7% of medical staff.
- Of nursing/support staff, 80% had updated their infection control training. Medical staff were falling behind at 67%.

- Staff said one of the areas to suffer from staff shortages, vacancies and unplanned absence was updating their mandatory training. Staff would ring-fence time to complete their mandatory training, much of which was computer-based, but this would be one of the things to fall by the wayside if the member of staff was needed elsewhere.

Assessing and responding to patient risk

- Surgery services were effectively using the system for monitoring acutely ill patients. The trust had implemented and was using the National Early Warning Score (NEWS) system for the monitoring of adult patients on wards. The hospital policy recognised best practice in this system as promoted by the National Institute for Health and Care Excellence (NICE) guidance on care of the acutely unwell patient in hospital (NICE 50). The policy made it clear how concerns about a patient's clinical condition should always override the NEWS system, and staff should escalate concerns even if the patient's scores were otherwise low. In patient records we saw the early warning score charts completed and in use appropriately.
- Audits completed each quarter of the use of NEWS on the wards were mostly good, but some results were not showing consistent improvement. The Surgical Admissions Lounge showed improvements. Completion rates in September to December 2014 were 78%, but this had steadily improved to 95% by July to September 2015. The Trauma ward scored 60% in January to March 2015 but this had steadily improved to 92% in July to September 2015. Pendennis ward had only scored 85% over the last four quarters on average and Wheal Coates 89%. Scores on Pendennis had slipped again and in October 2015 were at only 78%.
- The hospital had recently introduced an 'emergency care board' to identify high-risk patients. This had been an initiative of the medical director and running for three or four months. The board consisted of a multi-disciplinary review team as a response to the higher than average mortality rate at the trust. There was a review of patients each morning and those seen to be at a higher risk of deterioration highlighted at the morning safety brief on the wards/units. They would then be seen first by the doctors on the ward rounds.
- The hospital had a critical outreach team to respond to deteriorating patients and emergencies. The team was evolving to provide bedside teaching to ward-based nursing staff. The team, staffed by trained critical care nurses, provided cover 12 hours a day, but not 24 hours as recommended by the Faculty of Intensive Care Medicine Core Standards.

Nursing staffing

- There were a high number of vacancies among the nursing staff, nursing assistants and operating-department practitioners across the surgery services at Royal Cornwall Hospital. This included the wards, the Surgical Admission Lounge, and a high number of vacancies in the operating theatres. The vacancy rate for nurses/operating-department staff in the surgery division for September 2015 was 13.7% and 31.9% for non-clinical staff. The trust had been actively running recruitment campaigns with some limited success. Some recruitment of overseas nurses and operating-department practitioners had been carried out. New staff from those campaigns had started or were due to start in the coming months. Although not all rotas could be filled all the time, the teams made great efforts to secure bank and agency staff. In addition, overtime was offered to substantive staff to ensure the majority of nursing shifts were covered. It was recognised how the high use of agency staff was far from ideal for both safety and cost. However, the majority of agency staff were experienced nurses who were regularly booked. Many were block-booked for several months or longer to ensure some of the more technical areas, such as operating theatres, had the right skill mix. This was achieved most of the time. Senior staff in operating theatres told us they had authority and confidence to cancel operating lists if there were ever unsafe staffing levels.
- Due to the high number of vacancies, most of the senior nurses (predominantly band seven sisters/charge nurses) were not able to maintain their supernumerary status at all times. To help with staff shortages or not quite the right skill mix, most of the sisters/charge nurses we met on wards or the operating theatres were required to work clinically at least once or usually more

each week. The experience and flexibility of the senior nurses meant the priorities on their wards/units were fulfilled each day. However, this added pressures and stress when there were problems, such as staff not arriving for work (due to illness or other unplanned absences). Despite the respect they had for the value of the process, staff appraisals were one area of their work not completed on time due to higher pressures and priorities.

- Most shifts on surgery wards for nurses and healthcare assistants were filled to at least 90% in July to October 2015.
  - One of the lowest staffing levels was on St. Mawes ward where nursing staff dropped to an average of 81.7% of planned daytime shift hours filled in September 2015 but this had picked up to 87% in October. There was cover by 134% of healthcare assistants on St Mawes on daytime shifts in September, so nurses had good support.
  - The Trauma Unit (the largest ward) was at around 85% for daytime shifts by nurses in July, August and September 2015, but this improved to 90% by October. This was compensated partially by almost 100% cover from healthcare assistants during this time.
  - Most night-time shifts on the surgery wards in this period were almost all at 100% and none fell below 95%.
- There was a good induction programme for new or temporary staff (such as agency and bank staff). There were policies and procedures for the induction of locum, bank and agency staff and staff joining the trust. All temporary staff were expected to complete an induction process and sign a document to say they had been introduced to mandatory topics. An experienced member of the substantive staff met the new person and make sure they firstly knew their way around the department and the important aspects of working there. This included where to find the resuscitation equipment, the fire exits, the facilities, and an introduction to the other staff. The new member of staff would then be shown the various procedures for the area in which they were working. In addition, there would be an explanation on how patient records and observations were to be made and recorded. Agency staff we spoke with confirmed they had been made welcome to the ward and they were encouraged to ask any questions or raise concerns. In addition, temporary staff were able to give feedback to the trust on how they were welcomed and the success or otherwise of their induction.
- Staff described how nursing and healthcare assistant staffing levels were based on patient need and adjusted when required to. For example, staff on Pendennis ward told us they had seen an increase in staffing levels when it was recognised it was required to meet patient need. Staff on the Trauma ward also told us they had seen an increase in the nursing establishment to meet the increasing needs of patients. The hospital response to patient needs was good where possible. However, staff on St Mawes (the surgery receiving ward) had to care for patients waiting to be admitted to a ward in chairs in the corridor when there was nowhere else for them to be when the unit was full. Staff said this happened around two-thirds of the time. Despite this, the ward was not given additional staff to support the extra patients.
- The sickness levels within nursing in surgery services were variable within departments, but overall, at 4.7% in the surgery division. This was just above the NHS national average of 4%.
- There were handover meetings, ward rounds and safety briefings involving the nurses each day. The safety briefing reviewed all patients and areas of concern. It included, for example, any patients at risk from falls or infection risks. There were alerts for patients assessed as having dementia or at risk to skin damage (pressure ulcers). Attention was drawn to patients with high early warning scores and those with treatment escalation plans or specific wishes around resuscitation.

Medical staffing

- There was good coverage from experienced and senior medical staff. The trust medical staffing skill mix was slightly different to the England average with more consultants in post in percentage terms. Around 46% of medical staff were consultant grade (England average 41%) and there was a lower ratio of registrars (37% against the England average of 48%). There was a higher rate of foundation year trainees to the England average (17% against 12% nationally). We met many consultants, registrars and junior doctors during our visit and found them open, honest and dedicated.

Surgery

- The junior doctors and trainees we met said they felt well supported by the consultants. They said the consultants were approachable and could be contacted at any time when junior doctors needed clarification, opinion or support.
- There was some use of locum doctors to fill vacancies. There were some vacancies and unplanned absence among the medical staff and locum doctors used to cover many of the gaps. In data for the financial year April 2014 to March 2015, the use of locum doctors was approximately 8% overall. The majority of locum doctors worked in anaesthetics, the head and neck directorate, and trauma and orthopaedic services.
- Consultants and doctors carried out appropriate timely ward rounds. Staff on all the wards and units we visited said the ward rounds took place every day. Patients we met told us they had seen a doctor every day. We observed a number of ward rounds and saw good practice. The nurses said they were involved with the ward rounds as appropriate, and the nurse in charge would complete the whole round with the multi-disciplinary team as often as was possible.
- Nursing staff said they felt well supported by the medical staff. They told us the doctors worked alongside and in collaboration with the nursing teams and contributed to the multi-professional approach to the patient.

Major incident awareness and training

- The trust had a current major incident plan produced originally in 2010 and most recently updated in November 2015. Key staff knew how to access and distribute the policy and in what circumstances it was relevant. The surgery services knew of their responsibilities and actions in the event of a major incident. This included the allocation of South Crofty and St Mawes wards as primary receiving units. There was an action plan for the anaesthetics department, trauma and orthopaedics, theatres, and the surgery team as key personnel. There were other plans associated with the major incident plan, including, for example, the national burns major incident plan and the pandemic influenza plan. Key staff with named responsibilities were listed in the policy along with significant locations. There were also instructions for obtaining medicines and equipment for major incidents.

Are surgery services effective?

Good

We have rated effectiveness as good because:

- Length of stay in the hospital was good, being mostly below (better than) the England average.
- Patients' pain was well managed with specialist input and nutrition and hydration well supported. Knowledge of mental capacity was good.
- The hospital performed relatively well in national audits and outcomes delivered to patients. There was recognised quality care and effective assessment for patients with the risk of developing blood clots.
- There was encouragement and opportunities for professional development.
- We observed strong multidisciplinary working with a common sense of purpose among staff. Important services were provided seven days a week and there were no problems getting access to patient-related information.
- There was a wide range of policies and procedures incorporating best practice and national guidelines.

However:

- Surgery services were not operating effective enhanced recovery programmes for patients, particularly those recovering from orthopaedic surgery. There were not enough physiotherapy sessions to provide the right level of effective care.
- The trust was not operating on all patients needing hip surgery for a fractured neck of femur within 36 hours of their admission, as is best practice.
- Only two-thirds of staff had received an annual review of their performance and objectives.
- There had been no improvement to shortcomings in the audits around patient consent documentation.
- The hospital had a variable performance in the National Emergency Laparotomy Audits of 2014 and 2015. We were told there were actions plans to address the shortcomings. We asked the trust to tell us where they were with the actions, but after three weeks of waiting nothing had been forthcoming.

Evidence-based care and treatment

- The hospital had a policy for identifying and disseminating new or updated national guidance, standards and practice. This included guidance from NHS England, the National Institute for Health and Care Excellence (NICE) and Public Health England. NICE guidance and safety alerts would be implemented, disseminated and monitored through the trust's guidelines and alerts steering process group. Governance meetings and clinical leads were the route for introducing other specialist advice. Responsible staff were expected to analyse any new or updated guidance and produce an action plan to mitigate risks. This was managed through a governance process with the guidelines and alerts steering process team monitoring and approving any enduring gaps in processes.
- Despite delays in discharges, the length of stay for surgical patients was mostly below (better than) the NHS England average. It is recognised as not ideal for patients to remain in hospital for longer than necessary and a barrier to other patients being admitted. The latest available data produced for the trust by the Health and Social Care Information Centre covered July 2014 to June 2015.
  - For all elective (planned) surgery patients, the length of stay was 2.8 days (England average 3.3 days)
  - For emergency surgery patients, length of stay was 4.4 days (England average 5.2 days).
  - Within elective surgery there were, however, slightly longer stays than average for patients having trauma and orthopaedic surgery (4.0 against 3.4 days) but this was offset by shorter stays for patients in other specialties.
  - In emergency surgery, patients having general surgery stayed less time that the England average (3.3 against 4.2 days) as did trauma and orthopaedic patients (7.3 against 8.7 days).
- The hospital reported a high level of compliance with assessment for the risks to patients from developing venous thromboembolism (blood clots). The most recent submission to NHS England (for July to September 2015) reported the trust assessed 98% of the 30,108 patients admitted in that period. The trust had also gained accreditation for being a centre of excellence in the prevention of venous thromboembolism. It was one of 19 acute trusts nationally to be recognised. All assessments were routinely recorded in the electronic prescribing system to enable action to be taken for patients assessed as at risk. The surgery wards were audited each month to check completion of an assessment by a doctor of the risk to the patient from developing a blood clot. We reviewed the average compliance for assessments from October to December 2015. Most wards had over 95% compliance in these three months. The only area where this was not the case was in Theatre Direct where compliance was below 90% each month and just 75% in November 2015.
- The hospital operated and audited itself under a set of anaesthetic theatre standards. These were derived from upon guidance of the Association for Perioperative Practitioners, Royal College of Anaesthetists, and Association of Anaesthetists of Great Britain and Ireland. The standards were used in conjunction with the trust's resuscitation policy. The trust had self-assessed its practice as 100% compliant with the 30 standards.
- Patients were treated without discrimination with staff mandatory training and policies assessed and approved for equality and diversity. We looked at a number of policies where assessment against equality and diversity was an important aspect to consider. These included safeguarding, resuscitation, consent, care of the deteriorating patient, and treatment escalation planning. All of these had been ratified for their equality and diversity impact and found to be have been drafted in such a way as they did not contain any discrimination on equality grounds.

Pain relief

- Pain relief on wards and theatres was well managed. Those patients prescribed pain relief to be given 'when required' were able to request this when they needed it. Patients told us, and we observed, staff asking if they were in any pain and medicines were provided in line with prescriptions. Nursing staff on Pendennis ward said the hospital pain team called in each day on their rounds, and were contactable at any time for advice or a visit to review a patient.
- There was a hospital policy and protocols for ward doctors on the use of pain relief medicine. The document referred to a scoring chart for determining the patient's level of pain. There were various different strategies to follow depending on the level of pain including a strategy for severe pain. There was a protocol for the use of local anaesthetic infusions for post-operative pain relief where a patient would be deemed at high risk of pain following major surgery.

- Patients were enabled to use 'patient controlled analgesia' (PCA) devices in certain situations. The guidelines for the use of PCAs described how the devices should be set-up and in what circumstances. Staff training and competencies were clearly described, as were the care plans and pain score tools to be used.
- There was no specific tool used by ward staff for routinely assessing and managing pain for those patients not able to express themselves. Staff said they did not routinely use a recognised tool for pain assessment for patients living with dementia or cognitive impairment who may not be able to express how they felt. The clinical guideline on assessing pain in adults did not refer to any recognised tool for people with cognitive impairment, but suggested staff should refer to the specialist pain team for patients not able to verbalise.
- The hospital had performed well in a survey looking at patients' pain management. Of the 205 patients questioned in the surgery wards in October 2015, 90% said they had been asked if they were in any pain, and 10% said they had sometimes been asked. Only one patient said they had not been asked. Of the 197 patients who were asked if they felt everything possible had been done to help with pain, 88% said yes, 10% said sometimes and four patients (2%) said no.

Nutrition and hydration

- The hospital had a nutrition support team to provide patients with complex nutritional plans. The team made daily ward rounds and worked with ward-based dieticians and nurses to ensure there was consistency with delivery of nutrition.
- Protected mealtimes had been introduced in surgical wards to provide an atmosphere and environment more suitable for patients when eating. This limited interruptions and gave staff time to make sure people were given help where needed with eating and drinking. Visitors were discouraged from coming in at mealtimes unless they were specifically helping patients at mealtimes. This gave patients the opportunity to also rest after a meal and equally gave visitors a break. Doctors and other clinical staff only carried out essential visits with patients.
- The availability of or access to weighing scales (for monitoring patients with nutritional risks) had improved. An audit in 2015 showed there was only one ward without scales at the time and two with broken scales. These were on Pendennis ward and South Crofty ward which had since been replaced.
- Patients were fasted appropriately pre-operatively when admitted as inpatients or day-case patients prior to their surgery. There was a hospital policy in relation to safe sedation covering pre-operative fasting supported by the full policy for fasting patients. The fasting policy covered both adults and children undergoing planned or emergency surgery as inpatients or day-case patients. The policy outlined how the senior anaesthetist would manage patients operated upon in an emergency and consider their fasting status. If a patient had surgery in an emergency, their response to the risks of nausea and vomiting was managed in theatre and recovery with either appropriate medicines or close monitoring. There was a protocol providing anaesthetists with a recognised formula to follow when managing patients at risk of post-operative nausea or vomiting.

Patient outcomes

- There was insufficient physiotherapy for some time-critical procedures, including post-operative fractured neck of femur (hip) and knee-replacement patients. Staff in the trauma and orthopaedic services confirmed there had not been enough physiotherapists to provide therapy to support patients to achieve the best outcomes. New staff had recently been appointed and there were plans to improve post-operative therapy, but these were limited. Research has shown the earlier a person mobilises and is out of bed after surgery, the shorter their recovery time will be. In the period from 1 September 2015 to 22 January 2016, the physiotherapist team had been able to stand just 15% of patients on the first day following their procedure. This increased to a further 84% on the second day.
- Not enough patients were achieving their physiotherapy goals and subsequently reducing their length of stay following orthopaedic surgery. The physiotherapist team understood clearly how enhanced recovery reduced length of stay for patients and improved their recovery overall. The physiotherapist team had reviewed the length of time to achieve therapy goals. This study demonstrated how goals were achieved faster for patients who were given therapy on the first day. Goals were achieved in the period 1 September 2015 to 22 January 2016 as follows:

- For hip replacement: 2.7 days for first-day patients; 3.2 days for second-day patients; and 3 days for third-day patients. The first-day patients saw an improvement of 0.4 days in meeting their goals over the average length of time.
- For knee replacement: 3.1 days for first-day patients; 4.2 days for second-day patients; and 3.5 days for third-day patients. The first-day patients saw an improvement of 1.1 days in meeting their goals over the average length of time.

- Length of stay was reduced when patients were given therapy on day one. The review by the physiotherapist team had shown length of stay as:
  - For hip replacement: 3.1 days for first-day patients; 3.9 days for second-day patients; and 4 days for third-day patients. The first-day patients saw an improvement of 0.7 days in their length of stay in hospital over the average time.
  - For knee replacement: 3.7 days for first-day patients; 4.7 days for second-day patients; and 4 days for third-day patients. The first-day patients saw an improvement of 0.8 days in their length of stay in hospital over the average time.
- The physiotherapy team had recently recruited more staff but providing a full service for enhanced recovery was going to take time. The goals set for the team were, by the end of March 2016, to enable 30% of patients to stand on the first day following their procedure. There was a plan to increase to 60% of patients by the end of June 2016.
- The provision of physiotherapy on Saturdays was restricted to respiratory patients. There was no physiotherapy rehabilitation support to patients on Saturday or Sunday and patients were mobilised where possible by the nursing teams.
- The hospital was not meeting the best-practice outcome for patients requiring surgery for a fractured neck of femur. There had been an improvement in the key indicator (the number of patients being operated on within 36 hours after a fractured neck of femur) but this had recently declined. In the first quarter of 2015/16 (April to June), 68% of patients were operated on within 36 hours. This declined to 61% in the second quarter, but improved to 82% in quarter three. In January 2016, the percentage had declined to 67%.
- The hospital performed [AJG1]relatively well in the Patient Reported Outcome Measures (PROMs) for April 2014 to March 2015 (the most recent published data). These patients reported to the hospital on how they felt they had improved following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. Almost all patients having knee replacements and all those having hip replacements said they experienced improvements when asked more specific questions (called 'Oxford scores') about their condition. The hospital exceeded the England average for patient improvements in their health for groin hernia surgery. It was much the same as what was a very good national average for improvements in health following hip and knee replacement surgery. The results for health improvements after varicose vein surgery were not quite as good as the England average.
- The hospital performed well in the majority of measures of the 2015 national hip fracture audit when compared with national results. In particularly the hospital performed well for the length of stay for patients, which was well below the England average. In the overall audit, the hospital was better than the NHS England average in six of the seven key measures:
  - This included 95.4% of patients being assessed before their operation by a geriatrician, against the England average of 85.3%. The performance in 2015 had also improved slightly since 2014 for three of the seven measures.
  - The assessment by an orthopaedic geriatrician, for example, was up from 71.7% in 2014. The measure, which fell below the NHS average, was for patients having surgery on the day of admission.
  - The percentage of patients having surgery on the day they were admitted was 70%, which had fallen from 75.2% in 2014. The England average was 72.1% in 2015, so the hospital was only just below the average.
  - In more up-to-date information, the trust was reporting for September 2015 that 84% of patients had surgery within 36 hours of arrival. Overall length of stay of patients had improved (in that it had reduced) to 12.4 days in 2015 (from 14.2 days in 2014) which was significantly less than the England average of 20.3 days.
- Patient readmission rates after surgery (due to needing corrective measures or infections) were variable, although this data included patients returning to the hospital for replacement dressings and planned appointments. For planned surgery, two out of three of the most frequently performed operations had

readmission rates above the England average. In emergency surgery, none of the top three specialties was above the England average. These statistics were, however, relatively sensitive to small numbers of patients. However, overall, in data for August 2014 to July 2015 (the most recent available data), there were 9% more patient readmissions for elective surgery than the England average, and 10% fewer than average for emergency surgery. Within the detail, there were variable rates of readmission. Data for the top three elective specialties based on the number of procedures carried out showed:

- Urology surgery had 31% fewer readmissions over the England average.
- Ear, nose and throat surgery had 18% more patients readmitted.
- Colorectal surgery performed worst with 187% more readmissions.

In emergency procedures:

- General surgery had 3% fewer readmissions over the England average.
- Trauma and orthopaedics had 28% fewer patients readmitted.
- Urology surgery had 11% fewer patients readmitted.
- There was variable compliance with the National Emergency Laparotomy Audit (NELA) from 2014. This national audit looked at how the hospital responded to patients who required and underwent emergency laparotomy surgery. This is an operation for people experiencing severe abdominal pain to find the cause of the problem and, in many cases, treat it. In the full self-assessment audit of services, the hospital complied with 19 out of the 28 measures. This included key areas such as having an operating theatre reserved for emergency patients 24 hours a day. There was a formal rota for associated interventional and diagnostic procedures, and a critical care unit on site with consultant intensivist cover 24 hours a day.
- There were some important areas where the hospital was not meeting NELA 2014 recommendations. These included there being no formal calculation of the risk of patient death during surgery. There were no policies relating to seniority of operational staff present according to surgical risk. No explicit arrangements were made for patients to have a review by elderly medicine physicians, and there was no pathway for enhanced recovery of emergency general surgery patients.
- There was poor performance with the NELA 2015 patient-focussed review. This review showed what percentage of patients had been treated in accordance with certain standards. The service reached the 70% threshold to be compliant in just two of the ten standards. Results were between 50% and 69% in six of the others, which were considered a risk, and less than 50% compliance in the other two. The compliant standards were for a consultant surgeon being present in theatre, and the patient's arrival in theatre in timescales appropriate to the urgency. The standards failed (achieved for less than 50% of patients) were for patients over 70 years of age being reviewed by a specialist in medicine for care of the older person, and there being direct post-operative admission to critical care. The last of these standards was affected by the shortage of beds to move patients through the hospital, which caused delayed discharges within critical care and consequently delayed admissions.
- There was no recent evidence available to show how the performance against the NELA audits had improved. The surgery division had produced a report in May 2014 about their performance against the key standards for emergency laparotomies. This was presented to the trust medical committee and included an action plan. We were told there were updated actions plans to address the shortcomings. We asked the trust to tell us where they were with the actions, but after three weeks of waiting nothing had been forthcoming.
- There were variable levels of surgical site infections reported, with a process of internal investigations when higher levels were reported. The hospital reported to Public Health England (PHE) any patients with post-operative infections following procedures for hip and knee replacement and neck of femur repairs. A PHE report compared the hospital's results with national statistics. In addition, the hospital produced its own report discussed at specialty meetings within the trauma and orthopaedic department. The most recent published data was from the year 2014/15. There were 261 hip replacement operations reported upon, of which eight (3.1%) had a surgical site infection. The national average was just below 1%. The hospital score was also a significant increase over the two quarters

reported on in 2013/14 where there was one infection reported in hip replacement operations. An investigation by the trust revealed two of the patients had long-term infections, which were not due to the surgery. Royal Cornwall Hospital also performed more operations that were complex. The more straightforward elective procedures were carried out at St Michael's hospital. Of 154 procedures in the two quarters in 2014/15, there was one infection in knee replacement operations. This was patient reported and not diagnosed by a clinician so would not have met the normal criteria. There were two infections out of 179 operations for neck of femur repairs. This represented 1.1% and was below the national average.

- The hospital performed well in national cancer audits. In the lung cancer audit, the hospital achieved 96.6% for discussing patients at a multidisciplinary level. The England average was 95.6%. In the bowel cancer audit, the hospital achieved 100% for discussing patients at a multidisciplinary level. It was above the England average (so better) for the other key measures including patients being seen by a clinical nurse specialist, and receiving a relevant scan. The hospital was also credited for having relatively well-completed patient data.

Competent staff

- The hospital trust was not meeting the trust target for 100% of staff to have had their annual performance review. By 26 January 2016, only 63.3% of non-medical staff had gone through this annual review. Some areas were doing better than others were. On Wheal Coates ward, 100% of staff had had their annual review. However, this objective had been met for only between 20% and 25% in Theatre Direct, the Surgical Admissions Lounge, and Pendennis ward. The other areas and wards had compliance rates somewhere in between.
- The trust was making strides to improve education and training, and there was a strong commitment to staff development in the surgical department. This included point-of-care simulation training, which was very positively evaluated by staff. A practice development facilitator was employed in the operating theatres providing 'bite-sized' training sessions. There was an external training programme for operating department practitioners and development of band six nurses recognised with potential for promotion. All operating department staff were provided with 'theatre passports' detailing their competence, experience and skills. The clinical matron in theatres said there were courses available for band five nurses in undergraduate or postgraduate nursing and mentorship training. All staff who had applied for these courses had been accepted. The band three staff in the central sterile services department had all passed their Qualifications and Credit Framework (the replacement for the NVQ framework) level three modules. There was bedside teaching available from the critical care outreach team, although this team had only recently expanded, so this was an evolving service. However, staff said while they were encouraged to attend courses and obtain new skills, time to do this was limited due to staff shortages.
- Medical staff were evaluated for their competence, and mostly met targets for having an annual performance review (appraisal). This had improved significantly since it became a requirement of doctors' registration to have an annual performance review as part of the 'revalidation' programme (General Medical Council, 2014). We requested results for the doctors in the surgery division, but this was not provided. However, in the most recent report to the Department of Health, covering the year 2014/15, 82% of trust doctors had completed their appraisal but 66 trust doctors from 362 had not completed this by the deadline. Of these, 27 had credible reasons for this, such as illness or maternity leave. Of these doctors, all had completed their appraisal by the time the report was submitted (September 2015) but not within the period (by end March 2015). These results were similar to the NHS average for the acute sector where, for the same period, the completion rate was 81.3%.
- There were quite a number experienced and newly employed nursing/healthcare staff who had been trained elsewhere who were not able to use their skills in a timely way. It was perfectly acceptable that the trust required all new staff to be retrained in certain techniques or skills before they were put into practice. However, some experienced staff had been waiting for many months before getting onto the relevant training course. This included staff in theatres who were experienced in catheterisation, cannulation, and taking bloods. As not all refresher training was available in a timely way, many new staff were not enabled to use their skills for some time. Some healthcare assistants were not trained to carry out observations or take blood pressure until they had been at the trust at least three months.

- There had been a recent review of band two and three healthcare assistants in the operating theatres. There was now a proper structure and job descriptions for these roles. Staff were interviewed and appropriate offers were made to promote some staff in band two roles to band three
- Nursing/practitioner staff in operating theatres rotated through the different theatres and specialties to gain new skills and experience. This included working in the emergency operating theatre and experiencing working out of hours.
- The hospital had introduced apprentice schemes for healthcare assistants. The apprentices were working through a 15-month skills course, had a mentor within the staffing team, and went to college one day a week. One of the apprentices we met on Pendennis ward said: "I love it."
- The trust had recognised the value of 'human factors' training, which focused on improving safety and performance. This was achieved by recognising the value of teamwork, the way an environment needs to be understood and the culture among teams in often high-pressure and sometimes unpredictable situations. The training was being used with a positive impact in appropriate areas, such as operating theatres. Staff described how each member of the team was expected to be listened to, regardless of their seniority or otherwise, and their views, opinions and role within the team were valued.

Multidisciplinary working

- There was consistent collaborative working from staff contributing to patient care. There was a common sense of purpose among staff with the patient at the centre. We observed no obstructive hierarchical structure and staff were valued for their input and role in patient multidisciplinary care.
- The surgical wards had input from specialist clinical teams/staff where appropriate. This included the Stoma team, the pain team, the upper gastro-intestinal specialist nurse, and colorectal cancer services. On Pendennis ward (which was for colorectal and bariatric patients), there was a cupboard with supplies for Stoma patients with the stocks held being for the current patients on the wards. Staff commented upon the high level and quality of support for both themselves and the patients from the Stoma team.
- Therapy staff worked closely with the medical and nursing teams to provide a collaborative approach to patient rehabilitation. Staff and patients spoke highly of the physiotherapy care provided to surgery patients. However, there were concerns about the service being under-resourced to provide fully effective and timely care.
- There was multidisciplinary input involved with all patient care. The patient records demonstrated input from therapists, including dieticians, speech and language therapists, and occupational therapists, as well as from the pharmacist team, the medical team, and diagnostic and screening services.
- There was evidence of a strong multidisciplinary approach in national cancer audit results. In the 2014 bowel cancer audits, there was 100% compliance with there being a multidisciplinary discussion in the 307 cases reviewed. This was above the England average of 99.1%. In the lung cancer audit, there was 96.6% compliance with there being a multidisciplinary discussion in the 238 cases reviewed. This was slightly better than the England average of 95.6%.

Seven-day services

- There was good support from consultants on call out-of-hours. Registrar and junior doctors told us they had good support either by telephone or in person.
- The trust provided emergency surgery services around the clock. There was a surgery team on site 24 hours a day with support and specialist surgeons on call and able to attend the hospital within 30 minutes. The hospital sterilisation and decontamination services also operated seven days a week to provide services to theatres and elsewhere. The surgery wards were open and admitting patients seven days a week around the clock and the surgical admission units were open for referrals seven days a week.
- Access to clinical investigation services was available across the whole week. This included X-rays, computerised tomography (CT or CAT) scans, electroencephalography (EEG, tests for brain function) and echocardiograms (heart scans).
- There were arrangements for the supply of medicines when the hospital pharmacy was closed. A pharmacist was also available on-call out of hours.

Access to information

- Patient records were well managed. The notes were held in an electronic booking system, which tracked them when they moved around the hospital.
- Access to patients' diagnostic and screening tests was good. The medical and nursing teams said results were usually provided quickly and urgent results were given the right priority.
- There was a lack of access to computerised systems in some areas and some systems were not linked. For example, the central sterile services division (CSSD) did not have access to the theatre management system. This meant staff in theatres had to phone CSSD to request the surgical instrument sets required for the following day. The three different systems used in the operating theatres to manage the lists did not link with each other.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient consent was appropriately sought. Patients we met all said they had signed consent forms following a discussion with the doctor. They had been given the opportunity to ask questions and told the advantages and risks of the process they were about to undergo. For some procedures, such as taking blood samples or general tests, specific written consent was not required. However, patients would be required to give implied or verbal consent. Those patients we asked said they were always asked for their permission by staff before any procedure.
- Consent was being done well in practice, but records needed improvement, and those areas recognised as weak in previous audits had not improved in the 2015 review of records. The main findings of a recent comprehensive and detailed audit were:
  - Only 79% of patient records had a copy of a valid consent form. This was much the same as the result from 2011, where just 80% had the form available.
  - Very few records indicated a patient had been given a copy of the consent form and this had not improved. Only 14% of records indicated giving the patient a copy, and in 2011 this was 13%.
  - Although not all records had consent forms, all those seen had been signed by the patient. This had improved from 91% in 2013.
  - All those patients we asked said they were given information about their procedure verbally. However, not all records demonstrated this, with only 69% indicating the doctor had done so. This result had deteriorated since previous audits (86% in 2013 and 84% in 2011). There was a better result for indicating patients had been told of the risks (84% in 2015).
- There was a standard policy for consent based upon guidance from the Department of Health. This covered why consent was legally and ethically required. The policy included the principles to follow when a patient may not have had the mental capacity to provide their own valid consent. It gave guidance for how staff were to proceed if consent could not be gained in an emergency. There were details on consent for tissue storage, use and disposal, and clinical photography and video/audio recordings.
- The hospital had documents and processes for assessing a patient's mental capacity, competence to make their own decisions, and what to do if that was lacking. Those forms we saw in patient notes were completed as required. However, we met one patient on Pendennis ward where there was no evidence of any assessment for dementia although this was recognised as present by nursing staff. There were specific forms for use in the event a person did not have the mental capacity to make their own choices. These referred to national guidance to identify how the decision had then been made in the best interests of the patient. This included, where possible, involvement from the patient's family or those close to them.
- In September 2015, the hospital audited the use of the Mental Capacity Act and the consent form for people lacking capacity. Staff were surveyed about training and awareness of the Mental Capacity Act and the Deprivation of Liberty Safeguards. Conclusions of the audit found some areas were good but others needed improvement, namely:
  - Why capacity was assessed was clear in the patients' notes.
  - The assessment form was not being widely used.
  - An old version of the consent form was used too often and some could not be located in the notes.
  - There were incomplete sections in many form four documents.
  - Patients subject to a Deprivation of Liberty Safeguard were correctly assessed.
  - Only a quarter of those subject to a deprivation of their liberty had a care plan.

- The audit results were shared with the Safeguarding Adults Operational Group in November 2015 and an action plan was presented.
- Among those staff we spoke with there was a good understanding of Deprivation of Liberty. The trust had provided guidance around what actions would amount to a Deprivation of Liberty, and how to proceed to have the deprivation approved. There was a decision-making tool within the trust policy for staff to follow if there was a situation or potential situation where a deprivation would occur. There was guidance for staff to follow to apply for an authorisation to deprive a patient of their liberty. On those wards we visited on our inspection, there were, however, no current records to review.

Are surgery services caring?

Good

We have rated caring as good because:

- Feedback from patients and their families had been almost entirely positive. The Friends and Family Test produced good results. Patients we met in the wards and other units spoke without criticism of the compassion, kindness and caring of all staff.
- Staff ensured patients experienced dignified and respectful care, and worked hard to promote patients' individuality and human rights.
- Patients and their family or friends were involved with their care and included in decision-making. They were able to ask questions and raise their anxieties and concerns.

Compassionate care

- Patients spoke almost overwhelmingly of the kindness of the staff in all surgery areas. On all the wards and units we visited, we heard positive comments about the care patients received and the kindness of the nursing staff.
  - Patients we met in Theatre Direct said they "could not fault the staff", care was "very good" and "excellent", and "I have no complaints about anything."
  - On South Crofty ward a patient said of staff: "They are kind and compassionate, yes, but they're run off their feet. But if you need then, they're there."
  - On Pendennis ward staff were said to be "very caring and dedicated. They put you at ease." Another patient said: "They do all they can to make you comfortable. They are a dedicated team."
  - Patients on St Mawes ward said "everything is spot on" and "all the staff who have dealt with me have been amazing."
  - Patients on the Trauma ward said of staff: "They are always available if you need answers", and "it's excellent here; more than very good."
- A number of patients remarked upon the commitment and individual approach of the doctors. One patient on Pendennis ward specifically commented upon how the consultant treating them had been kind but also firm with them to make sure they understood how they might respond to treatment and make sure they got the best chance of recovery. A number of patients told us how they had great faith and trust in the consultants and junior doctors.
- We observed good attention from all staff to patient privacy and dignity. Any patients we observed in the operating theatres were fully covered in all preparation and recovery rooms, and when returning to the ward areas. On wards, curtains were drawn around patients, and doors or blinds closed in private or side rooms when necessary. There were screens provided in the Trelawny recovery area to give privacy and dignity to patients but enable observation by staff when they were close by. The recovery area in the Tower Block theatres was, unfortunately, not a discrete area as people could walk through from reception to access the theatre area. Staff said they discouraged people from walking through the recovery area when there were patients being recovered, but it was, nevertheless, a thoroughfare. The beds were also closer together than was ideal, so it was possible to overhear conversations.
- The NHS Friends and Family Test results for the surgery wards and units showed good results. Patients were asked to say if they would recommend the ward to their family and friends. In the six months from June to November 2015, and based on an average of response rates, 95% of patients were either 'extremely likely' or 'likely' to recommend their ward to family and friends. The test was responded to by an average of 28% of those patients admitted (1,760 patients responded). The best response rates in terms of the number of patients asked were on St Mawes (43%) and the Trauma Unit

(42%). The Surgical Assessment Lounge was falling behind with only 16% of patients on average responding in the six-month period. The individual ward details for November 2015 (the latest available data) were:

- Pendennis (general surgery) would be recommended by 96% of patients (response rate of 27%).
- The Surgical Assessment Lounge (general surgery and urology) would be recommended by 96% of patients (response rate of 16%).
- South Crofty ward (trauma and orthopaedics) would be recommended by 88% of patients (response rate of 24%).
- St Mawes ward (general surgery) would be recommended by an average of 92% of patients (response rate of 43%).
- Theatre Direct (day-case theatre) would be recommended by 98% of patients (response rate of 25%).
- The Trauma Unit (trauma and orthopaedic) would be recommended by 96% of patients (response rate of 42%).
- Wheal Coates ward (ear, nose and throat and ophthalmology) would be recommended by 96% of patients (response rate of 20%).

- One relative we met spoke highly of the compassion shown to them to enable them to stay with the patient. The patient was not able to communicate easily due to their illness. Their partner had been given a portable bed and bedding to enable them to stay at night with the patient. South Crofty ward had also arranged for two grandchildren to stay with a patient and a mother to stay with their 16-year-old child who was a patient on the ward.
- The trust scored relatively well for patient privacy and dignity in the Patient-Led Assessments of the Care Environment (PLACE) surveys in 2013, 2014 and 2015, although the good opinion of patients was in decline. The trust had scored 95/100 in 2013, 93/100 in 2014 and was down to 90/100 in 2015. This was, nonetheless, better than the England average for 2015 of 86/100.

Understanding and involvement of patients and those close to them

- Patients were given time to ask questions about their procedure and address any anxieties or fears. A patient on Pendennis ward commented: "The surgeons are amazing. They explained everything." A patient on the Trauma unit said they had been "advised, involved and informed." In conversations we heard (with the patient's permission) we found staff were informative, clear and open with patients. The patients were given the chance to ask any questions and staff gave helpful responses, which included providing some written information if this was requested or considered helpful.
- Friends and relatives of patients were kept informed and involved with decisions when appropriate. Relatives and close friends of patients we met said they were able to ask questions and could telephone the wards and departments when they were anxious or wanted an update. One relative of a patient on the Surgical Admissions Lounge said they had been able to describe to staff a mental health problem the patient lived with. They remarked on how the response from the staff was appropriate, helpful and empathetic. A relative of a patient with a learning disability said they were consulted and both they and the patient met with one of the hospital's learning disability liaison nurses. They had found this helpful and supportive.
- The trust had introduced an initiative in September 2015 whereby staff made sure they introduced themselves to patients and relatives with "Hello, my name is…" Staff continued with saying who they were and why they wanted to talk with the patient or relative. This was to ensure staff remembered to make this important first step with patients and carers. All those interactions we observed with patients and relatives, where the member of staff was a new face for the patient, started in this way. Staff name badges were printed with 'Hello, my name is…' Patients and relatives told us they liked this initiative as it made conversations already more personal. It also gave the relatives an opportunity to say who they were as some commented that, in the past, they had either not been asked, or not included in the conversation.

Emotional support

- There was access to a team of chaplains, chaplains' assistants, pastoral visitors and befrienders for people of all faiths or none. The team were available in working hours and then on call 24 hours a day all year round. There was a chapel, a prayer room and ablution facilities and all facilities were available 24 hours a day all year round. The trust described their services as "ranging from offering a listening ear to full requested

religious and spiritual needs for a group or individual basis." The trust also worked with community leaders across Cornwall to ensure all faiths were considered and religious needs were met.
- There was some, but limited emotional support for patients. The hospital had a team of mental health nurses who came to review a patient upon request of the medical or nursing staff. However, staff confirmed this was usually when the member of staff recognised something that might need support, rather than the patient asking for help.

Are surgery services responsive?

Requires improvement

We rated responsiveness as requires improvement because:

- The pressure for beds within the hospital meant the needs of patients were not being met at all times. Bed pressures meant patients were not always managed in the best way following surgery. There were delays, changes to surgery lists and cancellations resulting from the lack of beds and some inefficiency with getting patients into theatre. Some patients were sitting in a corridor in the evening while waiting for a bed. The flexibility of the surgery teams was limiting the impact on patients, but there remained a lack of thorough planning and communication. The shortage of critical care beds was putting some patients at risk following emergency surgery.
- There were limited facilities on the wards, such as easy to read signage and dining areas being used to help frail or confused patients.
- The information on the trust website was poor, although there was a good range of leaflets available to patients within the hospital.

However:

- The trust had been meeting targets to get patients through their procedure within 18 weeks for most specialities (it was slightly below for trauma and orthopaedic patients) although other procedures not reported in 18-week targets, such as bariatric surgery, were frequently cancelled.
- There was a re-launched and much improved pre-operative assessment service for patients. A 'Ring and Remind' service was being launched as a response to patients not arriving or not arriving prepared for their operation.
- Patients were complimentary about the food and drinks served, and there was some high praise for the quality and variety of the food.
- People who needed more support coming to hospital were well looked after. This was particularly good for people who had a learning disability.
- There was good practice in relation to staff with link or liaison roles.

Service planning and delivery to meet the needs of local people

- Surgery services at Royal Cornwall Hospital had been established to meet the needs of local people, and recognised the need to consider the tourist influx, which now extended to almost all year round. Services provided in consultation with the local area clinical commissioners included providing emergency and planned surgical services to patients needing the most common procedures such as trauma and orthopaedic (including hip and knee replacements), general surgery and urology.
- The hospital provided a dedicated emergency operating theatre 24 hours a day all year round. This was seen as an essential service as the Royal Cornwall Hospital was the only acute hospital in the county.
- Patients were assessed pre-operatively to ensure they were able to proceed or if any changes or adaptations needed to be made. There was a re-launched pre-operative assessment service following a planned investment programme implemented in late 2015 and early 2016. Some specialties had been using the service since November 2015 (dermatology and urology), others came on line in December and January (general surgery and part of orthopaedics) and the remaining part of orthopaedics, vascular and breast surgery being rolled out in February and March 2016. The re-launched service (which was now 85% complete) benefitted from a new electronic system for specialities adding patients to the surgical waiting list and creating a worklist for the pre-operative assessment unit. This had reduced the administrative time to list a patient from around 15 days on average to 48 hours. There were now no hand-written instructions that could be misinterpreted.

Another benefit was from accurate pre-operative assessment letters being sent to patients, and all the data available to decide what level of pre-operative assessment a patient needed.

- Patients were safely admitted for surgery. Many patients came through the emergency department or through the Surgical Receiving Unit on St Mawes. Planned surgery patients were admitted to Tower theatres through the Surgical Admissions Lounge, and in Trelawny theatres through Theatre Direct, St Mawes, or Newlyn Unit. The theatres received patients for two lists: one in the morning and the other in the afternoon. Staff commented on how well they felt the Surgical Receiving Unit on St Mawes managed despite being under pressure from the lack of available beds as were the other surgery areas.
- The operating theatre efficiency was sub-optimal. For reasons difficult to clarify with hospital staff, there were too many delayed starts with planned operations. In October 2015, of 731 sessions in theatre, 349 (48%) started late. In December 2015, of 641 sessions in theatre, 237 (32%) started late. In the week from 11 to 16 January 2016, there were 64 late starts (38%) in 168 sessions. When we were in one of the operating theatre units, the morning session due to start was already delayed. This was due to the first patient needing a fitted device switched off by a technician, but this having not been anticipated. When we spoke with the Surgical Admission Lounge, the nurse in charge was able to confirm this was a known circumstance with this patient and a technician had been booked to carry out the pre-operative procedure at the right time. Something else had therefore happened which was not correctly understood. This patient was what the trust was describing as a 'golden patient'. This was part of a recent initiative designed to reduce the number of late starts by putting a 'straightforward' patient first on the list where possible to avoid problems. A number of staff we met, however, felt this initiative was not yet working as it should be.
- The use of operating theatres was not as efficient as it should be, although it was affected by the lack of surgery beds, and surgery cancellations. In July, August and September 2015, theatre utilisation was around 78%.
- As a response to problems associated with the high volume of surgery cancellations, a 'Ring and Remind' service had been tested and was about to be introduced in full. Patients were (or were going to be) contacted twice and information checked. This was to make sure they had received all the information about their planned procedure and still intended to appear. This was already reducing the number of patients who did not appear, or enabling the hospital to make other arrangements where patients did not intend to present themselves for their operation.
- The hospital had a full time interventional radiology service. The National Emergency Laparotomy Audit 2014 had found the trust compliance with the recommendation to provide this service 24 hours a day. One of the consultants we met commented upon the good support of the anaesthetics team to this service. The interventional radiology and vascular access team were given the inspiration and innovation award in the trust's 'We Care Awards' for 2015.
- There was mostly a good supply of equipment to wards and theatres. Staff in recovery told us there was, however, a daily problem with a shortage of pillows for patients.

Access and flow

- Due to the use of surgery beds for medical patients, there were not enough beds in the hospital to meet patients' needs. In January 2016, 40 surgery beds had been ring-fenced for accommodating medical patients. On our unannounced visit to the hospital there were 84 patients who were fit to be discharged, but were not able to move on. This was due to the ongoing care they needed either not being available or not ready for them to take up.
- There were too many patients not moved through the recovery area in a timely manner and there had been patients recovered in the operating theatre. This was due to the recovery area being full. This problem had increased in 2015. The key points was: In 2014, there were 31 patients delayed due to lack of a ward bed, the bed-space needing cleaning, an 'other' ward delay, or inadequate staffing skill mix on the ward. In 2015, this increased to 63 patients held back for these reasons.
- There were insufficient beds available in critical care for all patients to be discharged from theatre recovery in a timely way. In 2014 there were 83 patients held in recovery as no critical care bed was available. This had not improved in 2015 when there were 82 patients held in recovery. There were considerable concerns among the surgical staff about patients who were not being

admitted post-operatively to critical care. The trust had been criticised in the National Emergency Laparotomy Audit 2014 and in 2015 for non-compliance with meeting the recommendation that all emergency laparotomy patients be admitted to critical care following their operation. The trust was rated as 'Red' in this area. This meant less than 50% of patients were admitted to critical care. Staff said there was no protocol for admitting patients, as recommended, in relation to their predicted mortality.

- There were delays to patients remaining in the recovery areas beyond an acceptable time. Not only did this cause other operations to be cancelled, but also there were no facilities available for patients who were otherwise well enough to eat, drink and use bathroom facilities. Patients delayed in the Trelawny theatres used the critical care unit next door to visit the toilet. Patients in the Tower theatres used the Surgical Admissions Lounge. These arrangements were not ideal for patients and not responding to their needs. Light meals were ordered for patients remaining in the recovery areas from the main kitchen but there were no storage facilities or fridges to store food. Staff made hot drinks for patients in their own kitchens, but these and other activities to support patients took staff away from the unit. Staff in the operating theatre teams told us patients were delayed in recovery for many hours after they were well enough to be transferred. We asked the trust to tell us how many patients were delayed and how long they were staying. We waited almost three weeks for the evidence but it was not forthcoming.
- The number of operations cancelled on the day of surgery for non-clinical reasons was significantly higher than (worse than) the England average. However, there were some reasons for this to be taken into account when making national comparisons. The statistics (with the exception of data provided to us for November and December 2015) were for the whole trust, but the vast majority were cancellations at the Royal Cornwall site. High levels of cancellations had been the situation at Royal Cornwall Hospital Trust for at least the last three years. However, the trust had taken the decision to continue to cancel operations at the last minute, rather than more than 24 hours before. Staff worked on the basis that if all the plans fell into place, the patient's operation would be able to proceed. Some NHS trusts acted at the last minute, but many did not, so the trust knew and accepted their position around cancelled operations would always look relatively poor. The data, nonetheless, was:
  - In quarter four of 2014/15 (January to March 2015) the trust cancelled 455 elective operations (of those operations meeting the NHS non-clinical cancellation criteria). This was the third highest number in England.
  - In quarter one of 2015/16 (April to June 2015) the hospital cancelled 289 elective operations compared with an average of 134 nationally.
  - In quarter two of 2015/16 (July to September 2015) the hospital cancelled 228 elective operations compared with an average of 137 nationally.
  - In the most up-to-date information, the hospital reported to us it had cancelled 92 operations in November 2015 and 83 in December.
- A significant number of patients who had their operation cancelled on the day they were due to arrive were not treated within 28 days of the cancellation. In the quarter January to March 2015 there were 131 patients not treated within 28 days. In the quarter April to June 2015 there were 97 patients not treated within 28 days and 57 between July and September 2015. This is against an NHS average of 11 breaches of this standard in April to June 2015 and nine in July to September 2015. The numbers of cancelled operations in these three quarters of 2015 were either the highest or the second highest number in England.
- Patients who had surgery in the Tower theatres and should have returned to the Surgical Admissions Lounge had to travel through the hospital because due to bed-pressures, the Surgery Admissions Lounge was unable to take them. This meant two members of the recovery team had to take the patient, usually on a trolley or a wheelchair, down the long and sometimes cold corridors from the Tower Block theatres to Trelawny Wing. This included using a number of lifts where there was no emergency equipment. Staff in Theatre Direct said some patients arrived there and just wanted to go home, so they would often get dressed and leave.
- Patients on St Mawes (the Surgical Receiving Unit in Trelawny Wing) were frequently asked to wait in chairs in the ward corridor when they were waiting to be moved to a ward bed. This enabled staff who had been

working more than a 12-hour shift to be able to close the ward as expected at 9pm and go home. Staff told us this happened once or twice each week. These patients were handed over to the Hospital at Night team.

- Medical patients were being admitted to surgical units not designed for this purpose. The ophthalmic unit, Newlyn, had been used over the winter months as an escalation ward for medical patients (and a small number of surgery patients). This meant the surgery in the Newlyn Unit was cancelled as the recovery area was being used as an overnight escalation ward.
- Despite the best efforts of the surgery teams, patient-flow problems were increased by people unable to be discharged for ongoing care. There were a high number of patients who were fit for discharge, but remained in hospital. The data about delayed transfers of care was for the whole trust (so included medical patients) but would have an element of surgery patients. It would also have had a knock-on effect to surgery patients. Of those delayed, there were 68% in the period April 2013 to November 2015 on average waiting for further NHS non-acute care. A further 16% on average in that period were waiting for placements in a residential or nursing home, or a care package at home. In November 2015, this number was a more significant 53%.
- Despite high levels of cancellations, the hospital was meeting or close to NHS England consultant-led referral to treatment time (RTT) standards in the six reportable surgical specialties. The surgery division had increased surgery time to include weekend operating for patients having elective trauma and orthopaedic surgery. Coupled with that, more elective orthopaedic surgery was undertaken at the trust's other hospitals. There had been increased resources at St Michael's hospital to increase the range of surgery to reduce pressure on the Truro site.
- When taken as an average based on the number of patients, in November 2015 (the most recent published data) the referral time for patients waiting to start treatment within 18 weeks (called incomplete pathways) was 93.5% against the NHS operational standard of 92%.
- The trust was meeting the target in November 2015 for urology, ear, nose and throat, ophthalmic, and oral/maxillo-facial surgery.
- It was just below for general surgery (91.2%).
- Looking at this financial year (April to November 2015 data available), trauma and orthopaedic surgery had consistently not met the 18-week target. It was, however, at 88.7%, very similar to the NHS England average. In November, the performance for trauma and orthopaedic surgery of 87.4% was only just below the average for the South of England commissioning area of 89.8%.
- All other specialties were performing better than the average for the South of England commissioning area. It was recognised by the trust that due to reducing the bed-base for surgery patients to manage the high number of medical patients, the RTT times would deteriorate over the coming months.
- Some waiting lists for treatment were increasing while others were reducing. The lowest waiting list total for the six specialties within April to November 2015 was in June, with 9,398 patients awaiting surgery. By November, this had increased by 824 patients or 8%. Incomplete pathways (patients waiting to start treatment) had reduced by November 2015 for some surgical procedures, but had increased for others. In the top three procedures comparing April with November 2015: There was an increase of 78 patients waiting for ophthalmic surgery. Patients waiting for trauma and orthopaedic surgery had increased by 179. However, in general surgery there were there 103 fewer patients.
- The hospital had better than average waiting times for other hospitals in the NHS South commissioning area. This was partly due to an objective by the surgery division to focus on patients who had been waiting the longest. In November 2015, the South of England average waiting time for the six surgery specialties was 6.5 weeks. The average for the six specialties at Royal Cornwall Hospital (in terms of how many patients were waiting to start treatment) was 6.1 weeks. There was some variation in the detail. Urology patients had only an average 5.7-week wait in Cornwall, but 6.4 weeks in the South of England area. The average for the South in ophthalmic surgery (the largest of the specialties in Cornwall) was 6.1 weeks, but 5.2 weeks in Cornwall. Trauma and orthopaedic patients waited an average of 7.2 weeks in Cornwall, but this was 6.8 weeks in the South area.
- Discharge home for patients was improving. A new discharge lounge facility had opened in November 2015 to help move patients from the ward to a safe area to

await medicines or transport. The unit had one female and one male bay with both beds and recliner chairs. The unit stayed open until 9pm, but staff said they had stayed later when a discharge was delayed.

Meeting people's individual needs

- There was some concern among patients about discharge arrangements. Patients we met who would be cared for by relatives or carers when they went home felt happy with the arrangements made for their discharge. However, we met three patients on different wards who were concerned about how they were going to manage when they went home. For example, one patient on the Trauma Unit, who lived alone, said no one had asked them about how they were going to manage when they went home. They did not have a support network around them, and when they mentioned this to a nurse, it was not picked up.
- The vast majority of patients complemented the food. The Patient-Led Assessments of the Care Environment (PLACE) surveys said the hospital had also improved for food provision. The patients' opinions had improved from 88/100 in 2013, to 91 in 2014, and 93 in 2015. This was against the NHS England average of 88 in 2015, and the hospital had been better than the NHS average in the other two years. All the patients we met were complementary about the food and made comments including: "It was really good indeed", "I have enjoyed every bit of it", and "there's some quite impressive choice and it looks like a lot of care and attention has gone into it."
- The hospital in-depth satisfaction survey of food and drink in July 2015 returned good results. The majority of patients surveyed (the data provided did not state how many) were positive about the choice and variety of food, the temperature of the meal and help they were given with food. Comments that were slightly more negative were made by patients who did not have their drinking water changed at least three times.
- The surgery wards reported no breaches of the requirement to maintain single-sex bays and areas in the recent data we reviewed covering the three months of October to December 2015.
- The hospital continued to score well in patient views of the environment and facilities in the PLACE surveys. The score had dropped slightly in 2015 to 94/100 from 95/100 in both 2013 and 2014. The scores had been better than the NHS average in each of these three years.
- There was relevant equipment for bariatric surgery patients. This included equipment in theatres but also on wards. On Pendennis ward, which specialised in admitted bariatric patients, there were specific side rooms or bays for bariatric patients. The side room had an overhead hoist, and was a larger room than average, with a larger bathroom.
- There was extra support for patients with additional needs coming into hospital. We were impressed with the care provided to patients with a learning disability and their carers on our visit to the hospital in January 2014. These proactive arrangements continued to be offered to patients with extra needs. There was a team of specialist nurses at the hospital to work with patients with a learning disability and carers supporting them. A hospital protocol produced to guide staff to caring for adults and children with a learning disability. It guided staff to ensuring they referred all patients to the hospital's 'acute liaison nursing service for learning disability'. Advanced, proactive arrangements could be made for a patient with a learning disability to make their hospital experience easier. Staff in theatres said this had included arranging a 'walk-through' of the operating theatre, the use of quiet rooms, or early appointments. Patients were able to bring with them a 'hospital passport' or have one produced with the learning disability liaison team. The hospital passport was a recognised document to help staff caring for a person with a learning disability to know what the person liked or did not like. It included medicines taken, important contacts, and the patient's level of understanding.
- Patients living with a dementia who came to the hospital were generally well supported. There was, however, an example of staff recognising the condition within a patient, but the patient's notes not capturing this, or any assessment of the patient's mental capacity. We checked their notes and the only reference we could find to an assessment indicated the patient did not have dementia (this was not a recent entry). The nurse looking after the patient on Pendennis ward confirmed the patient had been highlighted on the nurses' handover information as living with mild dementia. Although we could see the patient was quite able to make their own decisions the records did not demonstrate the ward had followed the hospital policy in providing support and access to services for them and their family. The hospital policy for looking after people

living with dementia was based on the guidance of the National Institute for Health and Care Excellence (NICE) quality standards. There were clear actions to follow when a patient was diagnosed or exhibiting signs of dementia.

- The surgery wards did not provide any specific prompts or much more than enhanced signage to assist people living with dementia. There were few places for people to sit other than by their bed, where patients also had their meals. Patients were not able sit together at a table to eat. This has been recognised as good practice or a trigger to help confused patients to eat and drink. Communal corridors were very similar and plain with no visible prompts to help orientation. There was, however, plenty of light on the wards to help with reduced vision or light perception.
- There was a limited range of information and guidance online for patients and carers and the trust website was significantly underdeveloped. We commented upon the poor or limited quality of information on the trust website for surgery services in our last comprehensive report from our inspection in January 2014 and this had not improved. For example, as we commented last time, if you looked up 'surgery' on the website, you were directed to a page about vascular surgery. None of the surgery wards was listed under services on the trust website. If you typed any of the surgical wards' names into the search engine, there were either no results or unrelated results. In the surgery pages there were only 18 patient leaflets. A number of these were for very specific conditions and some were not directly related to surgery. There was, for example, no information or guidance on the website for the major procedures carried out in trauma and orthopaedic surgery such as hip and knee replacement. The website for the ear, nose and throat (ENT) speciality had been criticised by that team at a governance meeting. The ENT team had asked to be able to influence the information provided, as it was out of date. This was turned down, as it was not trust policy.
- Although the trust website information was poor, there were a wide-range of leaflets available to patients and carers in the hospital. Patients we met on the Surgical Admissions Lounge said they had been provided with written information to take home, as did patients and carers on the Trauma Unit. There was a wide range of leaflets available on Wheal Coates for patients, including information on specialist surgery (such as maxillofacial and vascular).
- The hospital trust provided translation services where this was needed. The trust had engaged third-party services providing face-to-face, telephone, and written translation, Braille, and British Sign Language. Staff we talked with said they knew how to access services and had found them easy to reach, timely, and helpful when they had used them with patients and carers.
- There was good use of nursing and healthcare staff in link roles. These were staff on wards and units given lead roles in certain aspects of care and support. Where possible they linked with hospital lead nurses or doctors to be part of a network of support. This extended not just to the wards, but operating theatres and recovery units. Lead roles included urology and vascular surgery, infection control, tissue viability, and supporting patients with a learning disability.

Learning from complaints and concerns

- Complaints were resolved at local level where possible. We met a patient who had cause to complain about the way they were treated by an agency nurse. They complained to the ward sister and commented on how this person sat with them and listened to their concerns. The nurse took action on the patient's complaint, and the patient felt it was dealt with appropriately.
- Records provided showed there were 59 complaints to the surgery division up until the end of September 2015. Of these, six were partially or fully upheld, and 19 were still being investigated. The top themes within the complaints were communication problems, staff attitude and cancellations of operations. Actions were required were recorded. Meeting minutes demonstrated, themes and actions were discussed at specialty and divisional governance meetings. In a report covering April to September 2015, none of the action plans from complaints were 'off track' which suggested they were on target for implementation.
- Trends in complaints were identified, learning recognised and communicated. One of the complaints recognised by the surgery team was in cancellation of planned surgery and lack of communication. This was

highlighted at the divisional governance board, discussed at the complaints' review panel and patient ambassadors' meeting. The action to rectify communication problems included:
  - Including a statement in the letter inviting the patient to their appointment of the risk it may be cancelled.
  - A proposal for an apology letter to be sent to any patient when their procedure was cancelled.
  - A medicines leaflet designed to give to patients if their procedure was cancelled telling them what they needed to know about their medicines.
- The surgery division looked at the response rate to complaints and reported on those that were not meeting the deadline to respond to patients. The required response for the trust was between 25 and 60 days depending upon the complexity of the complaint. In the performance report for the surgery, theatres and anaesthetics division for September 2015, there were four complaints breaching the timescale to respond. Three of these were due to hold-ups by the consultant involved. Prior to that, the report showed it was rare for a complaint not to be responded to in time.

Are surgery services well-led?

Good

We have rated well-led as good because:

- There was an effective governance structure and there had been investment in both time and resources for this essential area. There was review and discussion of risks, incidents, audit work, complaints and quality performance indicators within divisional management and speciality governance teams.
- There had been innovation and improvement in surgery services
- There was commitment at both ward and unit level and with the senior leadership teams. All the staff we met showed dedication to their patients, the place they worked, their responsibilities and one another. There was a strong camaraderie within teams.
- Staff were positively recognised at the hospital for many things, including dedication, innovation and being caring.

However:

- There was a strategic plan for the future of surgery services, but it did not provide any plans for delivering the objectives.
- In terms of a sustainable high-quality service, meeting patient need was under pressure from too many beds on surgery wards accommodating unplanned patients from the medical division. There was concern from a number of the consultant surgeons that their concerns in this regard were not being listened to and decisions taken were not collaborative.

Vision and strategy for this service

- The vision and strategy plan for surgery, theatre and anaesthetics did not describe how to achieve its objectives. The surgery division had a business plan for the year 2015/16 based upon strategy, objectives and priorities for the coming year. Although the plan had quite a lot of information, and followed the trust template for content, it was hard to determine what the plans were and how they would be achieved. For example, in the objective covering 'People' (staff) there was an objective to "improve the quantity and quality of appraisals across the division". The first key measure was to "ensure that all eligible staff had an appraisal every 12 months to deliver at least 80% appraisal rate." There was no description of how this would be achieved. The statement was also contradictory in that a target of 80% would not meet the target of "all eligible staff" and it did not comply with the trust target, which was 100%. There were a number of objectives in the plan, but none of these had any actions or strategies describing how they were to be achieved.
- The section on 'Workforce' described potential risks to specialties but no actions as to how to resolve the impact of these. The template stated action plans should to be developed and described, but it did not provide an area for this to be included in the report.

Governance, risk management and quality measurement

- There were mostly good arrangements for governance and risk management although some inconsistency in the time and administration provided within the surgery specialties. Audits, incident reports, and other quality information was being received and reviewed at speciality meetings, although some specialties within the surgery division were good at producing minutes, others struggled with this.

- The surgery division had appointed staff responsible for governance arrangements. There were two divisional clinical governance leads, one a consultant anaesthetist and the other a consultant surgeon. Each surgical speciality had a named governance lead who was usually a consultant or specialist registrar. The governance teams were supported by a governance administrator for surgery and audit and governance manager for theatres and anaesthetics.
- Quality and safety assurance was undertaken through regular governance meetings. The divisional governance board met each month. It was attended by senior managers, clinical governance leads from each specialty, clinical matrons and service leads. The agenda for the meeting included:
  - Reviews of the action logs from previous meetings.
  - Reviews of action plans from external reviews.
  - Review of all serious incidents. Action plan themes were reviewed through the serious incident tracking system and presented quarterly.
  - Review of the divisional risk register.
  - Review of complaints.
  - Review of the speciality dashboards.
  - Updates from the divisions within the directorate though the specialty lead reports and more comprehensive reports from each specialty every three months.
- There was good use of the divisional risk register, although some actions were not fully updated or completed. The risk register described action plans and progress made for resolving or reducing the risks identified. Risks rated as 'high' or above (scoring 15 or more) were escalated to the trust risk committee. Those scoring eight to 15 were managed at divisional level, and those below eight were managed by the relevant specialty. There were mostly good action plans to address issues raised, but these did not all appear completed. For example, there was an identified risk from September 2014 where not all emergency patients admitted were being seen by a doctor, as required, within four hours – or there was insufficient evidence from patient records to be able to show this was being done. Actions were agreed to improve this, including a re-audit of records. This was done on a number of occasions, but improvements were still not satisfactory, specifically with out-of-hours admissions.
- Another risk added in November 2014 was from delays in emergency surgery. A review was to be undertaken of these delays, although only from any incident reports made by staff. The progress report indicated this had not been carried out, and there was therefore nothing to indicate the risk had been reduced.
- One of the action plans was of concern. It related to the lack of evidence of emergency surgery patients being reviewed within four hours. There was a plan to provide a registration book for patients or carers to sign on their arrival to St Mawes ward. The patient would have to indicate their time of arrival rather than this key responsibility remaining with the staff.
- There were specialty-specific newsletters on a governance theme shared with staff each month. Information included, for example: documents and publications; National Institute for Health and Care Excellent (NICE) guidance and clinical audit updates; incidents and litigation; complaint themes and trends; and information relating to quality, patient safety and patient experience.

Leadership of service

- There was committed leadership for the surgery division, although some key posts were currently vacant. Each specialty in surgery services had a lead appointed, although there was a vacancy in one area. There was also a vacancy within the surgery, trauma and orthopaedics team for a divisional director. Other posts would become vacant with staff stepping down or retiring in 2015/16. This was recognised in the 2015/16 strategic plan for the division, but there was no action plan to address this.
- The senior staff we met were fully aware where improvements and innovations could be made to areas of surgery services, as well as where pressures and problems existed. Staff within the division and elsewhere spoke highly of the support from the senior managers. They said they were available for discussions, spent time in the departments, and recognised problems and challenges.
- There was strong and committed leadership at ward and unit level. We met several of the matrons, and most of the senior sisters and charge nurses on the surgery wards and the theatre teams and managers. There was an extensive range of experience and commitment from the leadership staff with a focus on patient care and teamwork.
- There was a gap in leadership in the patient discharge lounge, although we were told this was to be filled

shortly after our inspection. The unit had opened in November 2015 and no manager had been in post since that time. The unit was being run predominantly with bank and agency staff and therefore did not have a clear direction or leadership.

Culture within the service

- We found surgery staff to be committed to their patients and their wards or units, and staff we met reflected a positive culture and flexibility. The issues worrying staff were almost all connected to them not meeting patients' needs, and their access to services at all times. Staff were otherwise positive about giving good care and supporting one another.
- There was a certain amount of discontent among consultant surgeons who believed their concerns about the service not being addressed. We met a number of consultant surgeons who told us they did not feel the trust was listening to their concerns about the current poor performance of the service to meet patients' needs. We also received letters and written correspondence saying the same thing. Consultants told us they believed the decision to ring-fence surgical beds for medical patients had not been made collaboratively.
- Although staff were dedicated to their patients and each other, staff spoke of a low morale among staff in surgery services due to high numbers of vacancies and the pressures caused by a lack of beds. Staff said it was hard for them, on a daily basis, to have to inform patients their operation was being cancelled or delayed, and there being regular and sometimes constant change and reorganisation. This had resulted in staff being unable to complete the more general but important jobs like appraisals and training. There were a number of staff we met with too many responsibilities to manage. For example, the experienced and highly valued matron in theatres felt overwhelmed with their responsibilities and the obvious distress they experienced from not being able to meet them all the time.
- Compliments were passed onto staff about their kindness and excellent care and treatment. We saw recent thank-you cards on wards and units for staff to read. We saw a high number of compliments including staff being singled-out by patients for their kindness and care. There were staff 'Excellence and Innovation' awards on a regular basis with staff recommended and rewarded for achievements in small and big areas. These awards included the 'Extra Mile' award, recognising staff or wards that had made special efforts for patients or relatives.
- Managers spoke highly about their staff. When we asked senior managers on wards and theatres what worked well in their role, they spoke about their staff. This was particularly the case in both the operating theatre areas. The manager of the Tower unit said the flexibility of staff and their attitude to often stressful situations and changes in plans for the day was "brilliant, and they are such a great team."

Public engagement

- Patients were able to give feedback on their experiences through the NHS Friends and Family Test (FFT). Results from the FFT were reported and discussed at divisional meetings and within wards and teams. Patient experience, including compliments and complaints, and the results of the FFT were displayed within the wards on 'How are we doing' notice boards. The board and divisional governance reports we reviewed did not contain any reference to more in-depth patient feedback, and included just the FFT results.
- Patients took part in Patient-Led Assessments of the Care Environment (PLACE), although the results did not relate to named wards or the surgery services specifically. The results, which were mostly better than NHS averages, were encouraging for staff, patients and the trust.
- Not all patients found the names for the surgery services easy to follow. A number of patients commented upon finding the names confusing and several commented upon how they had their phone calls directed to the wrong place. We spoke with receptionist staff who confirmed this. Some patients commented upon how they were getting used to the name 'Theatre Direct' but questioned why 'day surgery unit' had been dropped.
- The trust had links to a number of organisations to provide additional support to patients and carers. This included local carers' support groups, services for young people, drug and alcohol support, and links to national charities such as the Alzheimer's Society, the Red Cross, and the Women's Royal Voluntary Service.

Staff engagement

- There was good internal engagement with staff at both trust and local levels, although some staff had problems

with getting access to a computer to see messages and correspondence. The trust used an email broadcast facility to cascade messages through staff groups from the executive team and senior managers. Some staff working in theatres and wards did not have access to a computer at all times and needed to go to the education centre, often in their own time, to make sure they had seen all .

- There were local meetings in wards and units. We looked at examples of the minutes from meetings on St Mawes ward where a variety of subjects were discussed about the running of the ward. Other staff confirmed there were regular meetings on both wards and units and between different disciplines and multi-professional groups.

Innovation, improvement and sustainability

- Innovation and improvement was sought and encouraged within the surgical services. There had been a number of innovations and improvements in the surgery division. These included:
  - Completion of a two-year programme of investment in the operating theatres. The trust now had five integrated laparoscopic theatres, two new orthopaedic laminar flow theatres (which operated a system of airflow to reduce the risk of airborne contamination), and expansion of recovery areas.
  - Coaching and mentoring for trainee doctors in the anaesthesia team.
  - Review and rationalisation of venous thromboembolism prophylaxis (risk management) in the operating theatres.
  - Human factors training in operating theatres.
  - An electronic booking system for the emergency operating theatre.
  - Introduction of a new service for patients with reflux symptoms. This prevented the necessity for patients to travel out of county for tests.
  - Simulation training in wards, recovery units and with trauma teams.
- As the surgery division recognised and had escalated to the corporate risk register, the surgery service was not providing a high-quality sustainable service with the current ring fencing of 40 beds for medical patients on surgery wards. This was resulting in cancelled operations and some specialties, such as bariatric surgery, which were not part of national monitoring, seeing patients significantly affected by cancellations.

Critical care

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

Information about the service

Critical care at Royal Cornwall Hospital provides a service to patients who need intensive care (described as level three) or high dependency care (described as level two). Patients were admitted following complex and/or serious operations and in the event of medical and surgical emergencies. The unit provided support for all inpatient specialities within the acute hospital, and to the emergency department. A consultant intensivist (a consultant specialising in intensive care medicine) led the service with support from the consultant team, junior doctors, and a team of nurses and support staff.

The unit had 19 bed spaces used flexibly and funded by commissioners to provide care to 15 patients. Winter-pressure funding had enabled the unit to extend the provision to 17 beds until 31 March 2016. The unit was divided into two discrete areas built to slightly different standards. The 'north' side of the unit had seven bed spaces, and was the more modern build of the two areas. This area accommodated mostly level three patients when possible. The 'south' side of the unit had 10 bed spaces and two side rooms. This area mostly accommodated level two patients and patients who needed isolation facilities. Female patients were accommodated, when possible, on one side of the south side and male patients on the other. A nurses' station partitioned the two sides. The department admitted around 40% of patients from elective (planned) and emergency surgical procedures. The other 60% were non-surgical patients. Of the surgical procedures, around half were high-risk elective surgery, and the other half were following emergency surgery.

The hospital was experiencing a high level of pressure on the service at the time of the inspection. The unit was regularly at full capacity as a result. This reflected issues seen nationally. The number of patients treated had fluctuated over the past five years, but increased with the new bigger unit commissioned in 2013. There were usually around 250 patients each quarter or there had been as many as 100 per month. In 2015, the critical care team cared for approximately 950 patients.

On this inspection, we visited critical care on Wednesday 12, Thursday 13 and Friday 14 January 2016. We spoke with a range of staff, including consultants, doctors, trainee doctors, nurses, healthcare assistants, and a member of the housekeeping team. We met with the clinical lead for the service and the two senior nurses who ran the nursing team. We spoke with physiotherapists, including the lead for that service, the advanced nurse practitioner in charge of the outreach team, the lead pharmacist, and one of the ward clerks. We met with patients who were able to talk with us, and their relatives and friends. We checked the clinical environment, observed care and looked at records and data.

Critical care

Summary of findings

We rated this service as good because:

- Patients were protected from abuse and avoidable harm.
- There was a good record on safety with lessons learned from incidents and improvements made when things went wrong. Staff were aware of their duties to explain and apologise on the rare occasion when things went wrong. Staff were actively encouraged within the unit to raise concerns through an open, transparent and no-blame culture.
- There was safe monitoring of patients and staff responded to changes. Patient records were comprehensive, well maintained, clear, and contemporaneous.
- There was a safe environment and the right equipment and the unit was clean with low rates of infection. There was good management, storage and safe used of medicines and consumable stocks.
- Nurse staffing levels were safe, but they were too dependent upon the use of temporary staff. There was wide-ranging experience and skills among the teams of nursing staff and a strong commitment from the experienced consultant intensivists.
- The provision of pharmacist and physiotherapist services did not wholly meet recommended staffing levels, but the dedicated teams prioritised critical care patients and provided a safe service.
- Patients had good outcomes as they received effective care and treatment to meet their needs. There was good provision of treatment and care in accordance with best practice and recognised national guidelines. Patients' needs in relation to pain, nutrition and hydration were well managed.
- There was a strong multidisciplinary approach to assessing and planning care and treatment for patients.
- Mortality rates were better than expected.
- Most services required to meet patient needs were available across all seven days of the week.
- There was good support to new nursing/healthcare staff and junior and trainee doctors.
- There was valued support to patients and their families. They were treated with dignity and respect, and involved as partners in their care. Staff treated patients with kindness and warmth.
- People's feedback about the service had been entirely positive. Patients said staff were caring and compassionate, treated them with dignity and respect, and made them feel safe. The unit was busy and staff were professional, but they had time to provide individualised care.
- Relatives were able to ask questions and raise anxieties and concerns, and given answers and information they could understand.
- Consultants and nurses reviewed patients in good time.
- Patients were treated as individuals and equalities, diversities, and patients with different needs were supported. There were no barriers to people to complain.
- There was an example of outstanding care delivered to a long-stay patient enabled, by the work of a team of professionals, to go home.
- The regular reviews of safety and quality through governance meetings promoted the delivery of safe patient care. The staff in critical care were committed to their patients, their staff and their unit.
- The unit participated in the national audit programme through the Intensive Care National Audit and Research Centre (ICNARC). Data returned by ICNARC was adjusted for patient risk factors, and the unit could benchmark itself against other similar units to judge performance.

However:

- The service did not always meet patients' needs. There were bed pressures in the rest of the hospital that meant too many patients were delayed in their discharge from critical care to a ward, or discharged at night. Not all patients were able to get a bed in critical care when they needed one.

Critical care

- There was a good review of mortality and morbidity, but actions and learning were not evident within reporting.
- Not all targets were reached for mandatory training and staff updating their knowledge. Appraisal, training and development were not delivered to planned targets due to staff shortages. Not all staff were being trained for using specialist equipment.
- There was insufficient security of resuscitation trolleys to show they had not been tampered with between checks.
- Written protocols and procedures for the service required updating.
- The unit had not contributed to a tracheostomy self-assessment study or assessed the skills and experience in tracheostomy care when transferring patients elsewhere in the hospital.
- There was a lack of recognition of Deprivation of Liberty Safeguards.
- Critical care did not have a clear vision and strategy. Some risks in the unit had not been captured within the risk register and the document needed clearer written actions.
- The trust needed to resolve the long-standing issues with the sustainability and capacity of the service and the effect on staff morale from bed and staffing pressures.

Are critical care services safe?

Good

We rated safety as good because:

- People were protected from abuse and avoidable harm.
- There was a good record on safety with lessons learned from incidents and improvements made when things went wrong. However, staff were not always reporting some 'everyday' incidents. Staff were aware of their duties to explain and apologise on the rare occasion when things went wrong.
- Staff closely monitored patients and responded appropriately to changes.
- There was a critical care outreach team providing a hospital-wide support service, although this was only from 7:30am to 7:30pm seven days a week, and not 24 hours as recommended by the Faculty of Intensive Care Medicine.
- There was good and well-maintained equipment and a safe environment for patients, visitors and staff. The unit was visibly clean and well organised and staff adhered to infection prevention and control policies and protocols. This led to low rates of infection. There was safe management, storage and use of medicines and consumable stocks.
- There were safe nurse staffing levels, although there were too many temporary staff, and some shifts filled with agency staff at higher levels than recommended. There was wide-ranging experience and skills among the teams of nursing staff and a strong commitment from the experienced consultant intensivists.
- The provision for pharmacist and physiotherapist services did not wholly meet the recommendations of the Faculty of Intensive Care Medicine Core Standards in terms of cover, but the dedicated teams prioritised critical care patients and provided a safe service.
- Patient records were comprehensive, well maintained, clear, and contemporaneous.

However:

- There was good review of mortality and morbidity, but actions and learning were not evident within reporting.
- Not all the mandatory training targets were achieved to show staff had updated their knowledge were achieved.

- There was insufficient security of resuscitation trolleys to show they had not been tampered with between checks.

Incidents

- The safety performance of the critical care unit was good. There were low numbers of reported incidents of avoidable patient harm, unit-acquired infections, and errors leading to patient harm.
- Staff were open, transparent and honest about incidents and reporting them, although there was no ability in the electronic system for staff to categorise the incident at source or analyse themes. All staff we spoke with said there were no barriers to reporting incidents or near misses and they were encouraged and reminded to do so. Staff said the reporting system was uncomplicated to use, although equally too basic for useful analysis. From the report of incidents, we were unable to determine if both incidents taking place and near misses were reported, as they were not categorised in this way. Staff were not able to classify incidents by their type, such as a fall or a medicine error, for example. They were not able to grade them by their seriousness, as would usually be expected. A department in the hospital received and managed incidents centrally. They were graded and categorised therefore by other staff who were not involved.
- There was no blaming of staff for errors or omissions leading to incidents or near misses. All staff we asked said they were not afraid to speak up when something went wrong, or should have been done better. Staff said there would be open discussions and, where identified, reminders to all appropriate staff, additional training, mentoring and learning made available.
- Staff generally recognised incidents, but some 'everyday' incidents not routinely reported. Although it was not easy to analyse, the incident report did not, as would be expected, appear to include any failures of, delays to or night-time discharges of patients. A search of the document for the word 'night' or 'delayed' did not produce any results relating to delayed or out-of-hours discharges. As discussed below within the 'Access and Flow' section, critical care, due to bed pressure in the rest of the hospital, had significant delayed or night-time patient discharges. There was no evidence to show these incidents were reported, or they were considered as incidents by staff as they had become 'normal'.
- Although the system for reporting incidents was not easy to analyse, a review showed staff reported a wide range of different events. Entries included reports from both medical and nursing staff, and covered incidents from avoidable patient harm (such as falls and pressure ulcers) and errors with medicines. It was not possible to tell from critical care or hospital data if the unit was a strong reporter of incidents but the trust, overall, was below the NHS England average for reporting incidents. There were 7.2 incidents reported for every 100 patient admissions, against an NHS average of 8.4 incidents reported within the NHS. This could be an indicator of the need for the trust to improve the reporting culture among staff.
- Staff had feedback from reporting incidents. When there was recognition of a trend or pattern with some incidents, staff were informed by the central team managing incidents. There was evidence in staff meeting minutes of discussions of these incidents where there had been a developing trend, or specifically unusual or significant incidents. Staff would otherwise get feedback at local level from both incidents where there were trends, or unique circumstances.
- The service learned from serious incidents requiring investigation. There was one serious incident linked with, although not attributable to critical care staff in 2015. This involved an unintentional failure in communication in relation to a deceased patient, due to technical problems. The patient had passed away on the critical care unit. Although the technical difficulties had been elsewhere in the hospital, the unit staff had been part of the investigation into the failings. Staff described the incident and how there were lessons learned by all involved to avoid any recurrence. We noted also how staff in critical care had a genuine empathy for the people affected by the incident.
- There had been introduction and implementation of the Duty of Candour. Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation introduced in November 2014. This Regulation requires an NHS 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 that falls into defined thresholds. The trust had produced a guide for staff to follow explaining the legal requirements upon them and the trust when things went wrong. Staff we spoke with were aware of the new regulation to be open, transparent and candid

with patients and relatives when things went wrong, and apologise to them. The duty had been recognised and applied, as required, in the serious incident mentioned above when corresponding with the relatives of the patient.

- Critical care staff and a hospital-wide committee reviewed patient mortality and morbidity (M&M). There was a good attendance of consultants at the meeting in September 2015, although previous records did not list attendance. There did appear, however, to be no members of the senior nursing team in attendance or invited. There were good records of discussions held demonstrating reviews into patient deaths and any other concerns.
- There was insufficient evidence to show how agreed actions or learning identified from the M&M reviews was followed and led to improvements. There were no minutes within the M&M review evidence to demonstrate if or how staff were accountable for any actions agreed from reviews. There was some recognition of areas for improvement, but no actions to deliver changes. For example, in one death reviewed in July 2015, where there were some significant concerns with care provided within the hospital, there were no learning points recorded or actions required.

World Health Organisation checklist

- Critical care had introduced a World Health Organisation (WHO) checklist for insertion of tracheostomies. The checklist was based on the WHO surgical safety checklist: a system to check all the elements of any surgical procedure to avoid errors or preventable complications. As the introduction of this system was relatively recent, the quality of the use of the checklist had yet to be audited. This was due to take place in February 2016 with results presented to the governance committee in April 2016.

Safety thermometer

- Avoidable harm-free care was improving within critical care. The trust reported data on patient harm each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. It covered incidences of hospital-acquired (new) pressure ulcers (including only the two more serious categories: grade three and four); patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis). In the most recent published data for July 2014 to July 2015, critical care reported 100% harm-free care in just the last two months. When removing the category of 'all pressure ulcers' from the data (as these could be acquired elsewhere), the unit would have delivered 100% harm-free care in a further six months. There had been no incidences of venous thromboembolism since February 2015 and only one urinary tract infection in August 2014. The prevailing issue was with unit-acquired pressure ulcers, so those attributable to critical care, and not a condition the patient was possibly admitted with.
- Critical care had recently stopped displaying avoidable patient harm data within the unit for patients, relatives and staff to see, although it was considered as best practice to display these results. Staff were not sure why it had been removed from the public notice board. There was a display of other audit data in public places in the spirit of openness and transparency, but not avoidable harm.

Cleanliness, infection control and hygiene

- Rates for unit-acquired infections were relatively low although there had been incidences of unit-acquired Clostridium difficile in the past five years. Data reported by the unit to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland) supported this evidence. During this time most rates of infection had been below (better than) the national average, but there were relatively frequent single incidences of Clostridium difficile. Looking at more recent data on infections:

- There was one unit-acquired Methicillin-resistant Staphylococcus aureus (MRSA) infection in the year from October 2014 to September 2015 (the latest data produced by ICNARC). This was below (better than) the national average.
- There were four incidences of unit-acquired Clostridium difficile in the same period (0.4%), although over time this was much the same as the national average.
- There had been six unit-acquired bacteraemia infections (not MRSA) in the year to September 2015 (slightly more than average)

- There were no MRSA infections in blood (and just one in the past five years).
- There were consistently high cleaning standards. The housekeeper on the unit was part of the team and worked only in critical care. Audits showed a high level of cleaning. The regular housekeeper had won two awards for the standard and quality of cleaning.
- There was effective screening of patients for MRSA. Audits for the four months from July to October 2015 showed full compliance.
- There were root-cause analyses for any unit-acquired infections. These were completed investigations for the four incidences of Clostridium difficile and the one incidence of MRSA. Different members of staff including the infection prevention and control nurse were involved in the investigations. None of these found any non-compliance with hospital protocols or failings in care.
- At the time of our inspection, the environment and equipment in the critical care unit were visibly clean, well-organised, maintained and tidy. Bed spaces were visibly clean in both the easy and hard to reach areas. Bed linen was in good condition, visibly clean and free from stains or damage to the material. To reduce cross-infection, there were laminated notices, signs and posters on the walls or surfaces in clinical areas secured with pins or reusable adhesive.
- Equipment was stored and sealed to prevent cross-contamination. All disposable equipment was in sealed plastic bags and placed in drawers or cupboards where possible to prevent damage to the packaging. Equipment at the patient's bedside, such as oxygen or other tubes, were plastic-wrapped when not in use to protect them from cross-contamination. There was regular cleaning of any large equipment stored in cupboards, or it had dust covers where they were available. Staff said they would re-clean any stored equipment brought back into the unit. Most equipment in storage was on racks so the floor areas beneath were easier to keep clean and equipment did not need to be constantly moved to allow for cleaning.
- Nurses checked bed spaces at each shift handover. This included a check of the bed linen for cleanliness and good condition, tubing being clean and clear, the bed and pillows in good shape, and areas clean and tidy.
- Staff followed hand sanitising and personal protective equipment rules on the unit. This met guidance around safe hand-washing from National Institute for Health and Care Excellence (NICE) statement QS61 Statement 3. We observed a good standard of practice from doctors, nursing and all staff. They were following policy by washing their hands between patient interactions and using anti-bacterial gel. They wore disposable gloves and aprons at the bedside when carrying out patient care or, for example, disposing of fluids or waste products. Staff used hand gel when entering and leaving the unit or moving between clinical and non-clinical areas. All staff were bare below the elbow, and wearing no watches or inappropriate jewellery when they were within the unit.
- Visitors were required to follow infection control protocols. Staff requested them to use alcohol gel on arrival and explained why. Hand gel was available and reasonably well sited. Staff told us they would increase their infection control procedures for visitors by providing them with personal protective equipment (gloves and aprons) when circumstances dictated this was the correct thing to do.

Environment and equipment

- There was regular servicing and maintenance of equipment. We reviewed the maintenance schedule and requests from August to October 2015. This demonstrated completion of routine planned maintenance within a few days of it falling due. There were mostly effective repairs carried out relatively quickly. Staff said while repairs were being undertaken, they were able to hire or temporarily replace any essential equipment. There were acceptance tests recorded for new equipment to check it was functioning correctly, and routine electrical safety tests.
- The units had appropriate equipment for use in an emergency, although resuscitation trolleys were not tamper evident. The unit carried resuscitation medicines and equipment including defibrillators and a difficult airway intubation trolley. There was a requirement to check resuscitation equipment each day. The trolley on the south side had a few gaps in the checklists over the last three months (11 checks missing) and the north side had two checks missing. This issue was raised on our previous inspection and had clearly yet to be fully resolved. There was no apparent responsibility among the staff for reporting when they found gaps in checking. Staff said the difficult airway trolley was checked each day, but

this was not permanently recorded (it was part of a general safety check that was overwritten each day). The resuscitation trolleys were of a different type to those used elsewhere in the hospital. Critical care used plastic trolleys that were the same as other general trolleys used for equipment. They did not have drawers to make their contents fully secure or to prevent or indicate tampering with the medicines or other equipment between checks.

- The unit was not ideally designed in terms of security, but staff were aware of this and endeavoured to direct visitors. The main entrance doors were locked and visitors were checked before they were admitted. Once on the unit visitors came into the unit they could walk into the clinical areas as the waiting room was located beyond the clinical entrances (which had no doors). This had been recognised and staff had been reminded at a unit meeting to ensure all visitors were directed or shown to the waiting room, until they were met by staff.
- The facilities in the unit met most of the Department of Health guidelines for critical care facilities (Health Building Note 04-02), although the two distinct parts of the unit (north and south) were different. Some of the ways the unit performed against the guidelines were:
  - The main operating theatre complex was located immediately next to the critical care department for accessing emergency support.
  - Bed spaces were of a suitable size for, in an emergency, giving up to five staff enough space to work safely with a patient. The spaces in the north side achieved this well, but those in the south side were smaller. Most patients were visible from the central nurses' station but a wall in the nurses' station obstructed two beds on the south side.
  - There were separate buttons for patient call bells and emergency calls. The bed spaces had a suitable flat screen monitor.
  - Some service provision was below recommended levels. As recommended for safety at bedside, the north side had four oxygen outlets, four four-bar outlets, and four medical vacuum outlets. On the south side there were three oxygen outlets (the minimum level), but only one four-bar air outlet (as opposed to two) and two medical vacuum outlets (as opposed to three).
  - There was a reasonable level of mobile equipment available including haemodialysis/ haemofiltration machines, a monitor to generate an electrocardiography reading, and a bedside echocardiography machine. There was an ultrasound machine, defibrillators, non-invasive respiratory equipment (CPAP and BIPAP), patient warming equipment, and bronchoscopes. There were also cardiac output monitors at each patient bedside. The unit did not have a dedicated portable X-ray, but staff requested this from the imaging department when needed.
  - There were two patient isolation rooms with a changing lobby and hand-washing sinks to minimise infection cross-contamination, and air change facilities.
- The ways the unit failed to meet the guidelines were:
  - On the south side, the equipment around the bed space was not located on ceiling-mounted pendants for optimal safety. This meant there were some electrical cables on the floor, although they were close to the wall and kept tidy. Equipment was mounted on pendants on the north side.
  - On the south side, electrical sockets had on/off switches as opposed to being the type that were without switches. This gave rise to a risk of inadvertently switching off equipment still plugged in.
  - On the south side of the unit, not all beds had clinical hand basins. These were shared between a number of beds.
- There was safe management of clinical waste. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. There was a full range of disposable equipment in order to avoid the need to sterilise equipment and significantly reduce the risk of cross-contamination. We saw staff using and disposing of single-use equipment safely at all times. None of the waste bins or containers we saw, for disposal of clinical waste or sharp items, were unacceptably full. Nursing staff and the housekeeper we met said they were regularly emptied.

Medicines

- Non-emergency medicines were stored appropriately to prevent tampering or unauthorised removal. Medicines were stored as required in locked cupboards with access given only to authorised staff. Fluids, including those stored in bulk storage, were also locked away as required.

- Medicines to be refrigerated were kept at the correct temperature, and so would be fit for use. We checked the refrigeration temperature checklists in the unit, which were signed to say the temperature had been checked each day as required.
- Medicine storage audits had improved and recently showed good results. In the seven months from April to November 2015, compliance had improved from 85% in April to 100% in both September and October, and 97% in November. There was presentation and discussion of these audits at monthly unit meetings.
- There was management of controlled drugs in line with legislation and NHS regulations. There were clear recordings in the controlled drugs register of drugs being booked into stock, administered to a patient, and any destruction or return to pharmacy. We checked controlled drugs in tablet (all boxed) and liquid form and stocks of liquid potassium chloride 15% W/V. All were stored and secured appropriately as a controlled drug. Stocks were accurate against the records in all those drugs we checked at random. We cross-referenced two of the drugs with a patient drug chart and found the drug documented as administered on the occasions and at the dosage stated in the controlled drug register.
- There was a dedicated formulary for critical care medicine embedded within the electronic patient record. This was a list of medicines approved for the use of critical care patients, maintained by the lead pharmacist, lead nurse and the consultants. There were standardised medicine infusion regimes, which helped to reduce errors and maintain appropriate levels of stock.
- All patients' medicine records were checked and maintained on the electronic patient record system. A pharmacist checked these each day, and specifically upon admission or and discharge of a patient. The following morning the ward pharmacist checked the records for a patient discharged to ward at night. The critical care pharmacist carried out an independent check the following day. This ensured the patient and their records were accurately handed over.

Records

- Patient records were held confidentially in a bespoke electronic system. Only authorised staff could review patient records to keep them secure and confidential. Patients' care plans were developed on admission, and further expanded as treatment advanced. The system recorded patient infusions and medicines prescribed and given. There was automatic reconciliation of patients' fluid balances from measures of intake and output. Other records included pressure area care, ventilator care, and sedation monitoring.
- Patient records were well completed. We reviewed 12 sets of notes. They recorded the name and role of the person completing the record. We were able to determine from records how there was a review of patients by a consultant within 12 hours of their admission, as is best practice. There was clear diagnosis of the patient's condition and a comprehensive management plan.
- There was a problem with saving or seeing some new information entered by visiting multidisciplinary staff. If there was a review of a patient by a member of staff who did not have access to the system, they could be given access by a regular member of staff. Any information they updated then had to be saved otherwise it would be lost. If it had not been saved, and another tab in the record was used, the information would be lost. One visiting professional had also written comments in the patient's paper records rather than within the electronic record. There was a high risk this information could therefore be overlooked.
- Documentation audits showed a high rate of completion of patient records, although there was a significant drop in compliance in November 2015, which was against the grain. Audit results from April to October 2015 were all above 90% and October was 99%. However, the result for November 2015 was 76%. The document provided to us gave no explanation as to the failings in that month, but it was recognised and reported at the monthly governance meeting.
- The critical care discharge paperwork was not helpful to staff admitting the patient to another ward. One area of weakness in the electronic patient record system was with the lack of a comprehensive discharge summary or handover document. The document produced was a lengthy description of all patient care. The wards at Royal Cornwall Hospital did not use the same patient record system and notes were paper-based. Staff on surgical wards commented to us about the extent of the handover information. Admitting staff on the wards were having to trawl through the critical care records to extract appropriate information. This created a risk of important information not being found, or not found

easily, and possible misinterpretation. The presence of a structured critical care discharge summary providing essential information to ensure continuity of care after critical care discharge was a key requirement specified within NICE Guidance 50. The lack of a suitable discharge summary had not been included on the divisional risk register, although highlighted as a concern at the monthly critical care meeting.

- The resilience of the electronic patient record system had improved since our last visit. In January 2014, we criticised the lack of staff trained or experienced to make changes or deal with problems with the bespoke record system. This had improved since then with clear guidance on what to do (other than use the local member of staff) if there were problems. There were now other avenues, including the technology provider, who could assist and the unit was less vulnerable to the one member of the team being unavailable.

Safeguarding

- There were staff trained to recognise and appropriately respond in order to safeguard a vulnerable person, although not all had updated their knowledge by the trust's deadline. Safeguarding training covered vulnerable adults and children, so gave staff direction to safeguard any adult, children or young people admitted onto the unit. It would also give staff guidance to safeguard children of any age associated with a patient or visitor. Updating training was mandatory with an expectation of all staff completing it. The results at the end of December 2015 for the nursing/support staff were:
  - Adult-related training was 100% at level one, and 84% at level two.
  - Child-related training was 67% at level one, and 73% at level two.
- We did not have this information for the medical staff, but for the medical staff in the division in which critical care sat (surgery, theatres and anaesthetics) the statistics were as follows:
  - Adult-related training was 95% at level one, and 56% at level two.
  - Child-related training was 54% at level one, 59% at level two, and 100% at level three (although this was only relevant to one member of staff).
- There were policies, systems and processes for reporting and recording abuse. The safeguarding adults' policy had been implemented in accordance with national guidelines. The policy had been updated in 2015 to take account of the statutory requirements of the Care Act (2014) which had superseded the government's 'No Secrets' paper of 2000. The policy referenced the local authorities' policies to ensure approved and recognised local safeguarding systems and processes were recognised. There were listed definitions of forms of abuse and people who might be at risk. This linked with the provisions of the Mental Capacity Act 2005 in relation to deciding if a person was vulnerable due to their lack of mental capacity to make their own decisions. The policies (including the policy for child safeguarding) clearly described the responsibilities for staff in reporting concerns for both adults and children, whom, as required, were subject to different procedures. There were checklists for staff to follow to capture relevant information and inform appropriate people.
- Staff were aware of their responsibilities to report abuse, and how to find any information they needed to make a referral. We spoke with a range of staff who described those things they would see or hear to prompt them to suspect abuse of the patient or another vulnerable person (such as a child in the care of the patient or a visitor). This included some of the obvious signs such as bruising or broken bones. It extended to the less obvious markers including the patient or another vulnerable person being withdrawn, scared or uncertain. Staff recognised how abuse could be physical, but also emotional or neglectful. Staff were aware of their statutory duty to report their concerns and said there were no barriers to making referrals.

Mandatory training

- Not all staff were meeting the trust target and up-to-date with the latest mandatory training refresher courses. Staff were trained at induction in a wide range of statutory and mandatory subjects. Staff were expected to update this training at certain intervals set by the trust. The critical care staff were not meeting trust's target levels for 100% having updated their training. The training included a wide range of topics such as conflict resolution, infection control, equality, diversity and human rights, and health and safety topics. Compliance with the mandatory training requirements at the end of December 2015 for the nursing/support staff was 81%. Medical staff statistics were not provided just for critical care, but the results

for the division in which critical care sat (surgery, theatres and anaesthetics) showed 68% had updated their training. In terms of subject matter, some results should be highlighted:

- Of nursing/support staff, 100% had updated their equality and diversity training. Medical staff were just behind at 92%.
- Of nursing/support staff, 95% had updated their patient manual handling training, but this was completed by only 7% of medical staff.
- Of nursing/support staff, 68% had updated their infection control training. Medical staff were just behind at 67%.

Assessing and responding to patient risk

- Critical care staff were effectively using systems for monitoring acutely ill patients. The trust had implemented and was using the National Early Warning Score (NEWS) system for the monitoring of adult patients on wards. The hospital policy recognised best practice in this system as promoted by the National Institute for Health and Care Excellence (NICE) guidance on care of the acutely unwell patient in hospital (NICE 50). Audits of use of NEWS and patient risk assessments showed full completion of over 90% in the seven months from April to November 2015.
- Critical care staff responded well to patient risk through regular assessments and reviews. Ward rounds in critical care took place twice daily in the morning and evening led by the consultants on duty. There was input to the ward rounds from unit-based staff including the junior doctors, and the nurses caring for the patient.
- There was close monitoring of patients in critical care at all times so staff could respond to any change or deterioration in their condition. There were recommended levels of nursing staff caring for patients who were cared for by the same nurses when this was possible. This meant changes or deterioration in the patient might then be picked up faster.
- Each ventilated patient was monitored using capnography, which is checking the concentration or partial pressure of carbon dioxide in respiratory gases. Equipment was available at each bed on the unit and used during intubation, ventilation and weaning, as well as during transfers and tracheostomy insertions.
- The hospital did not meet recommended practice with the provision of outreach services, although the level of service had improved. The hospital had 12-hour daytime, but not 24-hour cover from the critical care outreach team. On 1 January 2015, following the appointment of two new staff to the team, the service had expanded to seven days a week. Experienced and skilled nurses provided the outreach service from 7:30am to 7:30pm, 365 days a year. The Guidelines for the Provision of Intensive Care Services (Faculty of Intensive Care Medicine, Intensive Care Society, and others, 2015) recommended outreach services be provided 24 hours a day. It stated the hospital should "ensure an appropriate response always occurs and is available 24/7." At night, deteriorating patients were the responsibility of the hospital-at-night team. The hospital-at-night team were skilled practitioners, but they had a multiple focus across the whole site and were not critical care trained. There was a risk therefore to patients of care or transfer not being timely when there were competing priorities.
- The critical care outreach team met with different staff teams to review patients, and were part of the emergency response team. Outreach staff contacted the hospital-at-night team each morning at 7:30am for an update on deteriorating patients. A member of the team attended the medical handover on the Medical Admissions Unit at 8am each morning. They received an update on any medical patients or new patients in the emergency department identified as particularly unwell. Patients reviewed overnight by the on-call anaesthetist were handed over to the outreach team at 8am each morning. At the end of the shift, the outreach team made the hospital-at-night team aware of any patients in the hospital who required review or monitoring overnight. Outreach team staff were part of the trauma, cardiac arrest, and paediatric emergency response teams.

Nursing staffing

- There were safe nursing staff levels in critical care in line with professional standards, but due to unfilled vacancies these were supplemented too often by agency staff and what should have been supernumerary senior nurses. There were shortages in filling healthcare assistant shifts, although this had improved. Nursing numbers were in accordance with the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. Therefore, patients assessed as needing intensive care (described as level three) were cared for by one nurse looking after that one patient at all times.

High dependency patients, (described as level two), were cared for by one nurse looking after two patients. The nursing rotas demonstrated meeting this nursing ratio although frequently with the use of agency or bank staff. When there were unfilled shifts, there was a request for any of the unit's own staff to offer to cover before going out to the bank of agency. Staffing levels over the period from July to October 2015 were as follows:

- In July, there was a good fill rate for nurses (97%), but healthcare assistant cover was down by 25%.
- In August, there was a good fill rate for nurses (98%), but healthcare assistant cover was down by 30%.
- In September, there was a good fill rate for nurses (96%), and healthcare assistant cover exceeded establishment by 38%.
- In October, there was a slightly reduced fill rate for nurses in the daytime (90%), but this improved at night (98%). Healthcare assistant cover was 95%.

- Critical care endeavoured to limit the use of agency staff, but did not always meet recommendations for restricting the number of temporary staff. The Faculty of Intensive Care Medicine (FICM) Core Standards recommended agency staff did not exceed 20% of the nursing staff cohort on any shifts. This was to ensure the unit was staffed by predominantly experienced nurses at all times. Senior staff told us, and rotas we reviewed for September to December 2015, showed there had been agency staff of around 20%-25% on a number of occasions. There were 20% agency staff on our visit on 14 January 2016.
- Staffing shortages affected the managerial time and responsibilities of the senior staff. The two nurse managers on the unit were not recognised as supernumerary in the staffing plans, which is to say they were not included in the numbers of staff delivering direct patient care. Both these senior staff had managerial responsibilities and oversight, and commitments to training and governance. They told us, however, they were now frequently required to work clinically on the department to ensure the safety of the unit. This did not meet the recommendations of the FICM Core Standard 1.2.5. To meet this recommendation critical care would need two supernumerary nurses at all times. Although there were two band seven nurse managers, these nurses were too frequently required to deliver direct patient care. Winter funding had improved staffing levels temporarily, and had enabled one of the sisters to reduce direct patient care requirements, be supernumerary more of the time, but this was not a permanent situation.
- There was good handover. Nurses safely handed the patients over to the new shift following a set protocol working through the patient's risks and care planning. A daily shift-change safety briefing included looking at any patient isolation requirements, any patients at risk of falls, patients awaiting discharge, the risk of pressure ulcers or to airways, and had there been any patients moved during the night.

Medical staffing

- Critical care leadership was by an experienced consultant clinical lead supported by a skilled team. The clinical lead was a consultant in intensive care medicine and Fellow of the Faculty of Intensive Care Medicine (FICM). The ten consultants working on the primary rota were consultant intensivists and therefore highly experienced in delivering care to some of the most critically ill patients in the hospital. One of the consultant team was a respiratory physician who brought a different and valued perspective to patient care.
- The level of consultant presence on the unit was in line with professional standards. The experienced consultant presence on critical care followed the recommendations of the FICM Core Standards. There was a good consultant to patient ratio, particularly through the week, although this was at the minimum level during weekends. At the weekend there was one consultant on duty from 8am, generally resident on the unit until 9:30pm, then on-call at home until 8am the next day, which meant the unit did not exceed the minimum level of one consultant to 15 patients. This coverage would fail to meet the recommendation, however, when winter-pressure funding increased admission to 17 patients.
- Consultants were available at all times and their time was committed to critical care. Consultants often took telephone calls from staff when on call at home, and came onto the unit out of hours when needed. This arrangement was in place seven days a week. When consultant intensivists were on duty or on call, this was only for critical care and not extended elsewhere in the hospital.

- The number of junior doctors on duty met the recommendation of the Core Standards. The unit's arrangements met the recommendation for there to be at least one junior doctor for a maximum of eight patients.
- There was a good commitment of consultant time on the unit. The FICM Core Standards required consultants to have a minimum of 15 programmed-activities of consultant time committed to critical care each week. This was achieved on the unit, and generally far exceeded. There had been some use of locum doctors, but this was relatively low.

Allied Health Professional staffing

- There was a good service from the pharmacist team, although it did not meet the recommendations of the Faculty of Intensive Care Medicine (FICM) Core Standards in terms of cover provided. The recommended cover level was a consensus of critical care pharmacists, the UK Clinical Pharmacy Association, and the Royal Pharmaceutical Society. If the unit was full with 15 patients, and patients were at levels used for planning (six level three and nine level two patients), the FICM Core Standards recommended there be one senior grade whole-time equivalent (WTE) pharmacist (band eight A or above) providing a full service to the unit. There had been occasion to admit 12 level three patients and three level two patients. This would have increased recommended pharmacy cover to almost 1.5 WTE senior grade pharmacists. In practice, the unit had cover from 0.5 WTE band eight A pharmacists, and 0.5 WTE band seven pharmacists. The senior pharmacist said this had been recognised by the trust and the level of cover was to be increased to one WTE senior grade pharmacist.
- The pharmacist team provided a routine on-call service to make sure advice was available and provided at all times. This extended to out-of-hours cover 24 hours a day.
- There was safe provision of physiotherapy for patients, although not enough therapy staff to meet the requirements of the FICM Core Standards. The team comprised currently of three whole-time equivalent staff led by a band seven physiotherapist. When the unit was at capacity and there were 15 patients, there would be a ratio of one physiotherapist to five patients. The Core Standard1.3.7 recommended a ratio of one to four. There was a vacancy for a band five therapist, and a technical therapist (a band three therapist focusing on rehabilitation with patients) so the team was not working at its established level. The team wanted to deliver a strong focus towards rehabilitation, but the vacancy for a technical therapist meant this service had been reduced. The physiotherapist team attended the unit each weekday. There was a small team available on the weekends who provided respiratory therapy, but no rehabilitation therapy. There was an on-call service out of hours including nights and the rest of the weekends.
- There had been no increase in staffing levels for allied health professionals to coincide with increases in patients. If the unit was caring for 17 patients, which it had been enabled to with winter pressure funding, there had been no corresponding increase in the staffing levels of pharmacists or physiotherapists to meet the increased demand.
- There was a good regular service from dieticians and speech and language therapists on weekdays. The dietician visited usually each day and would attend at other times when needed. The speech and language therapist came to the unit on request. There was, as described by the critical care staff, an excellent working relationship with both these specialities.
- There was a varied service from occupational therapists. There was fast attention for patients who needed a splint or a collar from the orthopaedic occupational therapists. There was also a good service from the neurological team. There was, however, very limited presence from the general occupational therapy service.

Major incident awareness and training

- The trust had a current major incident plan produced originally in 2010 and most recently updated in November 2015. Key staff knew how to access and distribute the policy and in what circumstances it was relevant. Critical care staff knew of their responsibilities and actions in the event of a major incident. There was an action plan and protocols for the critical care unit in the event of various types of major incident or pandemic. Key staff with primary responsibilities were listed in the policy along with significant locations. There were also instructions for obtaining medicines and equipment for major incidents.
- The hospital had the ability to increase its capacity temporarily to care for additional critically ill patients in a major incident such as a pandemic flu crisis or serious public incident. This would involve primarily using the

anaesthetic rooms and recovery area in the theatre suite adjacent to the unit. The recovery unit in the Tower operating theatre suite could also be used, but this was some distance away. Anaesthetic and recovery staff were trained in caring for ventilated patients and would be supported by the critical care team. In addition, help, support and advice would be provided by the South West region Critical Care Network.

Are critical care services effective?

Good

We rated effectiveness as good because:

- Patients had good outcomes as they received effective care and treatment to meet their needs. There was delivery of treatment and care in accordance with best practice and recognised national guidelines. There was good management of patients' needs in relation to pain, nutrition and hydration.
- There was a strong multidisciplinary approach to assessing and planning care and treatment for patients. Services required to meet patient needs were available across all seven days of the week.
- Data was submitted for critical care to the Intensive Care National Audit and Research Centre to reveal outcomes for patients compared with similar units.
- The mortality rates within the unit showed, over time, more people than would have been expected survived their illness due to effective care.
- The unit met recommendations for competent staff with more than 50% of the nurses having a post-registration qualification in critical care nursing.
- There was a dedicated and successful contribution to the national organ donation programme.
- There was good support to new nursing/healthcare staff and junior and trainee doctors.

However:

- There was a lack of up-to-date or revisited written protocols and procedures for the service.
- There was no formal or routine screening for delirium in patients.
- Due to pressure on the unit to admit patients, some, although a small number, were discharged before they were ready.
- The unit had not contributed to the tracheostomy self-assessment study. There was a recognised lack of skills and experience in tracheostomy care when patients were transferred elsewhere in the hospital.
- Performance reviews, training, and development were not being delivered as planned due to staff shortages, and not all staff were trained for specialist equipment.
- There was a lack of recognition of Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- The hospital had a policy for identifying and disseminating new or updated national guidance, standards and practice. This included guidance from NHS England, the National Institute for Health and Care Excellence (NICE) and Public Health England. The trust's guidelines and steering committee (known as GASP) implemented, distributed and monitored NICE guidance and safety alerts. Governance meetings and clinical leads were the route for introducing other specialist advice. There was an expectation on responsible staff to analyse any new or updated guidance and produce an action plan to mitigate risks. This was managed through a governance process with the GASP team monitoring and approving any enduring gaps in processes. The critical care monthly governance meeting had a standing agenda item on new clinical guidance and minutes showed updates and introduction of new information.
- There was assessment of patients' needs on admission and their care planned and organised to meet evidence-based standards. Patients were reviewed by a consultant within 12 hours of admission to intensive care, as is best practice. Consultant work patterns were such that they delivered continuity of care. Consultants worked in 'blocks' of five days, or across a weekend shift, and this provided patients with consistent care and treatment.
- Assessment of patients' care and treatment was continuous during their stay and delivered mostly along national and best-practice guidelines. For example, the critical care unit met most of the requirements of the key NICE guidance appropriate to critical care units. These were NICE 83: Rehabilitation after a critical illness, and NICE 50: Acutely ill patients in hospital. The unit had reviewed itself against these standards. There was an element, however, of NICE 83 not met in relation to rehabilitation post discharge from the unit or hospital.

This was in the area of providing patients with a structured and supported self-directed rehabilitation manual for use for at least six weeks after discharge from critical care (recommendation 1.1.18). The lead physiotherapist said this was one of their goals, but it was dependent upon staffing levels to achieve this. The lack of a suitable discharge summary did not meet part of the requirements of NICE 50.

- There was a consultant-led follow-up clinic for patients, to follow-up on their progress and determine if they needed further input after two to three months (NICE 83 recommendation 1.1.25).
- The unit had access to up-to-date trust policies and procedures. Staff did, however, admit openly how some of the written guidance and protocols relating discretely to the unit's practices and procedures were now out-of-date and possibly obsolete.
- There was close monitoring of patients through care bundles. Care bundles were recognised techniques and plans for specific procedures. For each patient there was a set of care bundles completed and monitored each day. These included reviews of antibiotic management (so ensuring all antibiotic prescribing had a duration and end date), venous thromboembolism risk assessments and prophylaxis (preventative measures), ventilator-associated pneumonia, pressure ulcer management, and patient posture.
- Patients were treated without discrimination through staff mandatory training, and policies assessed and approved for equality and diversity. We looked at a number of policies where assessment against equality and diversity was an important aspect to consider. These included safeguarding, resuscitation, consent, care of the deteriorating patient, and treatment escalation planning. All of these had been ratified for their equality and diversity impact and found to be have been drafted in such a way as they did not contain and discrimination on equality grounds. To complement this, almost all staff had completed their equality and diversity training.
- Patients were staying on the unit for an average length of time, and more recently slightly below (that is better than) average. Research has found it is sub-optimal in social and psychological terms for patients to remain in critical care for longer than necessary. The unit submitted data on patients' length of stay to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for intensive care patients). This provided national benchmarking against other units of a similar type and patient group. This factor in patient outcomes had improved. The length of stay had been below (better than) average in all but one month in the last two years, but prior to that was more often above average. The average length of stay for all admissions in the three months of July to September 2015 (the most recent ICNARC data) was 3.8 days, compared with the national average of around four days. Over the last five years, the average for the department was around five days against a national average of four days.
- Patients were safely ventilated using recognised specialist equipment and techniques. This included mechanical invasive ventilation to assist or replace the patient's spontaneous breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe in the trachea). The unit also used non-invasive ventilation to help patients with their breathing using usually masks or similar devices. There was constant review of all ventilated patients through safety monitoring equipment.
- Critical care staff followed NHS guidance when monitoring sedated patients and followed recommended guidance to provide optimal levels of sedation. Sedation is one of the most widespread procedures used in critical care. It was used to help deliver care and treatment safely and try to ease the patient though a distressing time. Maintaining light sedation in stable adult patients in critical care improved outcomes (Faculty of Intensive Care Medicine). Research has shown advantages to patient outcomes, their length of stay, evaluation of neurological conditions, and reduced levels of delirium from limiting the use of sedative medicines. In critical care, there was daily assessment of each sedated patient according to the recognised Richmond Agitation Sedation Scale (RASS) scoring tool. Sedation was then withdrawn, continued or adjusted dependent upon how the patient reacted.
- There was no routine or formal assessment of delirium for patients admitted to critical care. Delirium is a state of confusion and altered brain activity that can cause delusions and hallucinations in critical care patients. It is recognised as a fairly common experience. There was evidence of hallucinations experienced in a letter to the unit in 2015. The letter said: "the worst part of my

experience in critical care was the hallucinations under medication." Another patient said: "I also have had some problems working out what is reality and what was a hallucination, some were obvious but other were not." The FICM Core Standard 1.3.3 recommended screening all patients for delirium with a standardised assessment tool (usually the confusion assessment method, often called CAM-ICU) and a multidisciplinary, multi-modal approach. There was a comment in the minutes from a unit meeting in September 2015 requesting staff to complete CAM-ICU scores for patients, but patient records did not demonstrate this as a matter of routine.

- Critical care met best practice guidance by promoting and participating in a programme of organ donation led nationally by NHS Blood and Transplant. As is best practice, critical care led on organ-donation work for the trust. In the NHS, there are always a limited number of patients suitable for organ donation for a number of reasons. The vast majority of suitable donors will be those cared for in a critical care unit. The trust had appointed one of the experienced consultant intensivists as the clinical lead for organ donation. There was a specialist nurse for organ donation employed by NHS Blood and Transplant. They covered the South West region but spent time at Royal Cornwall Hospital to directly support the organ donation programme and work alongside the clinical and nursing team.
- The hospital trust was part of the National Organ Donation programme. It followed NICE guideline CG135: Organ donation for transplantation and had policies and strict criteria for organ donation. We reviewed data about donations from Royal Cornwall Hospital for the year from 1 April 2014 to 31 March 2015 and the most recent six-month report from April to September 2015. There had been 30 patients eligible for organ donation during this 18-month period. Of these, there was an approach to 20 families to discuss donation. The specialist nurse was involved with twelve of these families (60%), against a national average of 79%. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family. In the 18-month period, 10 patients went on to be organ donors and 23 people became recipients of those organs.

Pain relief

- There was effective pain relief for patients with strategies used based upon best practice. Staff used a scale to determine a patient's pain score based around an uncomplicated assessment. The scale graded pain on a scale of one to 10. This was recorded with changes monitored in the patient's electronic record. There were guidelines for pain management in relation to the use of different techniques. Most staff were trained in the use of patient-controlled analgesia (PCAs) and the use of epidural pain relief (pain-relieving medicines injected into the space around the spinal cord). The unit was endeavouring to get all staff fully trained in these pain management systems. Other recommended pain strategies were those based upon tried and tested regimes with standard pain medicine such as paracetamol and short-acting opioids.
- There was access to a specialist acute pain team. Staff in critical care said they had an excellent relationship with and support from the specialist team who were available during normal working hours for advice and guidance. There was provision of guidance and support for patients in relation to epidural management, patient-controlled analgesia and different infusions available for use. Out of hours, the anaesthetists on duty could provide specialist pain advice and treatment.
- There was consideration for patients who were unable to communicate if they were in pain. The unit had a pain chart for use with patients with cognitive problems, or could refer to the specialist pain team for advice.
- In the most recent questionnaire of patient care, 100% of patients in critical care felt their pain was well managed.

Nutrition and hydration

- There was effective assessment and response to patient nutrition and hydration needs. The patient records we reviewed were well completed, and safe protocols followed to ensure patients had the right levels of nutrition and hydration. Fluid balance was calculated, recorded in the patients' records, and analysed for providing the appropriate balance. We saw appropriate adjustments and consequent improvements.
- There was assessment and management of the risks to patients from acquiring pressure ulcers from dehydration or malnutrition. The unit was using the recognised Malnutrition Universal Scoring Tool (MUST) for all patients. This evaluated the standard risks from a patient's Body Mass Index (BMI) and any recent weight

loss, continence state, skin evaluation, mobility, age and sex. The dietician was able to provide specialist advice on nutrition by evaluating the MUST score against other factors. This included consideration of area such as tissue malnutrition from the patient being a smoker or having organ failure; any neurological deficit (such as suffering a transient ischemic attack); any major surgery performed; and prescribing of cytotoxic medicines such as long term/high dose steroid or anti-inflammatory medicines. All the scores appropriate to these tests were then calculated and the risks of dehydration, malnutrition and developing of pressure ulcers addressed through use of preventative therapies or treatments.

- The unit had guidance, protocols and support for specialist feeding plans. A dietician attended the unit on weekdays to support patients with naso-gastric tubes, total parenteral nutrition feeding (nutrients supplied intravenously through a central line), and Percutaneous Endoscopic Gastronomy (PEG) feeds. The unit had approved tools to enable nursing staff to determine a patient's nutritional needs. The unit had interactive tools to determine the most appropriate nutritional regime. Staff input relevant data into a computer programme, and this produced results to determine the appropriate plan to use. There was daily review of the plans and outcomes, and any adjustments, by the dietician. The flowcharts in the system highlighted potential risks to the patient and would produce individualised care plans.
- Nutrition careplans were drawn-up for all patients to identify patients who needed further supplements. There was prescription and administration of energy drinks and food supplements for patients who needed them.
- Adults receiving intravenous (IV) fluid therapy in critical care were cared for by healthcare professionals competent in assessing fluid and electrolyte needs, Staff were prescribing and administering IV fluids and monitoring patient response. This met the requirements of the National Institute for Health and Care Excellence (NICE) QS66 Statement 2: intravenous therapy in hospital.
- Patients could take their own food and fluids if they were able. For patients who could help themselves, drinks and any meals were available on bedside tables and within reach of patients. There were 'protected mealtimes' in the daytime where visitors were asked to give patients the opportunity for a quiet time over the lunch period.
- In the most recent questionnaire of patient care, 100% of patients in critical care felt their nutrition was well managed.

Patient outcomes

- There was routine monitoring of patient outcomes against those achieved nationally. Critical care demonstrated continuous patient data contributions to ICNARC for at least the last five years. Data contribution therefore met the recommendations of the FICM Core Standards: a set of recognised guidelines for intensive care units to achieve for optimal care. This participation provided the service with data benchmarked against other units in the programme and similar units. Data returned was adjusted for the health of the patient upon admission to allow the quality of the clinical care provided to come through the results. The service had been contributing a high standard of data: meaning the records submitted were mostly complete and could be evaluated and compared.
- There was an audit programme in use to test and report on clinical outcomes, although limited evidence of how they were used to improve care. The programme included an audit of the Department of Health Saving Lives programme implemented to reduce infections and improve the use of care bundles. Other audits included monitoring and diagnosing ventilator-associated pneumonia, central line associated infections, and compliance with the central line care bundle. Results of these examples were:
  - The unit was consistently below the target maximum for central line associated infections. The unit reported 1 infection in 1000 days against a target of 1.4.
  - There was 100% compliance with the use of the central line care bundle.
  - Ventilator associated pneumonia was low with 3.16 infections for 1000 bed days. This was against international best practice of 13 infections.
- Most critically ill patients were cared for at this hospital and not transferred to another unit elsewhere. Research has recognised how it is sub-optimal to move a patient to another hospital critical care unit without careful planning and management. According to ICNARC data,

there had been only one patient transferred to another unit for non-clinical reasons, and this was in the most recent data from July to September 2015. Patients often would be transferred for clinical reasons, as they needed more specialist care, or to be closer to home. Non-clinical transfers were usually due to a bed not being available. Other than this one episode in July 2015, the unit had not transferred any patients in five years, which was below the national average of transferring at least one patient a quarter.

- Mortality levels for patients admitted to critical care had been almost always below (better than) expected levels. For the first time for five years, mortality levels in the three months from July to September 2015 were just marginally above (worse than) the national average and expected levels. The latest ICNARC data showed a relatively stable trend over the last five years. Any blips in the trend were downward, that is due to better results than expectations.
- Some patients were discharged before they were ready. Statistics from ICNARC highlighted a number of indicators:
  - Over time, there were more early discharges from the unit than average. This is where clinicians recognised the patient would have ideally remained on the unit for a longer time, but were usually under pressure to provide a bed for a patient admission. In the last year reported upon by ICNARC (October 2014 to September 2015) there were more patients discharged early than the national average. In the last quarter of that period (July to September 2015), there were five early discharges which was the lowest number for the four quarters and just above (worse than) average.
  - One indicator of patients discharged too early was post-unit deaths, and in the last year, these were much the same as those of similar units. Post-unit deaths were patients who died before ultimate discharge from hospital, excluding those discharged for palliative care. For most of the last five years, however, these had been usually below (better than) the national and similar unit averages.
  - Early readmissions to the unit (those readmitted back for critical care within 48 hours of discharge to a ward) for the 12 months to September 2015 were mostly the same as the national average. There were three, for example, in July to September 2015 which was the same as the national average. Otherwise, most early readmissions in the last five years had been just below (better than) the national average.
  - Late readmissions (those readmitted later than 48 hours following discharge but within the same hospital stay) followed a similar pattern to early readmissions. There were five in July to September 2015, which was much the same as the national average. Previously, and for the last five years, there had been fluctuations above and below the average, but this had reduced to just below the average in the last 12 months.
- Early or late readmissions can indicate a patient was discharged too early. Due to the nature of critical care illness, it is recognised, however, that a number of these patients would return to the unit for conditions unrelated to their original admission.
- There was participation in the local Critical Care Operational Delivery Network and critical care had had a recent external peer review. As with recommendations from the NHS Commissioning Board, critical care was an active member of the South West Critical Care Network. The FICM Core Standard 2.14 recommended a critical care unit participate in "regular peer review". There had not been regular reviews, but the first in recent memory had taken place in November 2015.
- In terms of national audit, the unit/hospital had not contributed to the National Confidential Enquiry for Patient Outcome and Death (NCEPOD) 'On the right Trach': A review of the care received by patients who underwent a tracheostomy (2014). Units contributing to the review should have self-assessed their tracheostomy care against a set of standards, looked for gaps, and produced an action plan to meet any non-compliance. As the unit had not participated, it was not able to demonstrate through this method how compliant both the unit and the wider hospital was in care for tracheostomy patients. There were concerns from a number of key staff about the ability of wards to care for patients with a tracheostomy. There was no evidence this had been effectively audited or reviewed. The review of hospital-wide care was a requirement of the NCEPOD study.

Competent staff

- Many, but not all nursing/support staff were assessed each year for their competency, skills, and development.

The trust's target was for 100% of staff have a performance review each year. The rate for the critical care nursing/support team was 72% in mid-January 2016. Several more were booked to take place in the following two weeks. Falling behind in achieving targets for performance reviews was another problem associated with the low levels of permanent nursing staff.

- There was evaluation of medical staff for their competence, and mostly met targets for having an annual performance review (appraisal). This had improved significantly since it became a requirement of doctors' registration to have an annual appraisal as part of the 'revalidation' programme (General Medical Council, 2014). We requested results for the doctors working in critical care, but this was not provided. However, in the most recent report to the Department of Health, covering the year 2014/15, 82% of trust doctors had completed their appraisal but 66 trust doctors from 362 had not completed this by the deadline. Of these, 27 had credible reasons for this, such as illness or maternity leave. Of these doctors, all had completed their appraisal by the time the report was submitted (September 2015) but not within the period (by end March 2015). This results was similar to the NHS average for the acute sector where for the same period, the completion rate was 81.3%.
- Not all training and education in critical care was delivered as planned due to staff shortages. The nurse educator was not able to entirely fulfil their role due to being frequently required to provide direct patient care. There was, nevertheless, commitment to training and education within critical care, although the nurse educator post had not been established as a full time role. The nurse educator had extensive experience in critical care but their job description divided their time for education and governance responsibilities. The FICM Core Standard 1.2.6 recommended one dedicated nurse educator for around 75 staff. The unit employed close to this number of nursing staff, so the standard was not achieved. One of the senior staff described the nurse educator role as being "overrun by everything else."
- Critical care had an established and well-equipped simulation training room. Training included sessions in 'human factors'. The trust had recognised the value of human factors training, which focused on improving safety and performance. This was achieved by recognising the value of teamwork, the way an environment needs to be understood, and the culture among teams in often high-pressure and sometimes unpredictable situations. Unfortunately, due to problems with nursing staffing, the simulation training sessions, as with other mandatory training, had not been delivered as much as was hoped.
- There were resources for training and assessing new and progressing staff. There were written resources and workbooks for staff training in appropriate critical care topics. The trust's training and education centre (called the Knowledge Spa), worked in conjunction with critical care to produce and maintain these resources. Resources included, for example, enteral feeding, tracheostomy care, non-invasive ventilation, and various techniques for pain relief. Each part of the training module would assessed by an experienced healthcare professional.
- There were whole-day sessions for staff (both nursing and medical were able to attend) on specific subjects. The frequency of these was improving. The plan was for these sessions to be once per month, but due to other priorities connected with low nursing staff levels, this had not been happening. In 2015, there were three sessions, but plans were for these to take place each month. Topics and themes came from staff suggestions and annual reviews of personal development.
- The unit recorded how many staff were competent in the use of specialty equipment, but the records did not demonstrate if the numbers met safe or effective levels. There were 42 pieces of specialty equipment on the list. None of the equipment had 100% of staff trained. We were unsure of the accuracy of the list as 'defibrillator' (essential emergency equipment) was showing only 1% of staff competent in its use. There was over 50% competency with some of the equipment, but no guidance as to how many staff were required to be competent, if not all of them were.
- There was good support for new nurses in critical care. The unit required all registered nurses coming to work in critical care to work through and complete their Step One Competencies. This training programme was part of the National Competency Framework for Registered Nurses in Adult Critical Care.
- There was good induction for new staff. All new staff had an induction based upon the requirements of the trust. A form was completed and signed by the relevant manager to demonstrate a complete induction and the competence of the new member of staff. Mandatory

training appropriate to the role was delivered at induction for all new staff. This included health and safety, control of infection, and equality and diversity. All new staff were given time to shadow experienced staff and complete training and induction. The usual period was five weeks, but extended if the member of staff or their mentor felt they needed further time.

- There was an experienced nursing team in critical care in line with the FICM Core Standards. As recommended by the Core Standard 1.2.8, more than 50% of nursing staff should have a post-registration qualification in critical care nursing. At the time of our inspection, there were 65% of nurses in critical care with this qualification (43 from 66 registered nurses).
- There was good support to junior and more senior trainee doctors. Those we met said they felt valued members of the team. The consultants were approachable and provided good supervision and support. The junior trainee doctors told us they had good support. They were able to have hands-on teaching and experience in skills around, for example, ventilator support, use of inotropes (cardiovascular medicines), tracheostomies, lines, ultrasound use, and renal replacement therapy. The junior doctors presented studies, research and audits to the clinical governance meetings held each month. There was a journal club each Thursday. This was an educational meeting where doctors were able to present and critically review recent academic articles in a relevant field of interest.

Multidisciplinary working

- There was a strong multidisciplinary approach to daily handover meetings. We observed one of the morning meetings. This was attended by two consultant intensivists, eight junior doctors (four going off from the night shift and four coming on shift) and the lead pharmacist. The discussion included potential patients in the hospital who may need admission to the unit.
- Good multidisciplinary work produced effective care. The unit had input into patient care and treatment from the pharmacist team, physiotherapists, dieticians, speech and language therapists and other specialist consultants and doctors as required. The physiotherapy team had a daily ward round most days with the medical team. Consultants and doctors from throughout the hospital specialities visited patients in the unit on a regular basis to liaise with the critical care team.
- There was support from a microbiologist ward round (a healthcare scientist concerned with the detection, isolation and identification of microorganisms that cause infections). The microbiologist visited the unit each day around 12 noon and reviewed all patients with the medical team. Staff commented upon the excellent help and support from the microbiologist.
- There was a multi-disciplinary approach to weaning plans for complex and long-stay ventilated patients. Weaning is the gradual decrease in duration of mechanical ventilation with the goal of the patient breathing independently as quickly and safely as possible. The physiotherapist team had experienced staff able to contribute/construct a suitable weaning plan in collaboration with the multi-disciplinary team.

Seven-day services

- A consultant intensivist was available in person or on call across the whole week. They led the two ward rounds every day. When they were not on duty in the unit, there was good cover from the consultant intensivist team. Consultants lived within a 30-minute journey of the unit when they were at home but on call. Trainee doctors said the consultants frequently took calls or attended the unit when needed.
- There were arrangements for pharmacist and microbiologist services across the whole week. On weekdays, the pharmacist team and microbiologist were available on site in the daytime. Arrangements were in place for the supply of medicines when the pharmacy closed. The pharmacist team worked to ensure those medicines used regularly or infrequently, but needed for a complex patient, were available for supply out of hours. A pharmacist and the microbiologist were available on call in the evenings, at night and on weekends.
- Access to clinical investigation services was available across the whole week. This included X-rays, magnetic resonance imaging (MRI) scans, computerised tomography (CT or CAT) scans, electroencephalography (EEG) tests to look for brain activity, endoscopy, and echocardiograms (ultrasound heart scans).
- Therapy staff were available in person or on call across the whole week, but seven-day services were limited. If

therapy staff were off duty, there was access to certain staff out-of-hours through on-call rotas. Otherwise, therapy staff, including physiotherapists, the dietician, certain occupational therapists, and speech and language therapists, were on duty on weekdays. Physiotherapists were also on duty on weekends, but providing only respiratory physiotherapy. Nursing staff were able to provide patients with non-specialist rehabilitation physiotherapy on the weekends. There was no specialist rehabilitation on the weekends due to stretched staff trying to prioritise patient needs.

Access to information

- Most information needed to deliver effective care was available and accessible, although there was limited provision of discharge paperwork in summary form.
- Access to patients' diagnostic and screening tests was good. The medical teams said there was usually good and quick provision of test results and urgent results given the right priority.
- Patient paper notes and records were usually available in good time. Staff said records available at the hospital were provided relatively quickly in emergency admissions (all patient records were on paper for patients coming from other wards or new admissions). The notes were held in an electronic booking system, which tracked them when they moved around the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with legislation and guidance when treating an unconscious patient, or in an emergency. Staff said patients were told what decisions had been made, by whom and why, if, and when the patient regained consciousness, or when the emergency situation had been controlled.
- Staff had a good understanding and application of the Mental Capacity Act 2005. Staff acted in the best interests of patients who were not able to make their own decisions, due to a lack of mental capacity at the time. Staff correctly identified how capacity could fluctuate and could return in some patients and lost with others, so assessments needed updating. There were arrangements within the hospital to provide an Independent Mental Capacity Advocate (IMCA) if a decision was needed in a patient's best interests and the patient had no family or friends to speak for them at the time.
- There was a problem with the use and application of Deprivation of Liberty Safeguards (DoLS). There had been quite some considerable concern in many healthcare settings with this area in the past year, and conflicting information and guidance to staff. However, staff on the critical care unit had taken a decision based on some external advice not to use Deprivation of Liberty Safeguards until guidance was clearer. Some of the nursing staff we met had no knowledge or understanding of the subject. Nevertheless, the trust policy on DoLS was clear and followed the statutory framework of the Mental Capacity Act 2005 and supporting Codes of Practice. It included a checklist for staff to 'think about' and flowchart to guide decision making about making a referral for an authorisation to deprive a patient of their liberty. The policy went on to recognise how the managing authority (here the NHS trust) was able to make urgent authorisation to keep a patient safe through the use of DoLS, while simultaneously applying to the local authority for a standard authorisation. Staff told us they would urgently review their practice and seek more appropriate and helpful advice and guidance.
- There was some lack of consistency about the use of restraint. Some staff commented how physical restraint was never used, but incident reports clearly showed there had been times when a patient had to be restrained as they were injuring staff, themselves, and were a risk to others. Some staff said the unit did not use mittens to help prevent agitated or anxious patients remove tubes and lines, where other staff said they had just been ordered.

Are critical care services caring?

Good

We rated caring as good because:

- People were supported, treated with dignity and respect, and were involved as partners in their care.

- People's feedback about the service had been entirely positive. Patients said staff were caring and compassionate, treated them with dignity and respect, and made them feel safe.
- Patients, their family or friends were involved with decision-making. They were able to ask questions and raise anxieties and concerns and given answers and information they could understand.
- We observed staff treating patients with kindness and warmth. The unit was busy and staff were professional, but they always had time to provide individualised care.

Compassionate care

- All the patients and relatives we met spoke highly of the care they received. Due to the nature of critical care units, we often cannot talk to as many patients as we might in other settings. However, patients we were able to speak with said staff were caring and compassionate. A patient described staff as "so caring and kind." Patients said they felt safe and supported. Comments in the visitor's book included: "what was easily one of the worst days of our lives was transformed by the genuine caring and intelligent staff in this ward" and "what an amazing team. Thank you so much for your kindness and care shown to us when our loved one was on this ward. We felt very reassured every step of the way" and "every single member of staff we have encountered in the last 24 hours have been superbly kind, generous in spirit and totally professional."
- We observed good attention from all staff to privacy and confidentiality. Staff lowered their voices to avoid others overhearing confidential or private information as much as was possible or practical. Staff held confidential, sensitive or possibly difficult conversations with patients' relatives in private rooms. All patients we spoke with said they were treated with dignity. They said staff drew curtains around them for intimate care or procedures.
- The nature of most critical care units meant there was often limited opportunity to provide single-sex wards or areas. However, staff said they would endeavour to place patients as sensitively as possible in relation to privacy and dignity. There was some segregation of male and female patients in the more open part of the unit (the south side) and managed when possible. Staff located patients who needed extra support or observation closer to the nurses' station. We also saw a very anxious patient placed in a quieter area of the unit (the north side) where there was less activity or staff/visitors passing by.
- Staff made sure patients and relatives knew who the staff were and what they did. All healthcare professionals involved with the patient's care introduced themselves to patients and relatives, explained their roles and responsibilities. The trust had introduced an initiative in September 2015 whereby staff made sure they introduced themselves to patients and relatives with "Hello, my name is…" Staff continued with saying who they were and why they wanted to talk with the patient or relative. This was to ensure staff remembered to make this important first step with patients and carers. Staff name badges were printed with 'Hello, my name is…' We witnessed staff introducing themselves in many of the patient interactions we observed, even if the patient was drowsy or confused.
- Visiting times could be flexible to meet the needs of the patient and their loved ones. Visiting times prioritised the needs of the patient, while being supportive to relatives. There were set times for visiting hours (between 2pm and 8pm). Visitors were encouraged to visit after 2pm if possible to allow patients a quiet time for their meals, for staff to carry out rounds, essential tests and examinations, and meet with others in the multidisciplinary teams. Staff said they would accommodate visitors as much as possible at all times taking account of visitors who might not be local, and the patient's health. Visitors also said they were able to telephone the unit at any time to ask for an update on the patient or if they wanted reassurance.
- Staff were compassionate to the needs of relatives. One parent of a patient wrote in the visitors' book: "I can't thank you all enough for getting me a bed so I could be by [the patient's] side all night. You are so kind and caring and doing such a fantastic job." Another partner of a patient said: "special thanks to the nurses…who even found me a bed and food for the night to save me driving [home]." Another relative said: "I was very grateful that I was able to stay with my Mum all night."
- There was dignified care for people at the end of their life. A comment in the visitor's book said of the staff: "you treated [the patient] with dignity and love and enabled us to walk the last steps with [the patient] in peace and truly supported."

Critical care

- Visitors said staff indicated when they needed to support the patient and visitors had been asked to step outside or to the visitors' room for a short time. Visitors said the staff explained politely why this was necessary.
- In the most recent questionnaire of patient care, 100% of patients in critical care felt there was communication with compassion.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and those close to them so they understood their care, treatment and condition. Patients were involved with their care and decisions taken. Those patients who were able to talk with us said they were informed as to how they were progressing. They said they were encouraged to talk about anything worrying them. Communication between staff and patients was good, and this had extended to staff talking with relatives and friends. We observed staff, both doctors and nurses, talking inclusively with patients and their relatives. Conversations included discussing and negotiating care and treatment, and involving and encouraging the patient to remain independent and take their own decisions.
- Staff communicated with those close to the patient and kept them informed and involved. Comments written in the visitors' book contained many examples of good communication. These included comments to say: "thank you all so much – you have kept me involved and more especially informed every step of the way, and for that, I cannot thank you enough."
- Staff made sure visitors were identified and only gave information to them they were entitled to know. The ward clerks were an integral part of the team. They were aware of any confidential information and delicate or difficult situations with patients or their relatives in order to act promptly and sensitively.

Emotional support

- There was some support to keep critical care patients in touch with what was going on around them or tell them about what they might have missed when they were on the road to recovery. Critical care staff had introduced the use of the patient diary for longer-stay patients, although with limited success and input to them from relatives and visitors. Research has shown how patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post discharge. Diaries can provide comfort to both patients and their relatives both during the stay and post discharge. They not only fill the memory gap, but can also be a caring intervention to promote holistic nursing. Although they recognised their use, staff admitted they were not as successful as they had hoped and they had not yet persuaded relatives or visitors to use them to their full potential.
- There was a sensitive approach to relatives when a patient might be a possible eligible organ donor. We spoke with the clinical lead for organ donation and they were committed to this service but with sensitivity and understanding. They and the specialist nurse for organ donation were involved with families of a patient who had died or was at the end of the life. They had resources such as a kit for making handprints and locks of hair for families to take if they wished.
- There was access to a team of chaplains, chaplains' assistants, pastoral visitors and befrienders for people of all faiths or none. The team were available in working hours and then on call 24 hours a day all year round. There was a chapel, a prayer room and ablution facilities. All facilities were also available 24 hours a day all year round. The trust described their services as "ranging from offering a listening ear to full requested religious and spiritual needs for a group or individual basis." The trust also worked with community leaders across Cornwall to ensure consideration of all faiths and meeting religious needs.
- There was some, but limited emotional support for patients. The hospital had a team of mental health nurses who came to review a patient upon request of the medical or nursing staff. However, staff confirmed this was usually when the member of staff recognised something that might need support, rather than the patient asking for help.

Are critical care services responsive?

Requires improvement

We rated responsiveness as requires improvement because:

- Services did not always meet patients' needs. There were bed pressures in the rest of the hospital and too many patients were delayed in their discharge from critical care to a ward. These delays were worse than the national average.
- Some patients were discharged onto wards at night as a bed had become available, when this was recognised as less than optimal for patient wellbeing and mortality.
- Despite research and guidance into the potential poor psychological outcomes for patients in or discharged from critical care, there was no psychological support for patients or those close to them.

However:

- The facilities in critical care had been thoughtfully organised by the team to support patients, visitors and staff. The unit met most of the modern critical care building standards.
- Critical care responded to and received support from the operating theatres' department, which was next door.
- There was a good timely response from consultants and nurses with new patient admissions. Rotas were organised so all patients should be seen by a consultant within 12 hours of admission.
- Patients were treated as individuals and there was support for equalities, diversities, and patients with different needs. There were no barriers to people to complain.
- There was an example of outstanding care delivered to a long-stay patient.

Service planning and delivery to meet the needs of local people

- The service was designed and planned to meet people's needs. The unit was located to enable staff to respond to emergencies either within critical care or within the emergency operating theatres next door. The emergency department was, however, located on another floor and not co-located, as recommended by the Department of Health.
- The critical care unit met many of the recommendations of the Department of Health guidelines for modern critical care units as they related to meeting patient needs and those of their visitors. These included:
  - Bedspaces were capable of giving reasonable visual and auditory privacy.
  - Natural daylight for bed spaces.
  - Dimmable artificial lights, but with also sufficient strength to enable surgical interventions and response to life-threatening situations at the bedside.
  - Intercom-controlled entry to all entrances with CCTV in use. There were secure entrances, which could be opened only by authorised hospital staff.
  - Enclosed storage at the bedside for consumables or medicines, or limited patient property.

There were some areas not meeting the guidelines. These included:No facilities for patients who were well enough to have a shower.

- Limited high-backed chairs with adjustable foot rests for patients to sit out, and not, as suggested, one for each bed space.
- There was good provision of facilities for visitors to critical care. There was a large waiting room sited just within the entrance to the unit (outside of the clinical area) for visitors to wait or to enable them to step away if they wanted a break. There were kitchen facilities and a television provided. There was a second relatives' room where families and friends could meet with staff in private.
- There was a low level of noise on the unit, and patients were able to see a clock to help with orientation. An area generally criticised by sedated patients in critical care settings was from noise perception in hospitals. Research has showed how sedated patients can be affected by unfamiliar or familiar noise. The unit's equipment was relatively quiet (although alarms could be clearly heard for safety) and loud noise from bin lids was managed by quiet closing bins. The Department of Health recommended all patients should be able to see a clock, and this had been recognised with these put up around the walls in appropriate places.
- The unit had equipment to meet patient's health needs that could be unrelated to their critical illness or condition. This included, for example, haemodialysis machines to provide treatment for patients with kidney failure, which might be unrelated to their critical illness. These machines were dual purpose in also providing haemofiltration. Patients therefore needing renal replacement therapy for acute kidney injury were treated on the unit, and not transferred elsewhere for this specialist therapy.

Critical care

- Patients and visitors were given some information about critical care. There was a booklet produced for patients leaving critical care describing what they might experience as they recovered. The booklet provided information on eating and drinking well, exercising, and sleeping. There were suggestions around complementary therapies, and contact information for further information and support from external organisations. There was reasonable information on the trust website for critical care. There was no specific critical-care specific information or resources for some situations, such as bereavement, although a trust booklet was provided. The unit had recently started sending a card to bereaved relatives, but there was no specific bereavement advice or packs for relatives.
- Critical care provided patients with access to a follow-up clinic led by a consultant intensivist. This highly valued service, referred to in NICE guidance was, however, currently unfunded, so coming out of the overall budget for critical care. The service was for patients admitted for intensive care (level three) and stayed on the unit for more than three days. A patient invited to the clinic who had experienced a number of problems since going home had responded saying: "I feel attendance at your clinic will be an opportunity to address these issues and look forward to attending."

Access and flow

- Due to bed availability and safe staffing levels, patients with identified needs were not being admitted to the critical care unit at all times. There were insufficient beds available in critical care for all patients to be transferred from theatre recovery in a timely way. This meant they had to be cared for in the theatre recovery area for prolonged periods. In 2014, there were 83 patients held in theatre recovery, as no critical care bed was available. This had not improved in 2015, when there were 82 patients held in recovery. There were considerable concerns among the surgical staff about patients not admitted post-operatively to critical care. The trust had been criticised in the National Emergency Laparotomy Audit 2014 and in 2015. This related to non-compliance with meeting the recommendation for admission to critical care for all emergency laparotomy patients following their operation. The trust was rated as 'Red' in this area. This meant admission of less than 50% of patients to critical care. Staff said there was no protocol for admitting patients to critical care, as recommended, in relation to their predicted mortality.
- Nursing staff levels in critical care meant some patients unable to be admitted to a vacant bed. In September 2015, an incident was reported, as a patient in resuscitation in the emergency department was unable to be admitted to critical care. The report said there were five beds available but the staffing levels were not sufficient to safely care for the patient. No harm came to the patient as they improved under the care of the resuscitation team.
- Not all patients were cared for in critical care when they needed to be. In 2014 there were 10 patients transferred to recovery from critical care to make a bed available for a higher priority patient admission to critical care. In 2015, this increased to 12 patients. The recovery area was being used as an overspill area when critical care capacity was not available.
- There were too many patient discharges delayed due to a bed elsewhere in the hospital not being available. Similar to most critical care units in England, data from the Intensive Care National Audit and Research Centre (ICNARC) reported a high level of delayed discharges from critical care. In the last five years between 60% and 70% of all discharges were delayed by more than four hours from the patient being ready to leave the unit. That was mostly above (worse than) the national average of around 58%. Transfer within four hours was thestandard recommended by the Faculty of Intensive Care Medicine Core Standards. Although patients remained well cared for in critical care, when they were medically fit for discharge, the unit was not the best place for them. It also delayed patients who needed to be admitted, or meant the unit was always at higher occupancy than recommended. The delays were, however, mostly less than 24 hours although some were longer. The rate of delayed discharges had been high for the last five years and at no point had been better than the national or similar-unit average in the last five years.
- The discharge of patients from critical care was not always achieved at the right time for the patient, and the unit was above (worse than) national averages for moving patients at night. Studies have shown discharge at night can increase the risk of mortality; disorientate and cause stress to patients; and be detrimental to the handover of the patient. Data from ICNARC for 1 July to

30 September 2015 for discharges made out-of-hours (between 10pm and 7am) showed the unit had been above the national average for night-time discharges for similar units. In the third quarter of 2015, the out-of-hours discharges were 15% of all discharges against a national average of around 9%. Rates had fluctuated in different quarters but had always been above the national average.

- The critical care unit had higher occupancy levels compared with recommended levels and national averages. The high occupancy levels were due to a lack of a ward bed into which to move a discharged patient, and, as with the national picture, an increasing demand for critical care beds, which was not meeting rising demand. The Royal College of Anaesthetists recommended maximum critical care bed occupancy of 70%. Persistent bed occupancy of more than 70% suggests a unit was too small, and 80% or more was likely to result in non-clinical transfers that carry associated risks. Detailed occupancy figures for critical care for June 2015 to November 2015 showed the rate had been 100% on three of the six months. In the other three months, it was 87% on two occasions, and 93% in the other month. The average occupancy was 94.5% against an NHS average for the same six-month period of around 80%.
- The hospital bed management/site coordination meetings were now taking into account the bed status within critical care. There were two bed meetings at 8am and 12 noon, which were now an hour earlier than before. There was improvement in communication and consideration for critical care since the review and change to these meetings in the past six months. At the meeting, there was review and consideration of the status of all patients in critical care. Plans for elective surgery were reviewed and either confirmed or changed, with critical care staff able to say if they were able to accept post-operative patients. If not, the management of the patients was considered to see if there were other options to find them a bed safely so their operation could go ahead.
- The hospital was mostly caring for its own patients (as opposed to admitting them from other hospitals). In the ICNARC data for the three months from July to September 2015 there were slightly fewer patients than average transferred into the unit from an HDU or ICU in another hospital, and this rate had been below the national average for the last five years.
  - The rate of planned transfers was below the national average for similar units in the third quarter of 2015, and prior to this, had always been below the average.
  - The rate of non-clinical transfers in (that is unplanned admissions from another adult critical care unit) had been zero for the five years to September 2015. Therefore, the unit was mostly managing its own patients and predictable admissions.

Meeting people's individual needs

- There was an outstanding example of individualised and multi-professional care for a patient who had been in the unit for 10 months. The critical care team, the ambulance crew, the family and community teams were all instrumental in enabling the patient to go home safely. A member of the team arranged what was described as a "huge meeting with all the people who needed to be there to formalise [the patient's] discharge." In addition, there was the arrangement of two visits home for the patient to build their confidence before the permanent move.
- The services reflected the needs of the local population. There were no apparent barriers to admission due to a patient's age or gender. The average age for patients admitted to critical care was 60 years, which was similar to the national average and had been static for much of the past five years. ICNARC data for the three months from July to September 2015 showed a typical distribution of ages of patients admitted, and the unit, like other similar units, had treated patients in their late 80s and early 90s. Not untypically, the majority of patients admitted were male (around 58%).
- There was specialist advice and patient/relative input into end of life care. The hospital had a specialist palliative care team providing 24-hour contact for medical advice. A presentation was made to critical care staff in July 2015 on new documentation for anticipatory prescribing and symptom control. The hospital had introduced and was embedding Treatment Escalation Plan forms (known as TEP forms). These had been introduced for use in critical care to replace resuscitation-decision forms (previously known as DNR or DNACPR forms). The unit recognised patients who were admitted to critical care sometimes came with these forms in their notes, and these would need to be noted on admission. Otherwise, the unit was able to complete a form if this was appropriate.

- There was access to the unit for all patients and visitors. The unit was located on the third floor of the hospital but accessible by flat access at the main entrance and lifts to the third floor. The doors were designed to safely allow wheelchair access and remained open long enough for people to safely enter and leave the unit.
- When needed, the hospital trust had facilities to provide translation services. The trust had engaged third-party services providing face-to-face, telephone, and written translation, Braille, and British Sign Language. Staff we talked with said they knew how to access services and had found them easy to reach, timely, and helpful when they had used them with patients and carers.
- Due to issues with patient flow on the wards, critical care was rarely able to meet gender separation rules for patients. A patient would breach these rules when they were in a unit occupied by a patient(s) of the opposite gender and the first patient had been medically fit for discharge to a ward. Department of Health guidance recognised it was difficult to fulfil this criterion in units like critical care. Like many intensive care units nationally, critical care in Royal Cornwall Hospital had no separate gender toilets or washing facilities. However, there were efforts to segregate patients where possible. In the north side of the unit, used mostly for intensive care, patients were in what amounted to side rooms with partition walls. In the south side of the unit, mostly used for high dependency care, there were two discrete areas. As beds here were in an open area, staff endeavoured to maintain one area for females and the other, slightly bigger area, for males (who were statistically likely to be the larger of the two groups). ICNARC data showed there were around 60% to 70% of all patients delayed in their discharge from critical care to a ward bed by at least four hours. This meant the unit (technically) frequently breached the same-sex rules.
- Although recognised by consultant intensivists for its importance, there was no support available to patients in critical care with psychological problems or anxieties. There is increasing evidence showing the psychological impact of a critical care admission can be severe. Patients can experience extreme stress and altered states of consciousness. Patients will be exposed to many stressors in critical care. Acute stress in critical care has been shown as one of the strongest risk factors for poor psychological outcomes after intensive care. The National Institute for Health and Care Excellence (NICE) guideline CG83 stated that patients should be assessed during their critical care stay for acute psychological symptoms. There is also evidence that the critical care experience is difficult for families and a critical care psychologist can play a big role in communicating and working with distressed families.
- There was support from experienced and trained staff to patients with a learning disability and their relatives or carers. There was a hospital liaison team experienced and trained in supporting people with a learning disability. Staff would contact the liaison nurses if a patient with a learning disability was admitted to critical care to provide guidance and support. Carers or care workers were also encouraged to stay with the patient when and where possible to provide support. Patients who came to the hospital from a community care setting were asked to bring or produce a 'hospital passport'. This was a recognised document used for people who live with a learning disability, so staff are able to know as much about them as possible should they have difficult with communication.
- There was support for patients living with a dementia with use of link nurses and specific care plans linked to national strategies. The unit had two members of the nursing team who acted as link nurses. They were part of the team of link nurses throughout the hospital who had specialised training from the dementia team to provide advice and local guidance on the unit. There was a care plan in relation to providing nutrition to people living with dementia, and another on managing mild cognitive impairment. The 'This is Me' document, which was produced with the patient and their relatives, was in use on the unit. Patients could bring a completed document with them, possibly from their stay on a ward, or one produced on the unit. Essential information about the patient was included, such as how they normally behaved in certain situations. This enabled staff to more accurately know when something might be wrong, and the patient was not behaving as they usually would. This helped specifically, for example, with pain relief and nutrition and hydration management.
- Critical care staff exceeded the target for providing 'direct patient care'. There was a review of care provided to a patient in a four-hour period. It measured how much interaction there was with a patient and how much time spent on other tasks. In a recent audit, the unit scored 87%, exceeding the 60% target.

Learning from complaints and concerns

- There was active learning from any complaints or concerns. There had been very infrequent complaints to critical care. One had criticised the management and documentation of patients' property when on the unit. As a result, the electronic patient record system had been adapted to include a requirement to check and document all patient property.
- There was discussion of any complaints with staff. Complaints were a standing agenda item on the monthly departmental meeting agenda.

Are critical care services well-led?

Good

We rated well-led as good because:

- The leadership, governance and culture promoted the delivery of safe patient care. The senior staff in critical care were committed to their patients, their staff and their unit.
- There was good evidence anddata upon which to base decisions and look for improvements and innovation. The unit participated in the national audit programme through the Intensive Care National Audit and Research Centre (ICNARC). Data returned by ICNARC was adjusted for patient risk factors, and the unit could benchmark itself against other similar units to judge performance.
- Although the nursing team were under pressure from staff shortages, there was a high level of commitment and staff saying they were proud of the unit as a place to work.
- Staff were actively encouraged within the unit to raise concerns through an open, transparent and no-blame culture.

However:

- There was no clear vision and strategy for critical care, which had not been included as part of the divisional future strategy and planning.
- Some risks in the units had not been captured within the risk register and the document needed clearer written actions.
- The trust needed to resolve the long-standing issues with the sustainability of the service and the effect on staff morale from bed and staffing pressures.

Vision and strategy for this service

- The vision and strategy plan for the division of surgery, theatres and anaesthetics (which included critical care) made almost no reference to the service. There was no overview of critical care in the opening 'specialty overview' section. There was a minor mention of objectives for increasing staff skills in the workforce section on 'theatre staffing'. It appeared that the problems of access and flow in critical care were given a low priority within the larger plans for the surgical division.
- The strategic plan did not describe how to achieve its objectives. The division had a business plan for the year 2015/16 based upon strategy, objectives and priorities for the coming year. Although the plan had quite a lot of information, and followed the trust template for content, it was hard to determine what the plans were and how to achieve them. For example, in the objective covering 'People' (staff) there was an objective to "improve the quantity and quality of appraisals across the division". The first key measure was to "ensure that all eligible staff had an appraisal every 12 months to deliver at least 80% appraisal rate." There was no description of how to achieve this. The statement was also contradictory in that a target of 80% would not meet the target of "all eligible staff" and it did not comply with the trust target, which was 100%. There were a number of objectives in the plan, but none of these had any actions or strategies describing how to achieve them.

Governance, risk management and quality measurement

- The unit held multidisciplinary clinical governance meetings each month. There was good attendance from the consultants, pharmacists, nursing staff and support staff. There was no evidence of attendance by anyone from the outreach team in four sets of minutes covering July to September 2015 and January 2016. We joined part of the meeting in January 2016. There was an excellent staff attendance including seven consultants, three senior nurses and the senior pharmacist. There was a structured format and standard agenda. There were wide-ranging discussions about areas of concern. This included, for example, night-time discharges of patients and what the unit could do to improve this. Other notable practice and initiatives recognised from

national meetings were discussed with suggestions for adoption of good practice. One area highlighted at the meeting was the need to improve guidelines and protocols, many said to be out of date or obsolete.

- Critical care participated in a national database for adult critical care as recommended by the FICM Core Standards. The unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland. ICNARC reported the data supplied was well completed and of good quality.
- Critical care had appointed staff responsible for governance arrangements. There was a consultant intensivist and senior nurse with responsibilities for governance.
- There was sharing of quality and safety reviews. The consultant with responsibility for governance in critical care also attended the governance meetings for the theatre and anaesthetics team. This provided an opportunity to share areas of good practice and concerns, as well as new ideas and innovation.
- There was reasonable use of the critical care risk register, although most entries had mitigating factors, but not actions to resolve issues where this was possible. It did not help that the risk register provided by the trust was not complete and many entries were duplicates. We reviewed governance meetings and another document provided by the unit summarising risks and found the actual risks to be properly understood by the unit, and those we could see that were missing on the original document were accounted for.
- Not all audits against published standards and recommendations had been carried out, or included in the risk register. Critical care staff had assessed their service against the Faculty of Intensive Care Medicine Core Standards, although identified gaps had not been included in the risk register. The unit had not been risk assessed against the Department of Health guidance for modern critical care units (Heath Building Note 04-02, 2013). Audit against these guidelines was a recommendation of the FICM Core Standard 3.1 and any non-compliance (of which there was some for the unit) was not included on the risk register. The Core Standard recommended any non-compliance be identified and reported along with an indication of when facilities might comply with HBN 04-02.

Leadership of service

- The leaders of critical care services had the skills, knowledge, experience and integrity to lead the service. The clinical lead for critical care was a consultant specialising in intensive care medicine and respected member of the hospital. The matron was an experienced critical care nurse with many years of experience. The matron did, however, have extensive other responsibilities and limited time to give to all of those. The matron was supported by a strong team including a senior sister and senior charge nurse with many years of experience between them. There was support by experienced deputy sisters for the senior sister and senior charge nurse. The critical care unit purposely recruited new members of staff with different strengths and skills. This provided skills in academic areas, simulation training, respiratory medicine, organ donation, and governance.
- The leadership of critical care by the clinical lead consultant intensivist and the team of experienced staff was strong and committed. There was a commitment to delivering a safe service and saving lives. The nurses we spoke with had a high regard and well-earned respect for their medical colleagues and the allied health professionals, and commented on how they worked as cohesive and collaborative teams. This was something we witnessed and observed throughout our visit.
- The nursing leaders were strong and committed. The senior nurses, including the matron, demonstrated commitment to their staff, their patients and each another. The consultants we spoke with had a high regard and respect the nursing team, and the allied health professionals. There was clear mutual respect for each other's roles, challenges and talents.

Culture within the service

- There were facilities for staff to work and rest. In accordance with Department of Health guidance, there were staff offices and changing rooms. Senior staff shared office space but they said they were able to find somewhere for private conversations. There was a staff rest room with a kitchen for staff with access to hot and cold drinks and food storage/preparation areas. Staff facilities were far enough away for them to withdraw into some peace and quiet away from the unit, although they were able to return quickly in case of emergency.

- The culture encouraged candour, openness and honesty. It was centred on the patient and delivering the best care. Those staff we met said they felt supported within the unit to raise concerns or anxieties. They said they would support one another and help their colleagues to raise concerns if needed. All those areas of concern for the leadership of critical care related to delivering safe and quality care.
- There had been a relatively high number of incidences of violence and aggression by patients towards staff reported on the unit. This had been discussed at a departmental monthly meeting in July 2015, although there were other incidents after that time. Although senior staff highlighted there was a zero tolerance towards this behaviour, there was, at least as it appeared from the minutes, no consideration of these events and whether anything could have been learned to prevent them occurring in future. There was no recognition of these issues within the departmental risk register.
- Although staff were dedicated to their patients and each other, there was inevitable harm to morale due to the high numbers of vacancies and the pressures caused by a lack of beds. There was the need for regular and sometimes constant change and reorganisation. Staff were unable to complete the more general but important jobs like appraisals and training. The valued and experienced matron came to the unit each day, but they were overwhelmed with their responsibilities. Due to the need to support staff and deliver direct patient care, the band seven sister and charge nurse were unable to deliver their managerial responsibilities at all times. There was consequently a lack of operational and educational support for the unit staff from these otherwise dedicated and caring nurses.

Public engagement

- People's views were gathered through compliments, cards and letters to the services. There was a questionnaire given to patients to complete when they went home to ask them to comment on their care and how they were since being discharged. We saw this led to some follow-up calls by the unit nurses and medical team to other departments and the patient's GP for further support. All comments made were captured and made available for the staff to read. Staff were confident that should any complaints or negative comments be received, these would be discussed and, where possible, learning and actions taken.
- There was a 'know how you are doing' noticeboard on the wall just inside the entrance to the unit. This was information for patients and visitors about how the unit was performing in certain areas. This included staffing levels, the name of the nurse in charge, and new comments and compliments from people, and the result of recent audits or questionnaires.
- There was a visitors' book available in the waiting room for people to make comments. This was well used and the comments were almost entirely positive and full of praise for the staff and care delivered.
- The trust's clinical lead for organ donation had participated in promotion of this important area of medicine in the wider community. There had been an article on organ donation in the local newspaper, West Briton, in November 2015 to coincide with the launch of a photography completion in the trust. The competition had a theme of 'The Joy of Life' and aimed to raise awareness of organ donation and encourage people to talk to family and friends about their wishes. There were meetings with local Women's Institute groups culminating in a presentation to the regional meeting.

Staff engagement

- Staff were able to promote their department for awards and grants. There was a '12 days of Christmas' award within the trust each year. The critical care department won one of the awards in 2014, and upgraded and improved the relatives' room with the £1,000 award, and some charitable funds. One of the families of a former patient donated a painting to the unit, which was hanging in the newly refurbished relatives' room.
- There was good use of a message board in the unit. The system, called Hawkeye, delivered three key messages to staff each week. These included good-news stories, the results of audits and changes resulting from them, and other key messages. These were read to nursing staff at each shift change and the medical staff at handover. Staff commented upon the value of this system, and how it helped to embed messages. All staff were able to contribute ideas to the board.
- Staffing and bed pressures had limited the time for regular team meetings on the unit. Staff said they used

to occur relatively often but now were more intermittent. There were, nevertheless, regular handover and safety briefings each day giving staff the opportunity to comment and enquire.

Innovation, improvement and sustainability

- Critical care recognised where it needed to improve and innovate for sustainability. There had recently been a business case proposed to increase levels of nursing staff to safely staff the unit and release senior staff to carry out their operational roles. The business case included establishing a dedicated post for a nurse educator, and increasing the outreach team services to 24-hours. This business case was recognised by the senior team on the unit as fundamental to deliver to service to meet the Faculty of Intensive Care Medicine Guidelines for the Provision of Intensive Care Services (known as GPICS).
- The sustainability of the service would depend on its future configuration and capacity. The capacity was now at its maximum level most of the time. This was compromising care and particularly the ability of the trust to be responsive to people needing critical care. The division was looking at providing a post-anaesthetic care unit or high-care environment in the new financial year. We were told the business case for this environment had support at board level. It would allow the hospital to care for patients who needed extra support, monitoring or clinical input either post-operatively, following deterioration in their health, or some level of non-invasive ventilation.
- The critical care unit had recently been accepted as one of the sites in the UK to participate in the Provision of Psychological Support to People in Intensive Care, or POPPI. This was a study facilitated by the Intensive Care National Audit and Research Centre (ICNARC). Three nurses were to be trained to deliver psychological support to improve outcomes for patients being discharged from intensive care.

Maternity and gynaecology

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

Information about the service

The Royal Cornwall Hospitals NHS trust maternity services provided a range of antenatal, perinatal and postnatal care in the Royal Cornwall Hospital and within local community settings. The provision of maternity and gynaecology services were managed within the women, children and sexual health division of the trust.

At the Royal Cornwall Hospital, consultant led care was provided for women assessed as having low and high risk needs, on the Princess Alexandra Wing. There are three community midwifery teams and two free standing midwifery centres. Penrice, based at St Austell Community Hospital and Helston which was based at Helston Community Hospital. Women living on the Isles of Scilly used the one birthing room at St Mary's Community Hospital or were transferred to the mainland. Women assessed as low risk also had the option for a home birth. The community maternity services were reviewed using our data and intelligence and not visited during this inspection.

On the delivery suite at Royal Cornwall Hospital, there were nine delivery rooms and two patient bathrooms. Six of the delivery rooms were of a smaller size, able to accommodate limited additional birthing aids. These rooms shared one toilet between two rooms. The other three delivery rooms were larger. Two of these shared a toilet and bathroom and one room had en suite facilities. There were two dedicated maternity theatres with an anaesthetic room between them and a recovery area.

There was a pregnancy assessment unit, emergency gynaecology unit and fetal medicine unit all with consultation and assessment rooms and ultrasound services. These enabled prompt gynaecology investigations and pregnancies to be monitored, screening tests to be completed and potential problems diagnosed. These services were accessed on an outpatient basis. There was an 11 bed antenatal ward (Wheal Rose) for patients who required ongoing monitoring, treatment and support. Wheal Rose also had a one bed bereavement suite and licensed satellite (small) mortuary facility. Postnatal care for women who needed to stay longer in the hospital was provided on Wheal Fortune ward. This had 25 beds with shared bathroom facilities.

Between April 2014 and March 2015, 4,975 women received ante or postnatal care from the community midwives, some of whom chose to deliver their babies at services outside of Royal Cornwall Hospital's maternity services. During the same period, 4,268 women gave birth to 4,330 babies. Of these, 3,766 (87%) were born at the Royal Cornwall Hospital, 252 (5.8%) at Penrice, 46 (1.1%) at Helston, and 14 (0.1%) on Isles of Scilly. The maternity services achieved a high rate of home births with a further 242 (5.6%) women who were supported by trust midwives to deliver in their own homes.

Between April 2015 and December 2015, 3,584 women had received or booked to receive ante or postnatal care. There had been 3,313 deliveries within the hospital, midwife led community services or at the patient's home.

A range of gynaecological investigations and treatments were provided. These included services for general and emergency gynaecology, urogynaecology, fertility, endometriosis, colposcopy and gynaecological oncology. The gynaecology team was partly integrated with the

obstetric team, with six (of the eight) consultants working in both disciplines, with four further consultants working in gynaecology only. The majority of patients undergoing elective gynaecological procedures had these completed during outpatient clinics or as a day case. Women requiring inpatient care for gynaecological or early pregnancy care were admitted to the 28 bed Eden Ward.

A termination of pregnancy service was provided. Medical terminations were undertaken up to nine weeks of pregnancy and surgical terminations were provided up to 14 weeks of pregnancy. Terminations required beyond these gestation dates were referred to a specialist service.

During our inspection we spoke with nine patients, two relatives and 49 staff working throughout the gynaecology and maternity services. These included consultant obstetricians, gynaecologists and anaesthetists, registrars, senior house officers, sonographers, the head of midwifery, lead midwives for the community, screening, safeguarding and risk leads, delivery suite coordinators, midwives, nurses, health care support workers, maternity support workers, and ward clerks and reception staff. We held a number of focus groups and meetings, two of which were attended by 15 midwives.

We observed a staff handover on the delivery suite and an emergency simulation training session. We reviewed 10 sets of patient records. We visited the maternity services at the hospital as part of our unannounced inspection. Before, during, and after our inspection we reviewed the trust's performance information.

Summary of findings

Overall, we have judged the maternity and gynaecology services to be good for the caring and effective domains; we have judged the safety and well led domains as requires improvement; and the service as a whole as requires improvement, because:

- The maternity services required improvements to safety.
- The security of equipment and privacy of patients was compromised on Wheal Rose (antenatal) ward with open access and limited staff availability to direct or advise visitors.
- The consultant staffing levels on the delivery suite did not comply with the Royal College of Obstetricians and Gynaecologists guidelines for a trust of this size.
- Improvements were required to the type emergency equipment and storage of equipment on the antenatal ward (Wheal Rose).
- Improvements were required to the access and flow through both the gynaecology services. Trust wide service pressures on beds had affected the gynaecology inpatient service. This had resulted in cancelled surgeries and clinics.
- Increased service demands, combined with a lack of capacity had affected the delivery suite. This had resulted in a low, but consistent number of patients who delivered their babies on the antenatal ward, which had open access.
- Improvements were required in the maternity services to address the negative culture experienced by some midwives.

However, we also saw some good practice:

- Junior medical staff were well supported to learn and develop. There was evidence of good multidisciplinary working which extended to other clinical specialties. Staff were proud of the patient care they provided.

Maternity and gynaecology

- Care in the gynaecology and maternity wards and central delivery suite was consultant led and able to support patients with high risks and/or complex health needs.
- Systems were used to appropriately assess and respond to patient risks, which were reviewed regularly.
- Effective processes were in place to report and monitor incidents and there was evidence the Duty of Candour regulations were followed.
- Staff understood safeguarding responsibilities and processes. Records in clinical areas were stored safely.
- The availability and quality of simulation training provided to staff for the management of emergency situations was outstanding.
- Patient feedback was encouraged. This had identified the majority of patients were satisfied with the care and treatment they received and would recommend services.
- Records documented patients' choices and preferences and these were followed when possible.
- The maternity services had achieved full accreditation with UNICEF UK breast feeding standards.
- Both the maternity and gynaecology services had regular audit programmes. These provided assurance that treatment and care was provided in line with national standards. Counselling was available to patients as required.
- There were effective, risk, quality and governance structures in place. Incidents, audits and other risk and quality measures were reviewed for service improvements and appropriate actions were taken.
- The gynaecology and maternity services maintained an overview of clinical and governance performance with the use of dashboards, which ranked a range of measures and their outcomes. These were regularly reviewed to look for ways to improve.
- Systems were in place to effectively share information and learning.
- There was good evidence of learning from complaints.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Overall, we have judged safety as requires improvement because:

- The obstetric consultant staffing provided 45 hours of cover per week in the maternity service. This did not comply with Royal College of Obstetricians and Gynaecologists (Towards Safer Childbirth, 2007) recommendations on staffing for a unit of this size
- There was a lack of security on Wheal Rose (antenatal ward, where there was approximately one birth per month) and limited staff availability to direct or advise visitors.
- The baby resuscitaire was of a different type to those staff were trained to use. This was also stored inappropriately emergency use
- Some equipment and medicines were accessible to visitors and on the antenatal ward (Wheal Rose).

However, good practice was also seen:

- There were effective incident reporting processes, which staff understood and confirmed they received feedback for learning.
- There was evidence Duty of Candour regulations were followed.
- Women had individual risks assessed and these were regularly reviewed.
- Records contained clear plans of care, and appropriate referrals to other professions or services.
- Staff were knowledgeable about safeguarding process and understood their responsibilities.
- There were systems to appropriately assess and respond to patient risks, including those with high risks and/or complex health.
- The availability and quality of simulation training provided to staff for the management of emergencies was outstanding.

Incidents

- There were processes to monitor the level and type of incidents, identify themes, and share learning from investigations to improve clinical care and reduce risks to patients. The maternity and gynaecology services maintained a joint incident database. The lead for risk management for the maternity services and the lead governance midwife, who covered both the maternity and gynaecology services regularly updated, monitored and reviewed the database.
- We reviewed the database for the period between 1 December 2014 and 1 November 2015. During this time there had been 1,389 incidents reported, which was to be expected for a trust of this size. Each entry provided a summary of the incident and immediate actions taken to minimise risks to patients. There were additional actions taken following investigation. These included identified learning and through which forums information was to be shared with relevant staff. The lead midwife for risk management confirmed incidents were analysed for trends or themes. If these were identified, additional actions were taken such as audits or staff training. For example, during September and October 2015 a slight increase in maternal readmissions was identified. This prompted a retrospective review of medical records and a review of cleaning procedures in partnership with the trust's infection control lead. This identified incorrect cleaning fluid had been used to decontaminate the maternity theatre floors. This was corrected and the maternal readmission rate reduced.
- Analysis of incidents revealed the majority of the maternity incidents occurred during labour when care was least predictable. All the maternity clinical staff we spoke with demonstrated a clear understanding of the types of issues that should be recorded as incidents. This included possible problems associated with birth such as shoulder dystocia, post-partum haemorrhage and perineal tears.
- All the gynaecology clinical staff we spoke with understood the processes to follow to report incidents and gave examples of types of incidents they would report. These included medicine errors, delayed or failed treatments or procedures, development of pressure ulcers, communication failures, faulty equipment and poor management of discharge information.
- All staff we spoke with confirmed they were actively encouraged to report incidents and received feedback from incidents they had reported. This was completed on a one to one basis and through service wide emails

and meetings. We looked at a selection of meeting minutes. These reported incidents as standing agenda items. This included the rates and types of incidents, changes to policy and specific learning.

- Records showed serious incidents had been reviewed following a root cause analysis (RCA) process. Between November 2014 and October 2015 there had been two gynaecology and six maternity serious incidents. In addition, since January 2015 the maternity service contributed to the national quality improvement programme 'Each Baby Counts' (2015) Royal College of Obstetricians and Gynaecologists. All serious obstetric incidents were submitted to the national programme for review.
- We reviewed the investigation report (RCA) for one serious incident that had occurred during March 2015. The full action plan was not available so we discussed the incident with the head of midwifery and divisional service lead. It was not possible to establish how this serious incident had been monitored to ensure all necessary actions and learning had been completed. The head of midwifery assured us they would follow this up further. Revised processes since this incident had been put in place to investigate and learn from serious incidents. We reviewed four other serious incidents and saw detailed descriptions, action plans and arrangements for sharing learning. We spoke with a number of midwifery, medical and nursing staff who confirmed they received a copy of any serious incident, the RCA and action plan. We reviewed other documentation and meeting minutes, including governance and senior staff meeting minutes and saw serious incident information and actions were discussed.
- Perinatal mortality and morbidity (M&M) meetings were held every month. The attendance list for these meetings showed a range of staff attended which enabled multidisciplinary discussions. For example, GP trainees, obstetrics and gynaecology consultants and registrars, midwives and medical and midwifery students had attended these. No meeting minutes were available to review for actions and learning. The trusts divisional manager confirmed no meeting minutes were completed for gynaecology. There were systems to escalate mortality and morbidity information to the board and other relevant clinicians. We saw in other meeting minutes that mortality and morbidity summaries and actions were discussed. This included at the monthly governance, quality, and directorate meetings.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a new regulation that 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 that falls into defined thresholds.
- Staff we met in maternity and gynaecology services demonstrated an understanding of Duty of Candour. All staff were clear regarding their roles and responsibilities when patient treatment or care had gone wrong or had not been satisfactory.
- Records showed Duty of Candour regulations were followed. We saw documentation in medical records, letters to patients, and meeting minutes identifying how patients and their relatives had been informed of issues and invited to be part of investigations.

Safety thermometer

- The postnatal ward (Wheal Fortune) the gynaecology ward (Eden), delivery suite and ante ward participated in the NHS safety thermometer. This was a process to collect patient safety information in relation to avoidable harm from falls, catheter associated infections, venous thromboembolism (VTE), urinary tract infections, and pressure sores. Information provided by the trust confirmed from 1 November 2014 to 30 November 2015 there was no recorded avoidable patient harm under these categories.

Cleanliness, infection control and hygiene

- All ward and clinical areas in the maternity and gynaecology services appeared visibly clean. We observed stickers on some equipment to notify staff equipment was clean and ready for use.
- The patients we spoke with had no concerns regarding the cleanliness of the environment. Patients confirmed they observed staff washed their hands and wore personal protective clothing such as gloves and aprons before providing treatment or care.

- Antibacterial hand cleaner was available in clinical areas. However, we did not observe staff or visitors using or being prompted to use hand sanitiser when entering or leaving ward or clinical areas.
- Cleaning staff had responsibility for floors, bathrooms and communal areas. Staff confirmed tasks were completed to a satisfactory standard and any issues were responded to promptly by cleaning staff.
- Equipment used on the delivery suite was visibly clean. The midwifery care assistants had responsibility for this and cleaned equipment between patient admissions.
- There were processes to check the cleanliness of the environment and equipment in the maternity and gynaecology departments. We saw a range of audits covering all clinical areas dated June and July 2015 and October to December 2015. These had been completed by the infection prevention and control nurse. A minimum compliance target was set at 85%. Where compliance had dipped, actions had been taken and followed up improving compliance when the next audit was undertaken. For example, during October 2015 on the gynaecology ward, damage was noted to a shower, doorframes, and light fittings, all of which prevented effective cleaning. Records showed items had been fixed to a satisfactory level or followed up further with the estates' department.
- There was a low rate of maternity patients acquiring a post-operative infection. The post-operative infection rate following a caesarean section at Royal Cornwall had been consistent, with rates between 3% and 5% since the end of 2012. Between July and September 2015 the rate was 3%. This was below (better than) the national target of 5% and the England national average of 9% (Public Health England).

Environment and equipment

- The delivery suite environment was well organised, with equipment stored appropriately. All areas on the delivery suite were appropriate for use.
- The delivery suite, postnatal ward (Wheal Fortune) and gynaecology ward (Eden) were either locked or accessible with a swipe card for staff or controlled by a remote system for admitting patients and visitors. In these areas, CCTV was used by ward clerks, clinical and security staff to monitor unauthorised access to the delivery suite and wards.
- The antenatal ward (Wheal Rose) was not secure during the day. There were unlocked doors and the ward was fully accessible from 7am to 9pm. The reception area on the ward did not have clerical staffing the desk most days after 9am. This increased potential risks to the security of equipment and privacy of patients. We observed a number of visitors wandering around. We spoke to three visitors on the unit who told us they were unsure where to find the people they were looking for. We saw staff did talk with visitors when they had time or were available. We observed there was a delivery trolley near the reception area. This was not secure and there was access to all the equipment and medicines on the trolley. This included needles, syringes and vials of local anaesthetic.
- There was a bereavement suite on Wheal Rose which had one en suite bedroom and kitchen and sitting room areas. Near the bereavement suite was a licensed satellite (small) mortuary, which was specifically for patients and relatives who experienced the loss of a baby.
- The central delivery suite, ante and postnatal wards and the obstetric theatres all had adult and baby emergency resuscitation equipment. Cardiotocograph equipment for fetal heart monitoring was available for each delivery room and for two rooms on Wheal Rose.
- One baby resuscitaire design was different to all the others used and it was inappropriately stored on Wheal Rose ward. The resuscitaire was approximately 12 years old. It was a different specification than those resuscitaires used on the delivery suite that midwives routinely worked with. Staff told us there was 'in house' training available regarding this resuscitaire but it was not clear who had completed this or when. We also saw this resuscitaire was stored in a locked room. This could have delayed prompt access In the event of an emergency.
- Daily emergency equipment safety checks had not always been completed in any of the maternity settings. The adult resuscitation trolleys contained the necessary medicines and equipment was stored safely. We looked at equipment safety check records dated from January 2015 to January 2016. There were gaps in the safety checks of between one and 10 days.
- There were digital clocks in all the birth rooms and the obstetric theatres. This during emergencies, risk management processes were effectively timed and coordinated when clinical staff had to move around the unit,

Maternity and gynaecology

Medicines

- Most medicines and controlled drugs were stored safely. In the maternity theatres and other clinical areas on the delivery suite, we observed medicines in appropriately locked cupboards, and secured within the resuscitation trolleys. One delivery trolley on the Wheal Rose antenatal ward was not securely stored.
- Midwives and nurses told us they had adequate stocks of medicines and no issues with the pharmacy services.
- There was a lack of safe storage for oxygen with nitrous oxide cylinders available for the community midwifery teams. In addition, community midwives transporting nitrous oxide were not supplied with gas notification car stickers. If a community midwife's car were involved in a traffic accident, this information would have been necessary for emergency services to manage any potential risks.
- Oxygen with nitrous oxide (used for pain relief) was piped into delivery rooms. Records showed the maintenance of these gases were reviewed and monitored. Stronger analgesia was available if patients required it.
- Medicines that required storage at low temperatures were kept in dedicated fridges in locked rooms accessible only by staff. Records showed fridge temperatures had been checked daily.
- We observed some medicines were past their use by dates. For example, an IV fluid with an expiry date of March 2015 and medicine started on the 13 November 2015, which should not have been used after four weeks of opening. We alerted staff to these during our inspection.

Records

- Gynaecology and midwifery medical records and other confidential patient information were stored safely in lockable records' trolleys. When records were not required, they were stored in a central office, which was locked when not staffed. Otherwise, the trolleys and office were accessible to all authorised staff who required access to them. Staff told us they always had medical records in a timely way for clinical interactions with patients.
- Records demonstrated clear plans of care. We reviewed 10 maternity and gynaecology patient records and the maternity safeguarding files. Documentation showed referrals to other professions or services had been made where necessary and information shared appropriately.
- The way patient records were used and organised enabled clinicians to access relevant information to review care. Pregnant women had hand held records (a file of all the information related to their pregnancy) which was started at their initial booking of ante-natal care. These were maintained by maternity staff through to completion of post-natal care. We saw all necessary risk assessments were completed and regularly reviewed. Risks were recorded as having been discussed with patients.
- There were systems ensuring the legal requirements relating to a termination of pregnancy were documented in records. Processes were followed which ensured records were properly completed and information forwarded as required to the Department of Health in a timely way. Stickers were used on records to indicate when specific parts of the process had been completed. This followed good practice guidance recommended by the Royal College of Obstetricians and Gynaecologists.

Safeguarding

- Staff we spoke with were knowledgeable about the trust's safeguarding process and were clear about their responsibilities. Staff demonstrated an understanding of what kind of issues might alert them to consider possible safeguarding issues, and what they could do to respond to the patient in a safe and supportive manner. We looked at records which showed when concerns had been identified, appropriate referrals had been made and these were fully documented. Records were discretely marked and IT information tagged in order that all clinicians involved in a patient's care were alerted to vulnerabilities. The lead midwife for safeguarding was responsible for updated information as required.
- Women were assessed for mental health issues as part of antenatal, perinatal and post-natal care. There was a midwife who specialised in working with vulnerable adults which included those with mental health needs.

Records showed appropriate support was provided if issues were identified. Patients' consent was sought to make referrals and share information with other professionals involved with their care.

- There was a lead midwife for safeguarding, a Named Nurse for child protection and lead midwife for vulnerable adults. These staff provided advice and support to others when required. We saw records which confirmed this.
- Not all staff were up to date with the higher level safeguarding children training. Obstetric and gynaecology staff attended one of three levels of mandatory safeguarding children training, dependent upon their role. Records provided showed compliance by profession, not by department. At the beginning of January 2016, 100% of midwives, nurses and medical staff had level one safeguarding children training, and 83% of doctors and 100% of nurses and midwives had level two. At level three, there was less compliance with 50% of medical staff and 55% of midwives and nurses in date.
- Not all staff had in date safeguarding adults training. Records provided at the beginning of January 2016 showed 83% of medical staff and 67% of nurses and midwives, were in date with safeguarding adults training. This was below the trust's target of 100%.

Mandatory training

- There was a range of staff mandatory training, which included annual updates. This included conflict resolution, infection control, fire safety, equity and diversity, information governance, manual handling, safeguarding vulnerable adults, including the Mental Capacity Act and Deprivation of Liberty Safeguards, and one of three levels of training for safeguarding children. Records provided at the beginning of January 2016 showed between 83% and 100% of medical staff had in date mandatory training. Apart from level one safeguarding training, midwives and nurses showed a compliance level of between 50% and 89%. This was below the trust's target of 100%.
- Maternity staff attended additional mandatory skills and drills 'prompt' training (practical emergency obstetric training). This was multidisciplinary and included the use of a simulation model used to recreate emergency scenarios. The training in obstetric multidisciplinary emergencies (TOME) was provided on a monthly rolling programme. Sessions were delivered within the maternity department using the normal facilities and equipment routinely available. Staff spoke extremely positively about the quality of this training, stating it enhanced team working, learning and confidence.
- The band seven midwives completed annual updates of the UK Resuscitation Council Neonatal Advanced Life Support training. Other midwives completed neonatal resuscitation updates as part of the mandatory annual skills and drills training. These sessions were facilitated by a consultant anaesthetist.

Assessing and responding to patient risk

- All pregnant women had comprehensive risk assessments that started at their first appointment. This included screening for pre-eclampsia, gestational diabetes, venous thromboembolism, and other medical conditions. Other risk factors were assessed and discussed with women including: previous obstetric history, family medical history, social issues, and screening for domestic abuse and mental health. Risk assessments and action plans were reviewed with every subsequent contact with a doctor or midwife. Community midwives told us they provided an extended booking time to new patients. This was to ensure issues or risks were identified and actions to mitigate these were initiated.
- The delivery suite coordinators maintained regular review of the complexity of patients on the delivery suite and linked this with appropriate staffing levels. Minimum staffing levels (non-medical) had been established with reference to national guidance; Birth-rate Plus (June 2014). This nationally recognised tool (reflected in Department of Health and National Institute of Health and Care Excellence (NICE) guidance was used to provide assurance that staffing levels safely met service needs. When required, an escalation policy was used to maintain safe staffing levels. This triggered community, ward and specialist midwifery roles and responsibilities to be reorganised in order to safely meet patients' needs.
- Staff demonstrated an understanding of gynaecology emergency risk management guidelines, and knew where and how to access these for reference. Guidelines were based on national best practice standards and guidance. For example, National Institute for Heath and Care Excellence (NICE) clinical guidance 154 on the management of ectopic pregnancy and miscarriage

- The central delivery suite was consultant led and able to support women with high risk pregnancies and/or complex health. Women assessed as having low risks, who chose a home birth and developed unexpected complications were transferred immediately to the delivery suite at Royal Cornwall Hospital. The percentage of women transferred from home to hospital from April 2014 to March 2015 was 25%. The overall percentage of women transferred between April 2015 and November 2015 was 34%. There were no national standards to benchmark transfer rates but each case was reviewed for potential learning. Staff said the most common reason for transfers was failure to progress during the second stage of labour and requests for an epidural.
- Appropriate experienced and skilled staff were available at all times to respond to acute, severe and unpredictable obstetric emergencies. Anaesthetic and obstetric medical staff were available 24 hours a day, seven days per week. In addition, women requiring planned caesarean sections were provided a date of admission, but not a time. Staff told us this provided flexibility to prioritise those with the highest risks on the day.
- There were various emergency 'grab boxes' available on the delivery suite. These contained essential equipment and medicines to treat and manage specific obstetric conditions. For example, for pre-eclampsia and post-partum haemorrhage. There were systems to ensure clinical information on patients was updated. This enabled staff to have oversight of changeable patient risks and priorities. On the delivery suite and post-natal ward (Wheal Fortune) all staff were responsible for updating the patient information board. We observed medical and midwifery staff updating information after every clinical observation and/or when test results became available.
- Staff daily safety briefings were conducted twice a day on the gynaecology ward (Eden), labour suite and postnatal ward (Wheal Fortune). This ensured staff were aware of potential or emerging risks. We looked at records which showed a range of issues were reviewed and actions taken. For example, patient acuity (level of need), equipment and security issues, safeguarding issues and theatre activity and cover.
- Consultants and midwives regularly practiced emergency skills training. They were familiar with guidelines for the management of conditions such as cord prolapse and post-partum haemorrhage. Emergency skills' training was available to all maternity staff throughout the whole department every month. Gynaecology service staff confirmed they also practiced risk management scenarios such as the management of sepsis (severe infection). The maternity emergency briefings were devised randomly or in response to recent incidents or clinical issues. We observed a simulation training session. This was attended by a range of medical and midwifery staff including consultants and medical students. The session was used to stimulate discussion and debate regarding best practice.
- On the delivery suite there was adult and baby resuscitation equipment and sufficient cardiotocograph equipment for fetal heart monitoring. We observed 'fresh eyes' stickers had been signed to confirm trace readings had been double checked by a second midwife. These actions ensured any additional concerns or actions could be promptly responded to.
- There were processes and equipment for safe care or transfer of newborn babies requiring additional or specialist support. A paediatric registrar was based on the post-natal ward (Wheal Fortune) from 9am to 5pm, on Monday to Sunday. This person was joined by a paediatric consultant on a daily basis to review the care and treatment plans of all babies on the ward who required additional support or monitoring. The neonatal intensive care unit (NICU) was situated next to the delivery suite. Specialist staff were available within minutes if required.
- There were processes to treat and admit emergency patients. There was an early pregnancy and emergency gynaecology service used to triage patient risks. If required, emergency gynaecology patients were admitted directly to Eden ward. Gynaecology patients who attended the trust's emergency department were also transferred to Eden ward. However, staff on Eden ward told us there were regular instances when emergency gynaecology patients had to be admitted elsewhere in the hospital due to the high number of medical patients on the gynaecology ward. This meant some gynaecology patients were not always provided care by specialist gynaecology staff.

Midwifery staffing

- There was sufficient midwifery and other staffing to support the safe care of obstetric patients in Royal

Cornwall Hospital and within community settings. There were 150.9 whole time equivalent (WTE) established midwifery and registered nursing posts, and 33.3 WTE midwifery support worker posts. The trust followed the Royal College of Obstetricians and Gynaecologists (RCOG, 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour. This recommended a midwife to patient ratio of 1:30 for safe capacity to achieve one-to-one care in labour. The ratio at Royal Cornwall Hospital was 1:30 in line with Birthrate Plus. Care delivered to women was provided safely. We reviewed data from March 2014 to October 2015. During one month one to one care was achieved 96.6% of the time (the lowest rate). During the remaining 19 months, one to one care was achieved between 98.5% and 100% of the time.

- Shortfalls in midwifery staffing were covered from part time substantive midwives temporarily increasing their hours. If staffing issues were not resolved this way, the maternity escalation policy was followed. This required the community and ward midwives, and if required, the specialist midwives to be redeployed to fill any staffing gaps. No maternity agency staff were used.

Medical staffing

- There was inadequate consultant cover on the delivery suite. Between April 2014 and March 2015 there had been 4,330 births. The majority of these (3,787 or 87.5%) were at Royal Cornwall Hospital, with 543 (12.5%) deliveries at the patient's home or community birth centres. This rate of births had continued. Between April and October 2015 there had been 2,696 births. The majority of these (2,352 or 87%) were at the hospital. The Royal College of Obstetricians and Gynaecologists (Towards Safer Childbirth, 2007) recommended the obstetric consultant presence was calculated dependent upon workload. For units that had between 2,500 and 4,000 deliveries per year, the recommendation was 60 hours of consultant cover. At Royal Cornwall Hospital, there was 45 hours consultant cover per week and this was below the recommended level for safe care. This had been recognised and a business case (recommendation) was being pursued to increase the consultant hours on the delivery suite.
- There were sufficient anaesthetic and gynaecology medical staff to provide surgical and clinical support to the maternity and gynaecology services at all times. This was managed through a dedicated on call rota. The midwifery and junior medical staff confirmed the obstetric consultants were consistently supportive and responsive the needs of patients, attending the delivery suite during out of hours whenever required.

Other staffing

- Senior staff said there were sufficient staff employed in roles which supported the midwifery and gynaecology services. These included sonographers, ward clerks, and care assistants. There were 34.6 band three and 2.4 band two maternity support workers, who would increase to band three upon completion of a range of competencies.
- There were 5.7 band five nurses employed to work specifically in the maternity services. These nurses worked in the obstetric theatres and with patients with complex health needs.
- There was not always sufficient numbers of gynaecology staff or an adequate skill mix on the gynaecology ward (Eden). We looked at records dated April 2015 to August 2015. These showed 70% of staff shifts had inadequate staffing and 14% of shifts had an inadequate skill mix. Senior staff there said there had been issues with the recruitment of staff and with staff being redeployed elsewhere in the hospital.
- Senior staff on Eden ward confirmed the physiotherapy team (managed elsewhere) provided a responsive service to gynaecology patients.
- Other specialist staff were available at all times to provide direct patient care and support for colleagues. Medical patients were regularly placed on the gynaecology ward (Eden). A medical doctor was based on the ward. Each day the doctor was joined by a medical consultant in order to review the care and treatment of all medical patients. Similarly, a paediatrician was based on the postnatal ward (Wheal Fortune) to provide treatment for vulnerable infants and coordinate admissions or discharges to or from the neonatal intensive care unit.

Major incident awareness and training

- Senior staff demonstrated awareness of the trust's major incident plan and how to access this, but had not been included in any training or drills.

Are maternity and gynaecology services effective?

Maternity and gynaecology

Good

We judged effectiveness as good for the maternity and gynaecology services because:

- Guidelines had been developed in line with national policy and audits were used to assess the quality of treatment and care provided.
- Clinical dashboards were used effectively to monitor patient outcomes against national standards, the majority of which were good.
- Pain relief was provided on demand, and in a timely way on the delivery suite.
- The midwifery services had achieved full accreditation with UNICEF UK breast feeding standards.
- Clinical expertise and support was available to junior staff, including a range of specialist midwifery and gynaecology clinicians.
- There was evidence of effective, multidisciplinary and collaborative working within the maternity and gynaecology services.

However, there were some areas which required improvement:

- We observed compliance with the WHO surgical checklist in the obstetric theatres, but there was no evidence of collecting data to confirm this.
- Not all staff had an annual appraisal.

Evidence-based care and treatment

- We observed policies and guidelines in the maternity and gynaecology services had been developed in line with national policy, although some were out of date. These included a range of National Institute for Heath and Care Excellence (NICE) guidelines, the Royal College of Obstetricians and Gynaecologist; Safer Childbirth (RCOG, 2007), The Care of Women Requesting Induced Abortion (RCOG, 2011) and the Termination of Pregnancy for Fetal Abnormality (DH, 2010) guidance. Patients received care in line with NICE quality standards 22 (for routine antenatal care), 32 (for caesarean section) and 37 (for postnatal care). However, two policies were not in date. For example, the policy for 'Reporting Serious Incidents to the Human Tissue Authority' was dated November 2011 but should have been reviewed and updated every two years. Also the resuscitation guidelines we saw were dated 2010. New national resuscitation guidelines were published during 2015.
- There were processes to ratify new policies and procedures and share updates with all staff. A multidisciplinary maternity guidelines group met monthly to monitor and review the progress of any required audit or actions required prior to the ratification of policies or procedures. The group was attended by the lead midwives for risk and practice development as well as consultant obstetricians and paediatricians. We reviewed the meeting minutes dated November 2015. Guidelines were linked to national policy and discussions were recorded regarding the different levels of actions taken. For example: new guidelines for discussion; existing guidelines for ratification; those approved; and those uploaded onto the trust's internal documents library. Other records showed staff were informed of policy and procedure updates at meetings and through different monthly maternity newsletters.
- All gynaecology cancer patients received appropriate care, which followed national standards and guidance. Meeting minutes showed gynae-oncology consultants attended a regional gynaecology cancer network. This ensured standards and clinical care were coordinated and consistent across the region. This included NICE improvement outcomes guidance, 2003 (for ovarian cancer) and 2004 (for gynaecology cancer), and The Cancer Reform Strategy, 2007.
- The termination of pregnancy service was provided in line with RCOG (2011) evidence-based clinical guidance and standards. These included a pathway of assessment, treatment and support before, during and after procedures.
- The gynaecology and maternity services had an annual audit programme. This included local clinical audits and participation in national clinical audit. These enabled services to evaluate if treatment and care was being provided in line with national standards and to identify improvement actions. There was a range of audits (18) dated from 2015 through to 2016 at various stages of progress, planning and completion. We reviewed one audit report dated June 2015. This had audited compliance with the clinical management of perineal or genital tract trauma following childbirth. The

retrospective analysis of 40 sets of patient records established a high level (minimum of 90%) compliance with most of the standards. There were action plans where required and learning shared with staff.

- There were processes to monitor compliance with the World Health Organisation (WHO) surgical checklist and take any necessary actions to improve safety for gynaecology patients. We reviewed the audit information based on a combination of direct observation and retrospective review of patient records. The level of compliance was as follows: June 2015 97%, July 2015 92%, August 2015 100% and September 2015 100%.
- There was no evidence to show compliance with the WHO surgical checklist in the obstetric theatres. We spoke with consultant obstetricians about this who told us they were confident these processes were fully followed and complied with.
- The trust participated in the National Neonatal Audit programme (NNAP). The most recent evaluation was dated 2013 (published October 2014). This showed the standard had not been met for women who should have received steroids for babies born prematurely. This was provided to 72% of pregnant women which was below (worse than) the national standard of 85%. July-Sept 2015 quarter show that 92% of eligible births had antenatal steroids, and 100% of those who could be given antenatal steroids were given steroids.

Pain relief

- Patients we spoke with told us they regularly had their pain assessed by staff and were given medicines promptly. We looked at patient care records and saw pain and comfort needs had been assessed.
- A range of pain relief was provided on demand in the delivery unit. Each room had an electronic delivery bed which could be adjusted to support different positions and ease pain. Nitrous oxide gas (Entonox) and oxygen were piped into each delivery room. Epidurals and other pain relieving medicines were available for women in labour 24 hours a day, seven days a week. Midwives confirmed anaesthetists responded promptly to requests for support with pain relief.
- Birthing balls were available to support during pain in labour. Patients were able to bring in other equipment to support with pain relief as required. Birth pools, were not available but planned as part of the new maternity unit build (starting in 2016).

Nutrition and hydration

- The maternity services had full accreditation (level 3) with the UNICEF UK Baby Friendly Initiative. This meant staff had fully implemented breast feeding standards which had been externally assessed. This involved interviewing mothers about the care they had received and reviewing policies, guidance and internal audits.
- There was an infant feeding specialist who provided advice and support to patients and staff with all aspects of baby feeding.
- On the postnatal ward (Wheal Fortune) there was a dedicated baby feed fridge. We observed ample stocks of breast pumps which were available for use by patients if required.
- Patients were complimentary about the hospital food and told us they were offered plenty of hot and cold drinks. We observed water jugs were frequently refreshed.
- Between set meal times, snacks and drinks were available to purchase 24 hours a day. On the postnatal ward and the bereavement suite, there were kitchenette areas where patients and their partners could access hot and cold drinks and snacks.

Patient outcomes

- Women were encouraged to breastfeed following best practice guidance and the uptake was better than the national average. Records showed between April 2015 and October 2015 the uptake of breastfeeding by women supported by the maternity services ranged between 76% and 82% against the National average of 74% (NHS England. July 2015).
- The maternity services maintained a dashboard with clinical outcomes rated as red, amber or green (RAG). This related to birth figures and complications during perinatal care. The parameters of this were checked against Royal College of Obstetricians and Gynaecologists (RCOG) recommendations or against local targets if these were of a higher standard than national benchmarks. We reviewed the clinical dashboards for the period April 2015 to December 2015:
  - The rates of unplanned transfer from home to hospital were monitored for potential service improvements. Between April 2014 and March 2015, percentage of planned community or home births resulting in transfer to was 25%. The rate of transfer from April 2015 to December 2015 was 35%. We

spoke to senior staff about this and were told unplanned transfers were scrutinised for potential service improvements. The majority of transfers were due to unpredictable issues such as failure to progress during the second stage of labour and requests for an epidural.

- The rate of elective and emergency caesarean sections was 21% which was below (much better than) the national average of 26%.
- The rates of third degree tears at Royal Cornwall Hospital were below (better than) the recommended rate. The monthly rate of third degree tears ranged between 1% and 4% and there was only one incidence of a fourth degree tear recorded between April 2015 and October 2015. RCOG guidance stated tears should occur in fewer than 5% of deliveries.
- Postpartum haemorrhage rates were analysed for practice improvement implications. A rate of between 500mls and 1000mls is common (RCOG, Green-top guidance no 52, 2011). No trends had been identified other than an increase in patients body mass index (BMI), a known risk factor for postpartum haemorrhage. Between April 2015 and October 2015, the postpartum haemorrhage rate for vaginal and caesarean births was between 5.7% and 19.3%, with an average of 14%. The target was between 12% and 14%.
- The recorded rates of severe postpartum haemorrhage (1500mls to more than 2000mls) at Royal Cornwall Hospital was 1% or below. This was lower (better than) the recommended rate of between 1% and 5% of all births (RCOG).

- The delivery suite provided care to women and babies with high risks. The rates of babies born after 37 weeks of pregnancy and transferred to the neonatal unit were monitored. Between April 2015 and December 2015 the percentage transfers ranged between 0% and 2%. Any unexpected transfers were investigated as part of the incident reporting processes.
- The obstetric team had access to a specialist radiologist who completed interventional radiology procedures when required. These were treatments to manage rare complications associated with post-partum haemorrhage. Our specialist advisors considered this to be very good clinical practice.
- The maternity service participated in the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBBRACE). We reviewed the most recent report dated November 2015, containing data from 2013. Royal Cornwall Hospitals NHS Trust had a 10% lower rate of perinatal mortality than other similar-sized trusts. The low perinatal mortality rate had continued since this review. Between April 2014 and March 2015 the overall perinatal mortality rate accounted for 0.6% of births. Between April and December 2015, the rate was 0.5%.
- The maternity services had completed the Perinatal Institute, Gestation Related Optimal Weight (GROW) baseline audit. This was required prior to rolling out full use of the customised growth chart assessment tools. The Royal College of Obstetricians and Gynaecologist had recommended customised assessment of fetal growth and birthweight since 2002. This has been re-emphasised in 'green top guidelines' (RCOG, 2013). The lead consultant obstetrician told us the baseline audit results indicated the assessment of fetal growth was already at a level that other maternity services aspired to achieve once implementing the programme.
- The gynaecology services maintained a red, amber or green (RAG) rated dashboard of clinical outcomes. This related to outpatient, inpatient and emergency treatment and care. We looked at audit information dated April to September 2015. Standards were set for urgent, moderate and routine appointments. National guidelines recommend 90% of patients should have had an appointment within set time frames based on urgency (NHS Cancer Screening Programmes, 2010). The target times achieved were 62% (routine), 91% (moderate) and 96% (urgent).
- The fetal medicine department also maintained a red, amber or green (RAG) rated dashboard of clinical outcomes. The timeliness of appointments, treatments and results was monitored. Threshold targets were met between April to November 2015. This included new appointments provided within three and five days, and the provision of scans and other diagnostic tests.

Competent staff

- Clinical expertise and support was available to junior staff. Junior medical staff told us they felt very well supported in their roles by consultants who were available and supportive at all times. Some medical trainees who told us they had extended their placements in recognition of how well they were nurtured in their roles. There was an experienced labour coordinator on the delivery suite at all times. Records

showed this person was not included in the escalation process. This ensured there was additional clinical expertise to junior staff in the obstetric area with the highest level of unpredictability and therefore, risks.

- There were experienced specialist midwives who had completed additional training and had enhanced skills. This included midwives for, safeguarding children, vulnerable women, antenatal screening, diabetes, infant feeding, practice development, risk management, governance and bereavement. These midwives had lead roles for their specialties, providing clinical updates, audit information, advice and support.
- There were a number of specialist gynaecology nurses who had specialist skills and knowledge and were available to provide clinical support and advice to junior staff. This included nurse specialists for: fertility; unplanned pregnancy; urogynaecology; colposcopy; endometriosis and gynaecology oncology. These nurses took lead roles for their specialties, providing clinical updates, audit information, advice and support
- There were 2.4 whole time equivalent (WTE) midwives and 3.0 WTE gynaecology nurses who had completed additional training to be able to complete sonography examinations. This enabled patients, including those attending in an emergency, to access prompt treatment and care.
- There were appropriately trained nurses to recover patients from the obstetric theatres and provide appropriate care to those patients who presented high risks. All the band five nurses on the delivery suite had completed a maternity specific critical care course. This was validated at degree level (40 credits).
- Medical and midwifery staff had to be competency assessed before being able to complete tissue sampling in the satellite mortuary. We saw the records which identified training completed and named staff were able to provide this service. This was in line with the Human Tissue Act (2004) Codes of Practice.
- Each midwife was in the process of completing a 'Training Passport'. The passport included all skills updated training, the date of midwifery council revalidation, and dates of attendance at departmental meetings. The passport was countersigned by training facilitators or team leaders. It provided a tool to demonstrate midwives kept their knowledge and skills updated in line with the Nursing and Midwifery Councils, Code of Professional Conduct (NMC, 2014).
- There were processes to maintain the skills of midwives. On the delivery suite, ante and postnatal wards, there was a combination of core and rotational posts. Core midwives worked permanently in specific clinical areas. Rotational midwives moved every four to six months between the three clinical areas. This combination ensured midwives had the necessary skills to provide care in both a consistent and flexible way.
- There were systems to ensure junior midwives had the required skills for practice. Newly qualified band five midwives completed a preceptorship programme during the first year in post. This was to enhance confidence and competence in order to provide safe, effective care to patients. The programme included two to three months based within obstetric theatres and on the neonatal intensive care unit. Once competencies had been fully reviewed and approved, these midwives progressed to band six posts with increased independent working and responsibilities. This practice followed the recommendations in the Preceptorship Framework (Department of Health, 2010).
- The ratio of supervisors to midwives (SoM) did not meet recommended guidelines. The regulation of midwives includes an additional layer of investigative and supervisory responsibilities provided by a supervisor of midwives (SoM). By law midwives must have a named SoM with whom they meet once a year to consider their practice. The recommended ratio of SoM to midwives was 1:15 (Midwifery Rules and Standards, rule 12, Nursing and Midwifery Council, 2014). The ratio of SoM to midwives at Royal Cornwall Hospital was 1 to 20. There were three students undertaking the supervisors' training course which would improve this ratio.
- Not all staff were being supported to have an annual appraisal. We reviewed records provided by the trust dated April to October 2015. These showed midwives had variable rates of being supported to have an annual appraisal, dependent upon where they worked. For example, at Royal Cornwall Hospital this was between 84% and 100% and at Penrice community maternity hospital, this was 90%. On the gynaecology ward (Eden), 67% of nurses and five of the eight medical staff had in date appraisals. This was below the trust's target of 100%.

Multidisciplinary working

- The paediatric, maternity and obstetric staff worked collaboratively together for the benefit of patient

treatment and care. Staff were proud of multidisciplinary team working practice. All grades and specialities of staff throughout the obstetric and gynaecology services that we spoke were positive about multidisciplinary working. Communication and inter-professional support was described as good and excellent. Staff told us they felt part of productive teams who worked together for the benefit of patients.

- A multidisciplinary handover meeting took place every morning and evening on the central delivery suite. This ensured all staff were aware of the treatment and care plans of women requiring obstetric care. We observed a morning meeting, attended by obstetricians and anaesthetists, midwives and theatre staff. During the meeting the clinical needs of all patients were reviewed. This included those patients on the delivery suite, and the antenatal and postnatal wards and those using the bereavement suite. The day's theatre list and neonatal units capacity was discussed. There was a safety briefing which included discussion and reminders of recent safety and policy updates. Staff were allocated roles and responsibilities. All staff engaged and contributed to discussions, which were productive and well managed.
- The obstetric consultants told us other specialty doctors worked in partnership with the obstetric team, providing support for patients with complex health needs. For example, respiratory and cardiac consultants provided advice and support to the obstetric team.
- Information was shared appropriately with other professionals and services for the benefit of patient care. Some of the records we reviewed showed clear and detailed communication with other external services. For example, we saw information shared by the safeguarding midwife with the local authority.
- The community based midwives worked effectively with other community services. Ante and postnatal care was provided at a children's centre or GP surgery. Information was shared to improve outcomes and ensure consistency of care.

Seven-day services

- All the midwifery and junior medical staff we spoke with told us the consultants were supportive and responsive, attending the delivery suite at all times when required, including out of hours. All the consultants lived within a 30 minute or 10 mile radius of the hospital.
- A consultant provided anaesthetic cover in the obstetric theatres with a middle grade doctor between 8am and 8pm. Out of normal working hours, the resident anaesthetic registrar on the delivery suite provided cover. In addition, the on-call anaesthetic consultant would attend as required.
- The central delivery suite was staffed 24 hours a day, seven days per week. The maternity service had never closed to patient admissions. We were told this was to always be able to respond to the needs of local women. The location of next closest acute obstetric unit was in Plymouth and was approximately 60 miles away.
- The maternity day assessment and ultrasound unit were open during weekdays. The hospital's main imaging department provided imaging out of normal working hours.

Access to information

- Medical records were accessible and available for both gynaecology and maternity clinics. Reception staff told us previous medical records were requested and were available to be checked before clinics. This ensured staff had access to patient's medical history information, which assisted with care planning.
- Pregnant women looked after their own records (hand-held records). These were provided and started during the initial booking appointment. These were used by all clinicians involved with care during the pregnancy. After delivery, new records were made which included relevant information regarding the pregnancy, birth and baby. These records were carried by women and used for post-natal care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff followed the correct processes to gain consent. The patients we spoke with confirmed that staff had asked for permission before proceeding with any care or treatment.
- Procedures to gain consent were documented. The ten care records we reviewed clearly documented discussions regarding consent before carrying out any examination or procedure.
- Not all staff were in date with the trust's mandatory training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This formed part of the safeguarding vulnerable adults training. The overall mandatory training compliance level for all gynaecology and maternity staff apart from nurses and midwives was

81%. This was below the trusts standard target of 100%. The percentage of nurses and midwives with in date training covering Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was 100%.

Are maternity and gynaecology services caring?

Good

We judged caring in the maternity and gynaecology services as good because:

- Staff cared for pregnant women before, during and after birth with kindness, compassion, dignity and respect.
- Patients told us they felt involved with their care, had their wishes respected and understood.
- Feedback from patients and relatives regarding the care, treatment and support received was consistently positive.

Compassionate care

- Compassionate and sensitive care was provided to families who had experienced the loss of a baby, including those patients undergoing a termination of pregnancy for fetal anomaly. Staff provided personalised memory boxes, containing mementoes for bereaved parents. These had been developed in conjunction with the Stillbirth and Neonatal Death (SANDS charity). Specialist bereavement midwives worked across the maternity and paediatric service providing care and support to families when required.
- The maternity services had consistently positive feedback from patients who participated in the NHS Friends and Family test. Between December 2014 and November 2015 the percentage of positive patient feedback (would recommend the service) was between 90% and 100%. This was for antenatal, perinatal and postnatal care.
- There was a consistent level of very positive feedback from patients who had used the termination of pregnancy service. At the end of October 2015, 1,200 patients had provided feedback on their care and treatment of which 97% rated this as excellent or outstanding.

Understanding and involvement of patients and those close to them

- The Royal Cornwell Hospital took part in the NHS Maternity Survey 2015 and was rated as 'about the same' as the other 133 trusts who participated in the survey. A questionnaire was sent to all women who gave birth at the hospital during February 2015. Patients were asked about their experiences of care received and staff attitudes during labour, birth and after delivery. There were 142 responses received about maternity care at Royal Cornwall Hospital. Of the 19 questions asked, 15 were rated as 'about the same' compared to other trusts who participated in the survey. Two questions were rated as 'better'. This was for staff introducing themselves and for patients being involved in decisions about their care during labour and birth. Two questions were rated as 'worse' compared to other trusts. These were: Patients reported if they needed attention **after the birth,** staff did not provide help within a **reasonable amount of time; and, patients also reported they did not** feel they were given **information and explanations** they needed after the birth.
- Patients within the maternity and gynaecology services we spoke with told us they felt involved in their care, and that information had been presented in meaningful and understandable ways. One patient told us their care and treatment had been "faultless". This patient told us they had the upmost confidence in the doctors and midwives who provided care and support and they had felt encouraged to ask questions. Other patients told us the maternity staff were professional and organised which they found reassuring. Patients told us doctors explained what treatment needed to be carried out and why. Compliments were made regarding all levels of staff within the maternity services. One patient told us they "cannot think of a single negative word to say about the experience".
- We spoke with two partners of women who said they felt included and had been given explanations of care as it was occurring which they had found helpful and reassuring.
- We looked at 10 patients' records and saw discussions and treatment plans documented as discussed with patients and, where appropriate, with those close to them.
- Ward and clinical areas were relaxed and we observed staff had friendly but respectful interactions with both patients and relatives.

Maternity and gynaecology

Emotional support

- The specialist midwifes provided counselling and support to women undergoing antenatal screening.
- Staff said women who attended for termination of pregnancy for foetal abnormalities were allocated a side room to increase privacy. Partners were supported and able to stay for extended visiting and overnight.
- We observed emotional support provided to patients. We heard midwives supporting women on the telephone and in clinical areas. Individual concerns were promptly identified and responded to in reassuring and positive ways. Patients were spoken with in an unhurried manner, midwives checked if information was understood. When speaking on the telephone, women were encouraged to call back at any time if they continued to have concerns, however minor they perceived them to be.
- We observed how midwives cared for a vulnerable patient whose circumstances and discharge plans had been affected by external services not being available as expected. Staff appropriately supported the distressed patient with repeated explanations and reassurance in a kind and empathetic manner.
- All patients attending the termination of pregnancy service were able to access an accredited counsellor at any stage for support. All patients were routinely offered a follow-up appointment. Patients had the choice of attending the hospital or an alternative service within the community.

Are maternity and gynaecology services responsive?

Requires improvement

We judged responsiveness in the maternity and gynaecology services as requires improvement because:

- Access and flow through the gynaecology services was affected by trust wide and service specific pressures. This resulted in gynaecology treatment and care being cancelled or provided within an inappropriate environment.
- Access and flow through the maternity services were affected by a lack of facilities to meet local needs. This resulted in approximately one birth per month on the antenatal ward (Wheal Rose) Whilst this would be addressed upon the completion of new maternity services, these were not scheduled for completion until 2018.
- Improvements were required to support the provision of local community midwifery services in a timely way

However, good practice was also seen:

- There were private bereavement facilities and sensitive support provided for maternity and gynaecology patients who experienced loss.
- There was evidence of personalised care provided to patients and their relatives. This included gynaecology patients with memory loss conditions who had additional care and support needs.
- There was good evidence to show complaints were effectively monitored and appropriate actions taken in response to patient concerns.

Service planning and delivery to meet the needs of local people

- The maternity facilities and premises were outdated and not large enough to provide a full range of maternity services to meet the needs of local people. A business plan for redevelopment of the service had been approved. This included the development of a birth centre with four en-suite delivery rooms with birth pools. Building was anticipated to take two years and start during 2016.
- The community midwives (employed by the trust) provided care in community venues to suit patient needs. This included visiting patient's homes or their GP practice. The delivery of care in GP surgeries provided additional opportunities to engage with local people.
- The maternity facilities were in need of modernising and expansion to safely meet the needs of local women. There was a lack of choice of equipment available for women to support with pain and labour. For example, there were no birthing mats or pools available. The maternity service was part of an extensive redevelopment plan. These plans had been agreed with an anticipated start date of spring 2016 with completion during expected during 2018.
- There was a range of information available for patients in all clinical areas and on the trust's website. We observed all the information within the hospital was

written in English. Staff told us information could be provided in alternative languages when required. Information on the trust's website was available in 22 different languages.

Access and flow

- The maternity services responded to the needs of pregnant women living in the locality who required care, treatment and support before, during and after birth. Between April 2014 and March 2015, 4,330 babies were delivered. Between April and December 2015, 3,584 women had received or booked to receive ante or postnatal care. There had been 3,313 deliveries.
- Trust wide service pressures had affected access and flow through the gynaecology inpatient service. We reviewed the gynaecology dashboard information dated April to September 2015. During this time, 78 elective (planned) gynaecology operations (13%) had been cancelled on the day of surgery. Staff told us one of the reasons for cancellation included there being no bed available for gynaecology patients. The number of medical patients placed on the gynaecology ward (Eden) varied. This was monitored through the trust's incident reporting system. During the week of our inspection there had been between 16 and 22 medical patients accommodated on Eden ward each day. Staff confirmed that gynaecology inpatients were also moved to other wards due to the admission of medical patients to Eden ward. No data was being collected regarding this but staff said it was reported through the trusts incident system.
- A maternity triage service enabled pregnant women to call or visit with concerns or queries from 8am to 9pm. Women who required advice out of hours contacted the delivery suite. These processes supported effective flow through to the different maternity services. Additional midwives had recently been employed which would allow the triage service to remain open 24 hours, seven days per week. This was due to be rolled out.
- The gynaecology services were mostly responsive to patients' needs. We looked at records dated April to September 2015. This showed on average 219 women per month were reviewed and treated at the emergency gynaecology clinic. An average of 417 new referrals for general gynaecology services were accepted per month, with a further 148 new referrals for gynaecology oncology. However, not all of the national standards for cancer referral to treatment times were being consistently achieved. Between April and September 2015, the target (85%) for non-urgent, 62-day referral to treatment times, was only achieved in two of the six months.
- The postnatal ward (Wheal Fortune) had effective discharge processes. A midwife coordinated discharges between 10am and 6pm, seven days per week. Patients were individually assessed and taken a sectioned off area within the day room on the ward. Staff said this released beds to accommodate other patients.
- There was poor patient flow from the antenatal ward (Wheal Rose) to the delivery suite, which had an impact upon patient experience and care. The delivery suite was not always able to accommodate the numbers of patients in labour. All patient acuity (levels of risk and need) was kept under regular review. Those patients with the most complex needs/highest risks were prioritised to the delivery suite. However, for some patients assessed as having low risks this resulted in deliveries on the antenatal ward. Between April 2014 to March 2015, records showed 13 babies had been delivered on the antenatal ward. Between April and December 2015, there were 10 further deliveries on this ward. Senior staff told us this issue would be resolved upon completion of the new birth unit (2017/18).
- There was a lack of responsive and effective planning for some community midwifery services. One of the community teams had been given six months' notice to leave their clinic base. During this time senior staff had not found or agreed a suitable alternative and the team had been told to use the Royal Cornwall Hospital as an interim base. This meant some of the community services would be disrupted for women living in more rural areas of the wide geographic area covered by the trust. Some patients would not be able to travel to the hospital for appointments. In addition, the increase in travel time spent travelling by the community midwives would potentially impact further on their ability to meet patients' needs.

Meeting people's individual needs

- The maternity and gynaecology staff were responsive to individual needs. Patients told us staff provided personalised care and treatment. We spoke with nine patients and two relatives. We were told staff checked with patients how they preferred to receive their care, and which types of drinks they preferred to have.

- Patients who used the termination of pregnancy services were provided with written information. This was followed with a clinic consultation to review and personalise options and choices based on individual circumstances.
- There were processes to support gynaecology patients who had other conditions associated with memory loss. On the gynaecology ward (Eden), senior staff confirmed all staff had completed dementia training. In addition, there were two identified link staff who provided ongoing updates and information. A volunteer group provided stocks of individualised knitted items. These included shawls, blankets, mittens and 'Twiddle Muffs' (Alzheimer's Society, 2015) which provided additional comfort and helped to reduce anxieties.
- There was a bereavement suite on the antenatal ward (Wheal Rose) for use by patients and their relatives who were experiencing loss. This included patients who used the termination of pregnancy services. The suite was private and had one bedroom, lounge and kitchenette area. In addition, there was a licenced satellite mortuary. This was used solely for the gynaecology and maternity patients who had experienced loss. These specialist facilities enabled patients and their relatives to spend extended time together in a manner of their choosing.
- Midwives explained how they supported women with complex or specific needs at all stages of the maternity pathway. For example, patients who had complex family dynamics, mental health problems or were supported by other health or social care services.
- There was a lack of facilities for partners of patients on the delivery suite and postnatal ward (Wheal Fortune). There were few recliner chairs available for partners who needed to stay with patients for extended periods. There was a lack of bathroom facilities and limited availability of food. This meant partners had to leave the ward and access these facilities elsewhere in the hospital.
- A volunteer group of midwives had set up a charity with the aim of improving the maternity environment. The group had used surveys to gather patient feedback. Patients had asked for increased options to support positioning during labour. The charity had responded with the provision of birthing balls and comfortable, upright birth (CUB) stools.
- There were inconsistent processes to alert staff if a patient had a learning disability. The benefit of this would have been the ability to accommodate any required reasonable adjustments in advance of clinics or admissions. The trust IT system did not enable patients with a learning disability to be specifically identified. However, the maternity IT system was able to do this. Staff told us if patients had a learning disability, where possible they worked with other carers to provide personalised support or referred to the trust's specialist leaning disability team for advice.
- Postnatal care was coordinated effectively to support seamless patient care from the hospital to the community. Maternity administrator staff had systems in place which kept community midwives updated. This ensured clinical information was shared in a timely way. For example, sonography and other test results and delivery and discharge information.
- The midwives were familiar with, and used, a telephone translation service which was prompt and effective.

Learning from complaints and concerns

- There were systems for patients to register complaints and concerns. Patients told us they understood how to raise issues if they had concerns. Most patients told us they would raise issues directly with staff. There was clear guidance on how to raise concerns on information leaflets and the trust's website.
- There were systems to evaluate complaints in order to learn and make service improvements. Between April 2014 and March 2015 there had been 15 formal complaints made about the maternity service. Between April and December 2015 there had been 11 formal complaints. The governance lead and head of midwifery reviewed these. Complaints were investigated, actions recorded and learning identified. Complaints were reviewed for themes and learning and discussed as standing agenda items within governance meetings. For example, during 2014 there had been two complaints regarding poor midwifery attitudes and communication. With the consent and cooperation of the two complainants, this had led to the development of a bespoke training package. The patients provided a full explanation of their experiences, and this was recorded. The DVD produced was now an integral resource used as part of staff training. The last session provided had been during November 2015 and was attended by 23 midwives. The midwife responsible for governance told us the training always received positive feedback from

attendees. Additional sessions were being organised for 2016. We observed learning points from complaints were passed on through departmental meetings and various staff newsletters.

- Between April and September 2015 there had been 23 complaints regarding the gynaecology service. Senior staff told us the majority related to cancelled treatments and operations.
- The maternity department had looked for ways to learn and make improvements from other maternity services. Senior staff had completed a 'service gap analysis' in response to the five key learning points identified in the Morecambe Bay maternity services investigation (Department of Health, 2015). This had been shared with all staff and subsequent actions taken to improve treatment and care for patients. For example, the midwives' training passport had been developed to provide evidence that knowledge and skills were appropriate and updated.

Are maternity and gynaecology services well-led?

Requires improvement

We judged the well led domain as requires improvement because:

- A significant number of staff in the obstetric division reported a negative working culture across the maternity services.

However, good practice was also seen:

- There were thorough risk management and governance structures and processes. These linked risk and governance meetings and both departmental and trust level. This produced an effective flow of information from ward to board and vice versa.
- There was evidence to show risk and quality measures were interrogated for service improvements and responsive actions were taken.
- There were systems to share information and learning.
- Significant investment in services had been agreed, which included a new maternity led service.

Vision and strategy for this service

- The obstetrics and gynaecology services had a joint five year plan, which had been developed by senior staff. Throughout the services, staff demonstrated a broad understanding of the vision and strategy and of the trust's core values. All the staff we spoke with stated their goal was to provide high quality, person centred care.

Governance, risk management and quality measurement

- There were governance and risk management processes including audit trails to track any required actions. We looked at a range of departmental meeting minutes and information. These included monthly risk management and clinical governance meetings and obstetric and gynaecology directorate meetings. Governance, risk management, and quality information was recorded and appropriate actions taken. For example, on going audit and evaluation had identified an upward trend (increase) in caesarean section rates from 18% to 21%. This increased rate was still below the national average rate of 26% for caesarean section births (HSCIC, 2015). Despite this, staff maintained on going audit and evaluation of policy and procedure to review for any extenuating factors. This had not revealed any significant information, other than acknowledgement that the rate of patients with increased body mass index (BMI) (a known indicator for caesareans) had increased.
- Processes were in place to provide assurance to the trust board that service performance was effectively monitored and adequate measures were in place to reduce risks. Maternity and gynaecology clinical performance was reviewed against local and national standards. This was achieved through the on going maintenance of the maternity and gynaecology clinical and governance dashboards. These included a full range of clinical data plus other performance related information. For example, types and severity of incidents, complaints, use of the escalation policy, staffing levels and, equipment failures. It also included, slips trips and falls, needle stick injuries, medication errors and 'others' such as incidents related to poor record keeping. Each month the trust board was provided with a summary performance report of this information together with any actions required or being taken to reduce risks to patients or staff. These structures ensured an effective flow of information from ward to board and vice versa.

- The lead midwife responsible for risk management coordinated clinical risk activities within the maternity service. This included the day-to-day oversight and management related of risks affecting patient care. Other responsibilities related to promoting safe practice, sharing learning as a consequence of incidents and complaints and, reviewing any associated clinical policies and guidelines. Most days the lead risk midwife attended all clinical areas to liaise with directly with staff.
- Processes ensured effective communication on risk management issues with the trust's complaints and litigation team. The lead midwife for risk management reviewed all incidents reported for the maternity services. They were responsible for an initial assessment to establish an incident's level of impact and any immediate actions required to maintain patient safety. This midwife shared and office with, and worked closely with, the divisional governance lead (for both gynaecology and maternity). This person had direct links and monthly meetings with the trust's risk management team who oversaw all formal complaints and litigation procedures.
- Risk management workshops were provided so midwives understood their risk management responsibilities. Records showed issues had been identified and action plans completed to improve support and understanding of procedures for incident investigations. For example, midwives had felt a lack of support had been available when they had been required to complete written statements. In response, written guidance was produced and processes adapted so staff were able to discuss incidents with a risk or line manager or supervisor of midwives prior to writing a statement.
- There were systems to share obstetric risk management information and learning. The lead midwife for risk produced a newsletter every month. This provided a summary of incident reporting, summaries of patients with risk issues, reviews, audit and guideline updates. The newsletter was emailed to all maternity staff together with a copy of the maternity dashboard (summary of clinical and governance ratings). In addition, we observed in the trust's general surgery governance meeting minutes that an obstetric consultant had given a presentation. This related to the management of major obstetric haemorrhage (dated October 2015). This provided a clear overview of rates, risk indicators and clinical features of shock in pregnancy related to blood loss. Included were clinical, challenges and reviews of management processes. We saw that a number of pictures had been included. These supported effective risk management, as clinicians were able to reliably estimate the quantity of blood loss, and therefore provide the most appropriate treatment.

Leadership of service

- The consultants provided good leadership and support to junior medical staff. We spoke with junior doctors who said they had excellent support and working relationships with the consultants. The doctors told us they got the right balance of training opportunities and responsibility and they felt encouraged and nurtured by senior staff.
- Midwives and gynaecology staff gave mixed feedback regarding the leadership of senior staff. Some told us senior staff were approachable and that they felt well supported. Other staff reported less positive experiences. On the days of our inspection, senior staff were visible and present in clinical areas and demonstrated an understanding of current clinical activity and priorities.

Culture within the service

- We were concerned about the culture within maternity services as some midwives did not feel supported in all aspects of their role. Issues and anxiety were expressed to us by staff who worked in a variety of settings within the community and hospital maternity services. We spoke with a total of 45 obstetric staff, of which eight (18%) independently expressed concerns and reported a negative working culture. All of these staff told us they did not feel able to express their professional opinions candidly and openly without fear of reprisal. They also expressed a lack of confidence regarding the effectiveness of the trust's whistle-blowing policy. Staff were very anxious regarding possible repercussions of talking with us. It was not clear if the head of midwifery was fully aware of the extent and range of these concerns.
- Gynaecology and maternity staff we spoke with enjoyed working with their colleagues and were proud of the patient care they provided.

Public engagement

- There were processes to gather feedback from patients and local communities. The Maternity Services Liaison Committee (MSLA) gathered patient and public feedback on experiences and views on the maternity services. Membership was open to service uses, health professionals, voluntary, and health and community services. Royal Cornwall Hospital maternity staff had attended meetings and information was shared with the local Clinical Commissioning Group. We looked at meeting minutes dated May and June 2015. Information discussed included, a survey on breastfeeding support (responded to by 69 patients), and a survey on smoking and health weight in pregnancy (responded to by 140 patients). We saw action plans had been developed, including how to share findings widely.
- A Facebook page had been set up by midwives as another method to promote patient involvement and gather feedback on services. We reviewed this (January 2015) and saw feedback was requested regarding patient preferences for different types of epidural. We observed 494 people had positively rated the Facebook page.
- Patients staying within the gynaecology and maternity services were encouraged to provide feedback on their experiences. Patients with told us they had been advised to complete NHS Friends and Family Test forms prior to discharge. Departments received monthly updates and staff told us the majority of NHS Friends and Family Test responses were positive. We saw positive and negative patient feedback was shared with staff within monthly newsletters.
- The maternity service participated in a national patient experience survey. The most recent survey (CQC, 2015) identified 142 patients had participated. The results showed improvement in patient satisfaction since the previous survey (2013). We reviewed the labour and birth section feedback. The maternity services had scored better than other services in two areas. This was for staff introductions and involvement in decisions. The service had scored worse than other similar services in two areas. This was for information provided after birth and the timeliness of support after birth. The remaining 15 questions rated about the same as other similar services.

Staff engagement

- Staff were kept updated and encouraged to provide ideas. Information relating to trust or gynaecology and maternity service updates were distributed through various newsletters, service wide emails and staff meetings. We reviewed a selection of newsletters including those for Wheal Rose (ante natal) and Day Assessment Unit and the 'Divisional Express'. These provided a range of information and requests for ideas, thoughts or articles to be included in future staff newsletters
- Community midwives worked within local children's centres and either worked with or were based within GP practices. Staff said this provided opportunities to engage with community services and groups and bring back information to share at staff meetings.
- Systems were in place to gather staff feedback to enable more effective working and improved patient experiences. Staff on the gynaecology and maternity impatient areas and the delivery suite, participated in productive ward processes. The purpose of these was to gather staff views, identify actions to improve safety and efficiency, and increase time with patients. We looked at productive ward action plans dated January 2016. These showed nine staff suggestions with associated action plans or evidence of completion. For example, an additional telephone had been requested in a clinical recovery area. This had been provided with a silent facility to minimise disturbances for patients.

Innovation, improvement and sustainability

- There was evidence of innovation and improvements in practice. One of the consultant gynaecologists had been appointed as a specialist advisor for the scientific committee with the Royal College of Obstetricians and Gynaecologists (RCOG). This consultant was also the overall winner of the National Institute of Health and Care Excellence (NICE) 2015 shared learning award. This was in recognition of actions taken to improve clinical care for women with continence issues. Diagnosis and treatment processes had been reviewed. This had established that outcomes and patient experience was inconsistent. Actions were taken to simplify and improve the care pathway based on NICE guidance. In addition, teaching sessions had been provided on a rolling programme for GPs to share and reinforce best practice. This resulted in improved patient outcomes and experience, cost savings, and a reduction in unnecessary treatments.
- One member of staff on the gynaecology ward (Eden) used their initiative for the benefit of patients. This

person had contacted the Eden Project (tropical and botanical gardens in Cornwall). Arrangements had been made for the Eden Project to contribute to patient wellbeing by painting murals in communal areas of the ward.

- The long term use of Eden Ward for other medical and surgical patients had impacted on the retention and recruitment of skilled gynaecology nurses. There was a lack of opportunity for gynaecology nurses to use and continue to develop their specialist training and skills. Nurses on Eden Ward had to care for women with diverse medical needs.
- Midwifes had developed and facilitated midwifery recruitment sessions. Two information sharing days had been provided for individuals considering a career in midwifery. We were told feedback had been extremely positive and further sessions were being arranged. We saw on the trust's maternity Facebook page positive comments left by one participant. This person reported the day was "fantastic" (July 2015).
- Funding had been agreed to upgrade and reconfigure the maternity services to more effectively meet the needs of local people. This included a new midwifery led birthing unit at Royal Cornwall Hospital. It was anticipated this work would begin during 2016 and take approximately two years to complete.

Services for children and young people

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

Information about the service

The hospital serves a large geographical area of Cornwall and the Isles of Scilly. The region is popular for family vacations and the resident population can double during the summer months. Between July 2014 and June 2015 the children and young people's services had 7,272 admissions of which 84% were emergencies, 8% day cases and 9% elective admissions. Emergency admissions were higher than the England average of 67% and day case admissions were lower than the England average of 23%.

The hospital provides services for children up to the age of 18 years on the neonatal unit, children's inpatient wards, high dependency unit, admissions unit, day case unit and children's outpatient department.

The level two neonatal unit is situated adjacent to the maternity ward and has capacity to care for 20 babies who need further care before they are able to go home with their parents. There are separate areas for babies who need different levels of care with four intensive care, three high dependency and 13 special care cots. Babies who required ventilation for longer than 48 hours were transferred to a more specialist unit. Accommodation is available for parents to stay and be close to their child.

The ward areas are divided into areas with a Paediatric assessment unit, Polkerris and high dependency unit being on the west wing of the unit and Sennen, Harlyn and Fistral situated on the east wing.

The children's wards had accommodation for 41 patients 29 of which were inpatient beds with facilities for their parents/carers to stay. The unit is divided into sections within two ward areas which are on the same hospital floor, separated by a communal stairwell and elevators into east wing and west wing.

The east wing housed areas called Harlyn and Fistral and included four cubicles used for children with leukaemia and cancer (CLIC).

- Harlyn is a day surgery unit of eight beds arranged in two bays and two cubicles. It also houses a kitchen and lounge area for parent's use.
- Fistral, used for adolescents and is comprised of eight beds in two separate bays, two cubicles and a play room.

The west wing housed the Paediatric assessment unit, Polkerris and a high dependency unit.

- The paediatric assessment unit has four cubicles with a waiting area and examination room.
- Polkerris has eight cubicles and a four bedded bay used for babies and younger children.
- High dependency has three beds in one bay used for all ages of children.

A pre-operative assessment room is situated between the two wings with play rooms and a sensory room available for children to use.

Each inpatient space has room for a temporary bed to accommodate parents staying with their child.

Single sex toilet facilities are available for children and young people to use.

Services for children and young people

An outpatient department situated on the floor below the children's wards, is dedicated for use by children and young people. This also has four beds that could be used for children attending the hospital for procedures such as receiving medical treatment, undergoing tests and if monitoring is required before they can return home on the same day. Play areas and facilities are available in the outpatient department and on the wards to occupy children and young people of all ages.

A suite of four double rooms with toilet facilities was adjacent to the outpatient department for use by parents to stay close to their child or if their baby was receiving care in the neonatal unit.

A surgical theatre and recovery area are specifically for the use of children and young people.

Children and young people also attended parts of the hospital that were used for adult care. These included radiology, adult outpatients, fracture clinic, critical care and the emergency surgical theatre. Each of these areas has some provision specific to different age groups of children.

During our visit we spoke with 71 staff members which included consultants, medical staff, nurses, managers and support staff. We also spoke with15 parents, four children and young people. We visited the paediatric areas as well as facilities for adults which were also used by children and young people. In all areas we observed care and reviewed care records and other documents.

Summary of findings

We rated this service as good overall because:

- Processes were in place to report incidents with details of full investigations having been completed where appropriate. Staff were aware of the process although some staff told us they did not always receive feedback on progress of the investigations.
- Systems were in place to monitor medicines management and infection prevention and control with action plans identified.
- There were adequate numbers of appropriately qualified staff on the ward areas we visited. Staffing levels were monitored using an acuity tool and adjusted across the unit as the needs of the children changed.
- Records were kept securely to maintain confidentiality for the patient but were available for staff to view when required.
- Safeguarding training was not compliant with the trust target. The safeguarding leads had taken action to raise awareness of safeguarding for children, as well as having other plans in place to meet this target by April 2016.
- Mandatory training did not meet the trust target of 100% compliance although staff we spoke with were aware of when and how to update their training.
- Risk assessments were available to help staff in paediatric areas to recognise when a child or young person was becoming unwell and needed further clinical intervention. This was not available to staff caring for children in the adult critical care unit.
- Processes were in place to use available evidence to achieve good outcomes for children and young people.
- Guidelines were based on national standards of best practice and audits were undertaken to identify compliance with action plans for improvements.
- Services were provided seven days a week with busy periods identified and staff put in place to meet the demand.

Services for children and young people

- Systems were in place to ensure children and young people were cared for appropriately by competent staff in paediatric areas of the trust. Some areas where children shared areas with adult patients did not have staff trained in paediatric care.
- Specialist staff were available to provide advice and support for children and young people in a timely fashion. Professionals worked together from a variety of disciplines such as learning disability team, physiotherapy, child and adolescent mental health services and school staff. There was a limited availability of mental health beds for children and young people. The impact was that a child or young person would remain on an acute general ward when they were clinically fit to be discharged, with staff who were not mental health specialists.
- Staff were kind and compassionate in their communications with parents and their children. They were given information in a way they could understand.
- Children and young people felt informed and involved in their treatment options. Regard was given to emotional health and support was provided to promote independence when the child was discharged.
- Feedback from children and young people who used the service and their families was positive with quotes of “staff are fantastic”.
- Views of children, young people and their families was actively sought and responded to with changes made where possible and appropriate.
- Individual needs were considered and needs met wherever possible in a way that did not single people out as different.
- There were strong links with community resources to provide seamless care for patients when they were discharged from hospital.
- Individual needs were taken into account in all areas we visited. Children were prioritised above adults on surgical lists, areas were dedicated to children where possible and actions were taken to improve the environment for children.
- Senior staff were represented at trust board level and felt children’s services were listened to and action taken.
- Senior managers were using the recently updated standards in‘setting the future direction’ to develop their strategy for the future of the service. There was an atmosphere of openness and learning from experiences.
- Partnership working and engaging with patients and staff was a priority for the management team

Services for children and young people

Are services for children and young people safe?

Good

We rated this service as good for safety because:

- Processes were in place to report incidents with details of full investigations having been completed where appropriate. Staff were aware of the process although some staff told us they did not always receive feedback on progress of the investigations.
- Systems were in place to monitor medicines management and infection prevention and control with action plans identified.
- There were adequate numbers of appropriately qualified staff on the ward areas we visited. Staffing levels were monitored using an acuity tool and adjusted across the unit as the needs of the children changed.
- Records were kept securely to maintain confidentiality for the patient but were available for staff to view when required.

However

- Safeguarding training was not compliant with the trust target. The safeguarding leads had taken action to raise awareness of safeguarding for children, as well as having other plans in place to meet this target by April 2016.
- Mandatory training did not meet the trust target of 100% compliance although staff we spoke with were aware of when and how to update their training.
- Paediatric risk assessment tools were available to help staff to recognise when a child or young person was becoming unwell and needed further clinical intervention. Children cared for in the critical care unit had their condition monitored using an electronic system which did not incorporate levels of risk specific to paediatric patients. We were told of plans to add paediatric risk assessment tools to the electronic system used in critical care.

Incidents

- Systems were in place to report and investigate serious incidents.
- Never events are serious, largely preventable patient safety incidents. The children's services had reported no never events between November 2014 and October 2015..
- Two serious incidents were reported between November 2014 and October 2015. One of these incidents was unrelated to acute inpatient services at the trust. We saw comprehensive investigation reports with action plans to prevent re-occurrence of similar incidents. This included revising information given to parents when their child was discharged home, ensuring they understood when to seek further medical advice.
- Staff were confident in using the electronic reporting system although some staff told us they did not receive personal feedback about outcomes of their reporting. Incident reporting was a standing item at child health directorate meetings which were held monthly and attended by medical, nursing and community staff from children and young people's services. We saw records of incidents reported by staff with actions and learning points documented and updated. One example was regarding incorrect breast milk being given to mother. This had been investigated with actions identified and staff had received further training to ensure correct procedures were used.
- We saw minutes from meetings that discussed child deaths. Paediatric mortality meetings were held every three months and included information from Cornwall's child death and overview panel. Meeting notes showed attendance by a range of staff including paediatric doctors, nurses and ambulance staff. Cases were reviewed in detail with action points assigned to appropriate staff. Processes were in place to discuss any outcomes with staff at the trust during quarterly child mortality reviews and team meetings. Neonatal deaths were discussed at perinatal death reviews using a template to discuss individual case reviews. The attendance lists we saw showed a range of staff were present including GP trainees, consultants, medical students and midwifery students.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a new regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in

relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Staff we spoke with were not all aware of the term duty of candour but did explain how they were open and honest with patients and their families if an error occurred. If parents wanted to make further comment they would be guided to the patient advice and liaison service (PALs service).

Cleanliness, infection control and hygiene

- Processes were in place to monitor and report on infection prevention and control procedures and all areas we visited appeared clean.
- Hand sanitiser and hand washing facilities were available in all areas we visited and we saw staff using them appropriately.
- We saw protective equipment such as gloves and aprons were available used appropriately in all areas we visited.
- Audits were carried out monthly to measure compliance with a range of activities. This included hand hygiene, bare below the elbow, commode cleanliness and care plans use for those with intravenous lines. Results from October 2015 showed the paediatric wards were below trust compliance levels for hygiene procedures in hand hygiene and commode hygiene. In October 2015 Polkerris ward was below trust compliance level of 90% for having available care plans where children had intravenous lines. Infection prevention and control was discussed at meetings held by the child health directorate every month. The minutes from September 2015 mentioned lack of compliance around commodes but no action plan was seen. At the time of our visit, equipment we looked at appeared to be clean and had "I am clean" labels to indicate it was available for use. Audits of the World Health Organisations standard of five moments of hand hygiene and staff being bare below the elbows showed 100% compliance in each of the paediatric areas for August and September 2015. However, in October and November 2015 there was reduced compliance in these areas. We saw posters on the ward areas reminding staff of the five moments of hand hygiene actions.
- We were told there was no surgical site infection audit undertaken between November 2014 and October 2015.There were no reported cases of Clostridium difficile or Methicillin Resistant Staphylococcus Aureus bacteraemia for children and young people's services between August and November 2015.
- Further audits were undertaken regarding the state of repair and infection control risk of the environment. For example any mould in shower areas, any chipped paint. Results between April and July 2015 showed between 50% and 79% compliance against a trust target of 85%. The results and required actions were identified on the audit document and shared with relevant colleagues in estates department and the cleaning contractor.
- Staff in paediatric outpatients told us that children who may present an infection control risk were highlighted on the computer system. This would enable staff reduce any infection risk by isolating the patient from others in the unit.
- Most areas we visited were uncluttered with equipment being stored safely. The exception to this was neonatal intensive care unit (NICU) where we found equipment stored in an empty patient cubicle and corridors in the unit. We were told this was due to lack of storage facilities and that staff would need to store more equipment in the corridors if the cubicle was required for a baby. Staff made every effort to maintain access to all areas by keeping equipment spread along the corridor areas.
- The trust had documents to record weekly and daily cleaning which could be adapted for each hospital area. We saw this used effectively in each ward area we visited. Areas where children visited had toys available for children. In some areas these were cleaned according to a schedule which was signed and dated. Some areas had no schedule for cleaning toys. For example, children's outpatients staff told us they were constantly cleaning but this was not documented and radiology could not tell us when toys were cleaned. There was no assurance that toys were sanitised between use in these areas.
- We were told that floor cleaning solution was unavailable at the time of our visit resulting in the ward cleaning process being incomplete.

Environment and equipment

- Processes were in place to maintain equipment and the environment to provide safe use of facilities.
- Neonatal intensive care unit (NICU) had limited space available to provide an uncluttered environment. A

small x-ray machine was available for use and would fit next to the cots on the unit. It had very recently received confirmation of funding for a new unit to be built using existing buildings in another area of the hospital. We saw the approved plans which would provide a safer environment for patients and their parents on completion of the building work

- Equipment we saw in all areas was maintained and had a date of the most recent check attached.
- In all areas we visited appropriate resuscitation equipment was available for use with all ages of children and young people. Logs of daily and weekly checks were signed and dated with no omissions.
- The theatre and recovery department had a system in place to prevent children and young people being nursed alongside adults. There was a waiting area, anaesthetic room and surgical theatre dedicated for paediatric use. A wall separated children from adults in the recover area. If adults needed to be taken past the paediatric area, curtains were available to prevent children from viewing adults.
- Fridges and freezers used for storage of expressed breast milk were checked daily and the temperature recorded. There was a system in place to report any temperatures that were outside of the recommended range.
- Clinical waste was stored and disposed of safely. Used sharps such as needles were stored in dedicated sharps bins to prevent injury to staff.
- Protocols were in place to prevent injury to children from hot drinks being brought on to the ward.
- Play areas, including a sensory room were available for children and young people to distract their attention and provide a soothing environment.

Medicines

- Systems were in place to ensure medicines were stored and prescribed safely. An electronic prescribing and administration system was in place for the paediatric wards. NICU were using paper medicine charts as there had been a delay in providing the electronic system to that department. Fridges used for storage of medicines were checked by staff who signed the attached log daily to ensure it was maintained at the correct temperature.
- A pharmacist with paediatric knowledge visited the paediatric wards and NICU daily from Monday to Friday. We saw charts had been signed by the pharmacist as being compliant with trust policy.
- In all the areas we visited we found medicines were stored securely in locked rooms. Controlled medicines were stored in a separate locked cabinet in a locked room. They were checked daily by two qualified staff members who signed a log to verify the check had been completed
- Intravenous fluids, medicines and oral medicines were stored and prepared in an area away from access by children, young people and visitors.
- We observed staff following strict guidelines when administering specialist medication to treat cancer in children.
- Medication charts we saw were clearly documented with allergies and weight of the child.
- An audit of gentamycin prescribing and administration to neonates carried out in November 2015 showed full compliance with recommended procedures.

Records

- Systems were in place to ensure records were stored safely and available for professionals to use.
- Clinical records which reviewed a patient's condition and held test results were kept in paper format and in locked trolleys on the ward and NICU. These records were updated by all staff involved with the child including nurses, allied health professionals and doctors. The ward areas stored nursing records such as fluid recording and observation charts in the same cupboard as the clinical notes and close to the patient's bed space. NICU stored the nursing records at the end of each cot space.
- The nine records we viewed were clear and legible with entries signed and dated.
- An electronic patient record system was available for staff to use which recorded and highlighted known medical information about children admitted to the hospital. For example, staff told us they would be made aware of children who had infection control needs such as children whose immune system was reduced.
- The children's ward areas used an electronic white board that staff could access indicating where the children were placed on the ward. A screen saver activated within a short period of time after use to keep personal information confidential. NICU used a video link to consult with specialists from Bristol. This shared records, x-rays and results and gave medical staff specialist advice for the ongoing needs of the baby.

- Electronic systems ensured that GPs were informed of the child or young person's attendance as soon as the patient was discharged.

Safeguarding

- Processes were in place to protect vulnerable children and young people where safeguarding concerns were identified.
- Health Services for Children Looked After and Safeguarding had been reviewed by CQC January 2015 across Cornwall and included the Royal Cornwall hospital. The trust had devised an action plan which included safeguarding link nurses being offered group supervision, face to face supervision for staff who made a referral to social services and group supervision offered monthly to all paediatric ward staff.
- 25 staff across the trust were trained to offer and provide safeguarding supervision to their colleagues.
- There was an identified team for safeguarding children and young people including named nurse, doctor and executive lead. Guidance for reporting concerns was available for staff to view and included flow charts of advised actions, people to contact and body maps for use where appropriate.
- The named nurse and doctor engaged with regular supervision for their own practice with senior safeguarding colleagues. An annual report had been produced and presented to the trust board in December 2015 in line with national guidance.
- The electronic patient record system had a flagging system to alert staff about child protection concerns regarding a child or young person attending the hospital and was accessible in the wards and outpatient departments.
- Three safeguarding incidents were recognised and reported by the paediatric unit between July and December 2015. Staff we spoke with were aware of the procedures and could describe recognising and referring safeguarding concerns.
- Staff followed abduction policy and monitored entrances to paediatric wards and NICU by closed circuit television. Visitors gained entry and exit to the by ringing a buzzer before staff released the door. We were asked for identification by all staff at first meeting. We were told of a time when a staff member raised an alarm regarding suspected child abduction. The response was immediate and the suspect apprehended although it had been a false alarm on that occasion.
- There was a 'was not brought' policy for ensuring children who did not attend appointments were safe. Staff described the procedure of informing the consultant paediatrician, the patient's GP and a telephone call to the parent if another appointment was necessary.
- The named doctor and nurse monitored attendance rates at safeguarding training. The intercollegiate document - Safeguarding children and young people: roles and competences for health care staff, March 2014 states "All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns" should complete level three safeguarding training. Figures from January 2016 showed that staff having completed safeguarding training was below the trust target of 84.5%. There was a protocol identifying which staff across the trust needed to complete any of levels one, two and three safeguarding children training. Completion rates were:
  - level one - 70%
  - level two - 78.4%
  - level three - 68.2%
- The named nurse and doctor had a plan to increase staff compliance levels. Extra training sessions were provided with a training passport for staff to record and a multi-agency conference was arranged for spring 2016 with 150 places.
- All consultant paediatricians were compliant with level three safeguarding training.
- The named doctor and nurse had completed level four safeguarding children training and updated their knowledge using specialist national journals. Information was shared with staff using safeguarding newsletters.

Mandatory training

- A system to ensure staff were up to date with mandatory training subjects was in place.
- Mandatory training was monitored by the trust and included topics such as control of infection, fire safety awareness, manual handling, information governance and equality, diversity and human rights. The figure for paediatric staff having completed this training on 31 December 2015 was 83% for nursing and 67.7% for

medical staff, against a trust target of 100%. Staff we spoke with knew when their mandatory training was due to be updated and how to arrange attendance. We did not see any plans for improving the uptake of mandatory training.
- An induction programme was in place for all staff before they commenced work at the trust. Staff told us of the subjects it included (fire safety, safeguarding, manual handling, conflict resolution, control of infection equality diversity and human rights).
- Staff working with children and young people had completed paediatric basic life support training and NICU staff had completed further training for newborn life support.

Assessing and responding to patient risk

- Processes were in place to assess and monitor effective use of risk assessment tools.
- Paediatric areas used paediatric early warning scores (PEWS) and neonatal early warning scores (NEWS) to highlight when a patient's condition was deteriorating. The documented score indicated what action to take. The trust carried out audits of these early warning tools on a quarterly basis with a target of 90% being completed accurately. The paediatric wards showed compliance of between 75% and 100% between March and September 2015. NICU were shown to have 100% compliance with using the NEWS for the same period. Patient records we reviewed had appropriate actions documented using the NEWS and PEWS charts. A trust wide protocol for venous thromboembolism advised staff of actions to take for relevant children and young people at risk. There were no patients on the wards who needed any treatment for this at the time of our visit.
- Should a child need intensive care facilities such as for stabilisation of a condition before transfer to another hospital or for short term ventilation, a paediatrician and the outreach team from adult critical care would discuss the most suitable setting for the child. Critical care used an electronic form of the early warning score which was designed for adult care. If children were cared for on the unit they relied on clinical skills of staff to recognise a deteriorating condition in a child. We were told of plans for the PEWS to be added to the electronic record. A registered children's nurse worked on the intensive care unit part time and supported other staff with paediatric skills and knowledge. A policy was in place to guide staff in the transfer and discharge of children and young people. This included guidance for patients with complex continuing care needs but did not give detail about transferring critically ill children and neonates to more specialist units. A process was in place for arranging retrieval of a child to a specialist unit where specialist staff would travel to the Royal Cornwall Hospital to accompany the critically ill child.
- We saw the World Health Organisation Surgical Check list being used to document safety aspects when a patient was to undergo surgical procedure or investigation such as identity check and consent. These were audited and reported on every three months. The audit report for April 2015 showed all documents reviewed had been accurately completed.
- Services for children and young people in surgical theatres and recovery were overseen by a registered children's nurse. Immediately after anaesthesia children and young people were cared for by registered adult nurses who had obtained additional skills in paediatric care including resuscitation and administration of medications. One nurse was allocated to each patient in this area. A member of staff with advanced paediatric life support was always available in the recovery area when children were being cared for.
- The trust performed about the same as other trusts for all questions relevant to the safe domain in the CQC Children's Survey 2014. One of the questions was do you feel that your child was safe on the hospital ward.

Nursing staffing

- Systems were in the paediatric areas to ensure areas were staffed appropriately.
- NICU used a tool to assess staffing levels according to British association of paediatric medicine (BAPM) guidelines and were communicated to the South West Neonatal Network. This was so that the network could support areas under stress by diverting care to another unit, if it was necessary. For the period between 1st and 11 January 2016 the unit was understaffed on five occasions by between 08% and 24%. Staff ratio on NICU was 70%:30% registered to unregistered staff.
- Staffing levels on the ward areas were based on RCN 2013 guidelines of safer staffing for paediatrics. An acuity tool was being used to assess staffing based on patient clinical need. Figures reported actual staffing to be below the planned staffing levels by between three and nine percent for the month of December 2015.

Services for children and young people

- The outpatient department was staffed by registered nurses and clinical support workers.
- Each area had access to a senior paediatric nurse at all times and a nurse with advanced paediatric life support skills was on each shift.
- There was a process for accessing bank staff who were familiar with the areas when there was a shortfall of staff although this was not always possible at short notice. Agency staff were not used as they would be unfamiliar with the environment.
- The high dependency unit on the ward area was staffed by registered children's nurses with support from health care assistants where necessary. At the time of our visit we saw one nurse to one patient in high dependency which followed the RCN guidelines for safer staffing.
- Staff handovers between shifts took place in the ward office and was followed by bedside discussion for each patient about the plans for ongoing care. NICU handed over their patients to the new shift at the cot side.

Medical staffing

- Sufficient numbers of medical staff were available for all of the paediatric areas.
- The paediatric unit operated a system of 'consultant of the week which provided continuity of care for the child.
- Medical staffing had similar proportions of consultants and middle grade doctors as the England average in other hospitals. The proportion of junior grade doctors was double the England average. Consultants had rearranged their shifts to ensure there was senior medical cover until 9. 30pm each weekday. This meant junior colleagues were supported in their clinical practice. Advanced neonatal nurse practitioners were part of the out of hours medical rota. A consultant was always available for advice either on site or on call from home.
- Medical staff including consultants handed over to colleagues at the end of each shift. There was a daily handover meeting in the morning of each week day where plans for ongoing treatment, expected admissions and discharges were discussed. These meetings were attended by a senior member of nursing staff.
- Each of the patient records we reviewed had documented they had been seen by a consultant within 24 hours of their admission.
- The paediatric assessment unit provided a telephone advice line for GPs and was overseen by a consultant paediatrician.

Major incident awareness and training

- The trust had a major incident plan which staff were aware of and knew how to access. NICU staff explained how they would be alerted and would respond in assessing how they could support other paediatric areas.
- There was an escalation policy in place for the paediatric wards which detailed actions required when demand for services exceeded available bed spaces. NICU had a similar escalation policy in draft format.

Are services for children and young people effective?

Good

We rated this service as good for effective because:

- Processes were in place to use available evidence to achieve good outcomes for children and young people.
- Guidelines were based on national standards of best practice and audits were undertaken to identify compliance with action plans for improvements.
- Services were provided seven days a week with busy periods identified and staff put in place to meet the demand.
- Systems were in place to ensure children and young people were cared for appropriately by competent staff in paediatric areas of the trust. Some areas where children shared areas with adult patients did not have staff trained in paediatric care.
- Specialist staff were available to provide advice and support for children and young people in a timely fashion. Professionals worked together from a variety of disciplines such as learning disability team, physiotherapy, child and adolescent mental health services and school staff.

However

- Some areas where children shared areas with adult patients did not have staff trained in paediatric care
- There was a limited availability of mental health beds for children and young people. The impact was that a

child or young person would remain on an acute general ward when they were clinically fit to be discharged, with staff who were not mental health specialists.

Evidence-based care and treatment

- Services for children and young people used available evidence to provide good quality care.
- Policies, procedures and guidelines were available for staff to access on the trust intranet and documents we saw were based on national guidance from specialist organisations such as treatment of diabetic ketoacidosis followed guidelines from the British Society of Paediatrics Endocrinology and Diabetes, 2013.
- The trust contributed to national audit programmes such as the National Paediatric Diabetes Audit, National Neonatal Audit Programme (NNAP) The results were variable although we were told there had been some problems with recording results.
- An audit and guidelines group for the directorate met every two months. This was attended by a variety of staff including nurses, doctors, specialist nurses and managers. Existing guidelines, audit in progress and adoption of new guidelines were discussed. Meeting notes from May 2015 recorded discussions about adopting National Institute for Health and Clinical Excellence (NICE) guidelines for gastro-oesophageal reflux disease. Many of the neonatal guidelines had hyperlinks to those used by Bristol Children's hospital which had been assessed by the group as appropriate to use. The group identified further training needs would result from updating guidelines such as for high dependency unit staff when treating asthmatic children.
- Audit programmes were undertaken to monitor compliance with policies. As an example the paediatric service contributed to the trust's audit report on patient consent to treatment in 2015. Action plans were identified for improvement of the process.
- The paediatric wards had completed the self-assessment for You're Welcome accreditation and were in contact with an organisation for young people to arrange the next stages such as secret shoppers. Neonatal intensive care (NICU) had met the Unicef baby friendly standards and signposted parents to the organisation BLISS (a charity which supports premature and sick babies and their families).
- NICU staff encouraged skin to skin care between babies and parents (an established method of promoting bonding, lowering stress levels and optimising brain development in babies) with leaflets and physical support where needed.
- Rights of people subject to Mental Health Act 2005 were protected. Information was provided in a way that children, young people and their families could understand and consent was obtained appropriately.
- Specialist nurses were supported in their practice by linking with specialist centres for conditions such as cystic fibrosis, oncology and palliative care. A transition programme was provided for young people with long term conditions moving into adult care.
- The 2014 CQC children's survey results were similar to those of other trusts for most of the questions asked. They scored better than other trusts for children and young people saying they liked the food at the hospital.

Pain relief

- Children and young people had their pain assessed and appropriate methods of reducing pain were offered.
- A team of professionals was available to advise staff if a patient's pain was difficult to control. This team was led by an anaesthetist and contact numbers were available in each patient's record.
- Nurses assessed children's pain by using age appropriate assessment tools such as smiley faces and numbers to grade pain. These assessment tools helped children of all abilities to communicate how much pain they were in and were included in every child's nursing record. Children and young people we spoke with told us they had been offered pain relief. Parents and children fed back on survey forms that pain had been monitored and treated effectively.

Nutrition and hydration

- Suitable and sufficient food and drinks were available to maintain patients' nutrition and hydration. Staff had access to dietician advice if they needed it and were able to offer a variety of drinks and food from a children's menu. This offered a variety of foods to appeal to children of all ages. Food was checked before serving to ensure it was at the appropriate temperature to be safe for consumption.
- Breast pumps, fridges and freezers were available on NICU and the children's ward for mothers to express and store breast milk safely for future use.

- On admission to the children's wards patients were assessed for fluid and nutritional needs. Patient records we reviewed showed that any fluid or dietary intake was monitored and recorded where necessary.
- A previous alert from the National Patient Safety Agency (NPSA) had identified a risk of hyponatraemia (low sodium levels) remaining undetected in children receiving intravenous fluids. The children's services audited their practice in December 2015 were shown to be compliant with recommended guidelines.

Patient outcomes

- Outcomes for children and young people were monitored by the service and they engaged with national audit programmes.
- The results of the National Paediatric Diabetes Audit 2013/14 (published in March 2015) showed trust to be performing slightly better than other areas in England. The mean HbA1c result was 69 compared with 72 in England
- Between June 2014 and May 2015, emergency readmission rates for children and young people following discharge at this trust were slightly higher (worse) than the England average. The rate was between 0.5% and 1% higher than other areas in England.
- Multiple admission rates for children and young people with Asthma was better than the England average for the period between July 2014 and June 2015. This indicated asthma control was effective. For the same period patients living with epilepsy had a greater number (32.7%) of multiple admissions than the England average (27.8%).
- The NNAP results for 2014 (published December 2015) suggested that NICU were not meeting the standards in three areas when babies were admitted to the unit. Senior staff told us there had been a problem reporting NNAP data resulting in incorrect data being published. The corrected figures they showed us indicated they had met all of the standards except one and there had been an improvement on the one not met.
- Audit meetings were held every two months and assessed compliance. The minutes of 21st May 2015 reported they were 100% compliant with National Cancer Peer Review Programme, Children's Cancer Measures 2014.

Competent staff

- All staff on the children's wards, outpatients and NICU were appropriately qualified for their roles. Some areas where adults and children attended were not always staffed with registered children's nurses.
- NICU had nurses who were trained in their specialty and four advanced neonatal nurse practitioners working on the unit.
- All staff we spoke with told us they had completed an induction programme before working in the paediatric areas. This included student nurses, bank staff and medical staff.
- Physiotherapist staff on the children's ward had additional paediatric training.
- Anaesthetists did not take part in an emergency rota for children's services. There was a process for ensuring that an anaesthetist with paediatric experience was available and present at any child's planned or emergency surgery. They would either support a colleague wishing to gain paediatric experience or perform the anaesthetic themselves.
- Practice educators worked on the ward areas and NICU. Part of their role was to monitor mandatory training and offer support where further training needs were identified.
- A training schedule was organised for staff which included medical, nursing and allied health professionals. Simulation training was used in the paediatric areas to give staff experience in emergency situations without risk to patient care. Trainee medical staff felt supported in their practice and commented that the training in their placement was "awesome" The Sims model was also used to test out new practices and identify areas for improvement. As an example, a recent change in bleep system was tested using this process.
- Revalidation for consultants was linked to the appraisal process. The responsible officer ensured revalidation of medical staff was up to date. Consultants had revised their job plans to be available for staff and patients until 9. 30pm.
- Outreach nursing staff had extra qualifications in their specialty such as cystic fibrosis and oncology. Physiotherapy and nursing staff worked as an outreach team with cystic fibrosis patients to prevent admission to hospital. Specialist nurses worked with regional networks to support and update their own practice and shared updates and training with paediatric ward staff.
- Paediatric and critical care consultants discussed suitability for children to be cared for on the adult

critical care unit. Staff on this unit had undertaken specific training for high dependency patients and one staff member was a registered children's nurse. There was a process in place for all children and young people to have been reviewed by a consultant paediatrician before they were discharged.

- Two radiographers with training in imaging children and young people with suspected non-accidental injuries had recently left the trust. Radiographer's undergraduate training included routine x-ray imaging for paediatrics. Staff informed us that parents usually accompanied children to the department.
- The trust performance report dated October 2015 showed a completed staff appraisal rate below the trust target of 80%. Ward areas were 74% and 75%. NICU had a completion figure of 37% but we were told by ward managers that 80% of their staff were up to date with their appraisals. Staff told us they had appraisals and their manager would arrange it with them.

Multidisciplinary working

- Ward and department staff worked with a range of other professionals to ensure a multi-disciplinary approach to care and treatment.
- We saw other professionals supporting the care of children while they were patients on the ward.
  - Paediatric trained physiotherapists treated patients on the ward seven days a week.
  - Occupational therapists supported discharge planning for children and young people.
  - Dieticians and specialist nurses were available for advice.
  - Education staff provided support for children and young people who were able to engage in school work.
  - A team of play specialists supported children and young people of all ages across the hospital areas. As an example they would attend general outpatients in helping to distract children undergoing a procedure. All the staff we spoke with in other departments were aware of how to contact play specialists.
- Child and adolescent mental health services (CAMHS) were provided by an alternative provider and a member of their staff would contact the ward daily including weekends and visit patients needing their support. The CAMHS service also supported ward staff in caring for children and young people with emotional and mental health needs.
- Discharge planning was started on admission whereever possible by staff recording social history and any special needs. Multi-disciplinary team meetings were not held daily but professionals were available for advice and support when it was necessary. Staff informed us of the challenges a patient with learning difficulties presented to ward staff. The learning disabilities team were contacted and a pathway plan was put in place for all staff. When the patient attended emergency department staff were able to assess whether the patient needed to be admitted. This resulted in the patient having fewer admissions to the children's ward.
- We were told that some young people could not be discharged from the children's ward due to a mental health need and there being no appropriate bed. For example in the case of a child or young person self-harming and being a danger to themselves. CAMHS offered support to staff on the children's ward in dealing with these patients.
- Discharge letters from the children's wards were reviewed by consultants and provided to parents on discharge. An electronic copy was sent to the patient's GP at the time of discharge and staff informed community staff such as health visitors, school nurses and specialist nurses for ongoing care.
- The acute and community paediatric services worked closely together. Community paediatric services were part of the child health directorate and attended meetings, shared safeguarding responsibilities and were available for consultation.
- Outreach nurses worked in partnership with other organisations to provide effective specialist care. The cystic fibrosis service was run as a joint service with Plymouth.
- Transition services were in place for patients with long term conditions to move to adult services at a time and pace suitable for the child or young person. This process could start from the age of 10 years if it was appropriate.
- A psychologist had recently been employed by the trust to replace one who left. They would be providing support for children and young people including input to the pain team.

Seven-day services

Services for children and young people

- Services were available seven days a week including physiotherapy, radiology and pharmacy.
- Pharmacy staff trained in medications for paediatrics and neonates visited the ward daily Monday to Friday. Pharmacy staff provided advice and support on Saturday and Sunday mornings.
- Physiotherapists visited NICU and the children's ward at the weekend to provide care for those who needed it.
- Consultants reviewed their patients daily, including weekends and were available for advice, support and treatment at all times.

Access to information

- Staff across the children's service were able to access information in a timely way.
- Parents were encouraged to take the personal child health record for the child to any clinic appointments they attended.
- Children's outpatient department staff told us records were available for any child's appointment when they arrived. We were told of occasions when children or young people arrived at the general outpatient department and records were not available. This was usually due to the patient having been at a minor injuries unit the previous evening. Staff mitigated this by viewing the patient record electronically and providing the information for the health professional.
- GPs were informed of a patient's discharge electronically on the same day.

Consent

- Systems were in place to support children young people and their families to provide informed consent for any procedures.
- A consent policy was available for staff to view. This included details on when and how to seek patient consent and included information regarding a child being competent to consent for themselves, parental responsibility, mental capacity of parent and making decisions in the 'best interests' of a patient.
- Staff demonstrated the use of Gillick competency principles (used to help assess whether a child or young person has the maturity to make their own decisions and to understand the implications) when assessing people's ability to consent to procedures. We witnessed nurses involving children and young people in making decisions about their care and treatment and using terminology the child could understand.
- Staff were aware of consent issues of children who were in foster care and told us of an occasion when a child's surgery was delayed until consent could be obtained from a person with parental responsibility.
- An audit was carried out in June 2015 for how well documented consent procedures were and the understanding of the patient. Areas it included were surgical departments, oncology, gynaecology and paediatrics and results were compared against previous audit results. The paediatric results were using the same data as for adult consent. For example it did not include the age of the child or young person, who had parental responsibility, whether the child or parent/guardian had mental capacity to sign their own consent form, what the child understood of the procedure, or whether parent signed or countersigned the consent form.

Are services for children and young people caring?

Good

We rated this service as good for caring because:

- Staff were kind and compassionate in their communications with parents and their children. They were given information in a way they could understand.
- Children and young people felt informed and involved in their treatment options. Regard was given to emotional health and support was provided to promote independence when the child was discharged.
- Children and young people were involved in their care and were aware of their treatment options.
- Feedback from children and young people who used the service and their families was positive with quotes of "staff are fantastic".

Compassionate care

- We saw staff treating patients and their families with dignity, respect and compassion. Children told us they felt looked after and that their siblings were looked after when they visited.
- Parents were encouraged to be with their child during any procedures such as in the anaesthetic room, radiology and when child was returning to the ward from recovery.

Services for children and young people

- Privacy and dignity was protected by the use of child specific areas. Recovery area had a process of caring for children in a way that kept them separate from adults. Screens were used to maintain privacy for each child.
- Children and young people's services contributed to national surveys. The response rate to the 2014 Picker survey was 31% which was above the national average of 27%. Friends and family response were 100% positive with a response rate of 77%. The results and responses were displayed for patients and their visitors to see. Survey forms were given to patients and parents before the child or young person was discharged and further forms were available in different areas of the ward and Neonatal intensive care unit (NICU). Locally designed surveys were also used to gather views.
- Results from the CQC children's survey for 2014 showed they performed the same as other trusts in England for questions in the caring domain and better in two of the questions. Children and young people and their families thought that staff were friendly and they had enough privacy when receiving care and treatment.
- A parent told us they thought the care was "fantastic" and the child stated they felt "cared for".
- A mother whose baby was being cared for on NICU told us she felt able to ask questions of any staff and felt safe leaving her baby if she needed to.

Understanding and involvement of patients and those close to them

- Parents told us they felt involved with the care options for the treatment of their child. Parents were offered the opportunity to be with their child whenever it was possible and appropriate.
- We saw staff communicating with parents and their children with respect and in a way they could understand. Parents and children told us they understood the plan of care and potential outcomes.
- Parents and children we spoke with knew who their consultant was and the nursing staff caring for them that shift. Children we spoke with were clear about their planned plans of care, what to expect and what their options were.
- Private spaces were available for young people to talk to a clinician without a parent present.
- Staff were aware of the facility for using interpreters if there were language difficulties. NICU staff informed us of how they had used interpreter services for a family who spoke mandarin.
- Locally run surveys had gathered views from children and young people and resulted in the provision of facilities in the adolescent area such as football table and games.

Emotional support

- Parents and their children told us they felt safe on the ward areas and in NICU.
- A bereavement service was available. NICU would use a single room to provide privacy for families of a baby at end of life. The multi faith chaplain service contacted paediatric services regularly and attended at the request of a patient. We were told of a recent occasion when a chaplain attended a sick child at the request of the parents. The chaplain service offered support on the community after a child was discharged where it was possible.
- A team of play specialists was available to support children of all abilities to relieve any anxieties.

Are services for children and young people responsive?

Good

We rated this service as good for responsive because:

- Views of children, young people and their families was actively sought and responded to with changes made where possible and appropriate.
- Individual needs were considered and needs met wherever possible in a way that did not single people out as different.
- There were strong links with community resources to provide seamless care for patients when they were discharged from hospital.
- Individual needs were taken into account in all areas we visited. Children were prioritised above adults on surgical lists, areas were dedicated to children where possible and actions were taken to improve the environment for children.

However

- A lack of space on NICU had an impact on how parents could care for their child although there were plans in place to rebuild the unit.

Services for children and young people

Service planning and delivery to meet the needs of local people

- Children and young people had been involved in designing some aspects of services available.
- Engagement with patients and their families was undertaken with the use of surveys. One survey was designed to gather views about the adolescent area of the ward. This had resulted in feedback that adolescents wanted more age appropriate facilities. The teenage social area was redecorated and more facilities were provided including a games table and Wi Fi provision. Some patients said they could not access the Wi Fi and others could. Help was available for patients to access the facility but young people were not always aware of it.
- Bed spaces on the paediatric wards were used flexibly for different ages of children. Children of similar ages were kept together and bays were single sex.
- A young person's community support group had been approached to help with You're Welcome accreditation of the paediatric wards.
- Patient information was provided in age appropriate formats in the different areas of the wards. For example the adolescent area had information about mental health and asthma control.
- A check list was in place for staff to ensure needs of children attending theatre for surgery were met. We saw electronic games used to distract children from the procedure and reduce anxiety.
- Play specialists were available to provide support for children of all ages and abilities with emotional needs.
- Neonatal intensive care (NICU) had recently received confirmation of funding to replace the unit in an existing part of the hospital. Their plan was to consult with parents of children who had been cared for on NICU about facilities they would like to see incorporated.
- The radiology department had a box of toys for young children used to distract them during a procedure. The waiting area for children was within the adult waiting area and children attending radiology would be seen as soon as possible. We were told of a project to create a children specific waiting area. Radiology staff had won a bid from the trust for charitable monies to be spent on refurbishing an area where children could wait separately from adults. Arrangements had been made with a local college for students to design the area.
- In all paediatric areas there were facilities for parents to prepare food and drinks, relax and sleep if they needed to stay with their child. A national charity had agreed to refurbish a parent stay area of four bedrooms and facilities but had recently decided not to go ahead. Parents we spoke with were grateful for somewhere to stay but said the rooms needed some refurbishment.
- School staff supported educational needs of children on the ward they were part of a 'readathon' scheme that provided books for patients of all ages. The books were new and patients were able to take them home to continue reading them. School staff told us of a scheme that organised story tellers to visit ward areas. They would tell a story using props to bring it to life and move around the ward to enable all children to listen. The next story teller was due to visit in February 2016.
- There were strong links with community services for children and young people. NICU, paediatric wards, children's outpatients and community children's services all formed a service called Child Health. They attended joint meetings sharing knowledge and skills.
- A transition policy was available for staff to guide staff in their care of children who would need ongoing support in adulthood for their condition. Transition clinics were in place for these patients and were tailored to the individual.
- Urgent clinics had recently been set up starting with two a week. This was for patients who had been discharged and had further concerns about their condition.
- At the time of our visit there were no adolescents with mental health issues. Staff told us they would be cared for in single sex bays and any risk to their safety including ligature risk, would be identified using a check list and removed, before the patient was admitted to the area.

Access and flow

- Children and young people of all ages have timely access to care and treatment
- Admissions to NICU were from the post-natal wards and on return from more specialist neonatal units to be closer to their families. There were separate areas for babies who needed different levels of care with four intensive care, three high dependency and 13 special care cots. Babies who required ventilation for longer than 48 hours were transferred to a more specialist unit. Occupancy between July 2014 and July 2015 ranged between 15% and 100% full. The most recent occasion

they were full to capacity was in June 2015. An escalation plan was written in draft form giving advice on assessing availability of beds and actions that needed to be taken. Senior nurses informed the south west neonatal network of this information on a daily basis. This allowed the network to offer support to all the areas it covered but most babies eligible for care at Royal Cornwall Hospital's Neonatal Intensive Care Unit were able to receive it there.

- If there was space on the children's wards children and young people of between 16 years and 18 years of age were given a choice of being cared for on an adult or a paediatric ward. Admission to the paediatric wards was from GP, day assessment unit, planned admission, from an outpatient clinic and emergency department. One ward area was arranged as mainly medical and younger children and the other ward area was allocated mainly to surgical, children needing procedures for leukaemia and cancer and adolescents. There was a range of four bedded bays and cubicles which could be used flexibly depending on the needs of the patients. Senior ward staff assessed acuity of the wards and called on other areas for support when it was needed and available. For example, paediatric trained nurses would move from outpatients to work on a busy ward area if their clinics allowed. An escalation protocol was in place for the children's wards.
- Children attended outpatients department for tests, short term day treatment and paediatric reviews. Some clinics were held in other areas as part of an adult clinic such as hand clinic and fracture clinic. We were told of an occasion that a patient arrived to see a paediatric consultant at the incorrect time. Staff tried to contact the consultant but he was not available so apologised to the patient and arranged a further appointment.
- GPs could call the advice line for discussion about a child's condition and refer patients to the day assessment unit if they needed a paediatrician's review. Patients had access to two emergency clinics a week if there were urgent clinical problems.
- Surgical procedures were prioritised for children when it was arranged as part of a general adults list. Parents told us their child had not waited a long time for appointments and surgery.
- Patient records we reviewed showed a consultant had seen each patient within 24 hours of their admission.
- Planned admissions for surgical intervention attended a nurse led preadmission clinic. It included gathering information about the child's medical history, individual needs and a risk assessment of suitability for surgery at this location.
- Outreach nursing services linked closely with the inpatient areas for children and provided support to patients and their parents to reduce admission episodes for their condition.
- Some children and young people were admitted to the ward with behaviours resulting from emotional or mental health problems such as self-harm. Some needed further intensive support for mental health issues. If there was no mental health bed available the young person would need to remain on the acute paediatric ward. This reduced bed availability for patients with physical clinical need.

Meeting people's individual needs

- Children and young people with complex health needs were supported to access health care in a co-ordinated way. We were told of a time when the learning disabilities team and the ward staff created a pathway plan for a frequently attending patient with learning difficulties. The pathway was shared with emergency department staff and it resulted in less frequent admissions for the patient. Staff in other areas of the hospital told us of the support they had received from the learning disabilities team. Many children and young people attending the hospital were living with some form of disability. We saw they were helped to access care by staff identifying their needs in discussion with parents and the child or young person.
- Specialist nurses supported children and young people with other complex needs such as those with leukaemia and cancer. Community nursing staff were informed of discharges and arrangements were made for ongoing care of the child.
- None of the substantive ward staff were registered mental health nurses. CAMHS staff were supporting ward staff with monthly meetings to discuss issues around mental health needs of children and young people.
- Play areas were available for children of all abilities. One area included a sensory room for children to relax in. This was a darkened room with varying light sources,

sounds and textures. An outside children's play area was available within the hospital grounds but five floors below meaning children would need to be supervised if they wanted to visit it.
- We saw information in a child friendly poster format displayed on the ward areas. Some common conditions and treatments were described such as asthma and mental health issues.
- Play specialists were available to provide support for children undergoing procedures and were present at the preadmission clinic to help in reducing any anxieties.
- Translation services were available and staff told us they had used them on the neonatal unit for parents who spoke Chinese. The service was offered by phone or in person depending upon the needs.
- NICU had rooms the could use for parents who were nervous about taking their bay home so that staff could offer privacy and support where needed.
- An outreach service was provided by NICU staff to support parents with breast feeding, and other general concerns.
- Child and adolescent mental health services were available for children and young people who needed further emotional support. A psychology service was also available for all children including those with long term complex needs although the staff member had recently been appointed and was still planning services.
- Space on NICU did not always allow for skin to skin care between babies and parents. One occasion we witnessed a parent's first cuddle with her baby cut short because staff needed to provide more intensive care to the baby in the next cot.
- A chaplain service was available for children and families of all religions. Staff were aware how to contact the service and the ward was visited by a chaplain frequently.

Learning from complaints and concerns

- The service used the comments and complaints as learning opportunities to improve the service they delivered.
- Information was displayed and leaflets were available in child friendly versions for patients and their families to feed back their comments to the trust.
- Staff we spoke with were aware of the complaints process and told us they would try to resolve any issues immediately. If this was not possible they would direct the family to the complaints process.
- There was a system of gathering views from patients and their parents on the children's wards. The feedback was analysed on a monthly basis.
- We were told of a complaint a parent had made to NICU which was followed up with an investigation. This resulted in written information being made available for parents whose baby was suspected of having an infection. It gave reasons, symptoms and any follow up actions parents needed to take in simple language.

Are services for children and young people well-led?

Good

We rated this service as good for well led because:

- Senior staff were represented at trust board level and felt children's services were listened to and action was taken where necessary.
- Senior managers were using the recently updated standards of the royal college of paediatrican and child health to develop their strategy for service improvement.
- There was an atmosphere of openness and learning from experiences.
- Partnership working and engaging with patients and staff was a priority for the management team.
- Risks were reported and actions identified and monitored.
- Innovation and improvement was encouraged.

Vision and strategy for this service

- The trust values of 'one and all we care' were displayed around the hospital areas we visited. All staff we spoke with knew about the values and demonstrated them in their actions and approach to their work.
- Staff we spoke with were clear that they wanted to provide the best possible service they could for their patients.
- We were told by senior staff that the clinical service strategy was to meet the recently updated standards for the royal college of paediatric and child health. A

document 'setting the future direction' set out plans and goals with time frames for the period between 2015 and 2018. Some of these goals had been identified during a staff away day in June 2014. The aims were aligned with the strategic aims of the trust and business plans had been developed to achieve some of the aims. For example, a business plan was presented to the trust board to recruit additional consultant paediatricians to meet the seven day service standard.

Governance, risk management and quality measurement

- Governance procedures were in place to enable the directorate to monitor and report a range of information to trust board level. There was no non executive director on the trust board who represented children's services. However, the clinical and divisional nursing leads had been having regular meetings with the trust medical director and were able to raise any issues at board level when they needed to.
- Ward performance in a number of quality areas were reported on a trust dashboard which included quality, operational workforce and finance measures.
- Children's services called themselves 'child health directorate' and were part of the women, children and sexual health division. Child health was an umbrella term for acute paediatrics, community paediatrics and neonatal unit. The child health directorate met monthly and was attended by a range of staff including nursing staff, community staff, managers and clinicians from community and acute areas of the directorate. Standing agenda items included safeguarding, medicines management, mortality updates and patient feedback with information shared between the staff attending. As an example learning from reviewing child deaths was discussed. There was no non-executive director representing children and young people's services. There was representation when required at trust board from the directorate's senior nurse and clinical leads.
- Staff in all areas we visited were clear about their roles and understood what they were accountable for. The annual report for safeguarding children was presented to the trust board in the 15 November 2015 meeting. Issues recognised from this report were low numbers of training in safeguarding children uptake by staff and the mitigating actions safeguarding leads were taking.
- Audit programmes were in place to monitor compliance with procedures and standards. These were reported monthly at child health directorate meetings.
- Staff were able to report risks to their managers. These were placed on the trust risk register and actions were identified. Lack of space in NICU was rated as a high risk. Actions had been updated with a business plan having been produced and funding approved by the department of health.

Leadership of service

- Ward managers were confident in their skills with children and young people they cared for as well as providing expert advice to other staff. The staff we spoke with were aware of who their immediate managers were and described the managers of both areas as being supportive and approachable.
- There was an identified lead nurse on the ward and NICU for each shift. Two clinical leads had responsibility for their specialties; NICU, and acute paediatrics. There was always senior medical advice available from clinical leads for the paediatric areas and staff told us they were approachable and available
- Directorate managers and clinical leads were aware of the needs of the service and had identified goals at an away day in June 2014. Many of these goals had been met such as providing evening consultant cover.
- All consultants had job plans which were linked to the yearly appraisal process.

Culture within the service

- Throughout the areas we visited there was an atmosphere of openness and friendly interactions between all grades of staff and patients. Learning from experience in order to improve services for children, young people and their families was central to the work of staff. As an example, staff had consulted with local school children to improve food choices for paediatric patients.
- We saw staff giving time for parents and children to ask questions even when they were visibly busy. Children were communicated with in a sensitive and caring way.
- Staff engagement and communication was being encouraged by managers. A recent away day for band six nurses was organised by the senior nurse and resulted in staff saying they felt valued and respected.

- Ward staff in all areas we visited worked in collaboration with other professionals, such as learning disabilities team, CAMHS, specialist nurses.
- Student nurses on NICU had received mentorship and expressed a desire to return once qualified.

Public engagement

- Views from children young people and their families were actively sought. Responses were analysed and actions taken wherever possible. Children's thoughts on food provided on the ward prompted staff to redesign menus for children and young people. A collaboration of staff from the children's ward, hospital catering and patient involvement team resulted in a consultation with local school children regarding children's menus.
- National surveys were used such as friends and family test. In addition to this NICU and the ward areas ran their own surveys. The senior nurse was working with engagement staff in the hospital to design a survey that incorporated valid friends and family test questions. The aim being to streamline the survey process.
- Surveys were designed to encourage children of all ages to contribute their opinions and these were displayed on ward areas. Student nurses and medical students were collecting feedback from parents and children and feeding comments back to staff on a fortnightly basis. Most of the comments had been positive and staff appreciated the communication.
- Volunteers had been approved to create a more child friendly environment by using artistic skills to paint walls of the children's ward areas with beach scenes.
- NICU staff had recently developed a parent group Facebook page which was monitored by staff and used to gather views of parents.

Staff engagement

- Some staff we spoke with could not recall having protected one to one time with their manager but said they could raise any concerns they had with their manager and would be listened to.
- The senior nurse manager had some positive outcomes from an away day format of staff engagement with band six nurses. This was to be continued and extended to other grades of staff with the aim of supporting staff to contribute their views in a safe environment.
- Staff told us they had heard of the 'listening into action' (LiA) process that was in place in the trust. Some staff found the meetings difficult to attend due to work pressures.
- NICU staff had recently developed Facebook pages for staff which was used for social purposes and in organising duty rotas.
- The trust had a process for recognising when staff had performed well. NICU staff had been nominated by parents and won the 'for one and all - we care' award in the care and compassion category for "the way parents were made to feel"

Innovation, improvement and sustainability

- We saw areas of practice that had been reviewed and changed in order to improve services.
- Each month children's safeguarding leads would visit six areas of the hospital on a 'walk around' and discuss safeguarding issues with staff.
- Well-structured training programmes for staff included simulation events to provide experience of situations without risk to patient safety. These were held in each area on a regular basis and were found by staff to be effective. The Sims model was also used to test out new practices and identify areas for improvement. As an example, a recent change in bleep system was tested using this process.
- NICU was taking part in national research projects one of them being the neonatal and paediatric pharmacokinetics of antimicrobials study.
- Safeguarding leads had successfully changed the format of the safeguarding children operational group meetings to improve attendance.
- We were told of how the electronic white board on the paediatric wards used for patient data was being redesigned locally to incorporate further information useful for staff such as next review dates and PEWS scores.
- Partnership working was encouraged throughout the children's and young people's services with specialists for ongoing advice, networks for specialties such as the south west neonatal network, linking with tertiary centres to provide care locally where possible and using technology to gain advice from specialists in other parts of the country.

End of life care

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

Information about the service

Palliative and end of life care at Royal Cornwall Hospital encompassed all care given to patients who were approaching the end of their life and following death. Care of the end of life patient could be delivered on any ward or within any service of the trust and included aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services. The definition of end of life includes patients who are approaching the end of life when they are likely to die within the next twelve months, as well as patients whose death is imminent.

The hospital palliative team comprised a team of two full time clinical nurse specialists and one part time support nurse clinical nurse from April 2016 and one consultant, who was also the trust lead for end of life care. At the time of the inspection the trust were in the process of recruiting an end of life care facilitator to work across all wards in the hospital. This was to be for a twelve month period from the time of appointment.

During the period July 2014 to June 2015 the trust reported there had been 1594 deaths in the hospital. Between April 2104 and March 2015 there were a total of 830 referrals made to the specialist palliative care team. Of these 72% were cancer related and 28% non-cancer related.

During the inspection we visited twelve wards and the emergency department. We spoke with four patients and six relatives. We talked to 4 consultants, 16 nurses, 4 health care assistants and two ward receptionist/administrators. We looked at twenty two sets of patient records. We visited the bereavement office and the mortuary area and spoke with staff working there. We also visited the chaplaincy service. We met with the interim medical director who was the board lead for end of life care in the trust.

End of life care

Summary of findings

We have judged the overall end of life service as inadequate.

- We found that a combination of inconsistent provision of training and guidance to staff had led to varied understanding and implementation of the trusts end of life strategy and guidance.
- We found that the safety of patients was potentially compromised by the non-completion of patients records in relation to mental capacity assessments and the decision making documentation around resuscitation. We found that records had not been completed and some were incorrectly signed. This meant patient safety and well-being were compromised as plans were not fully understood. There was limited recording of a patient or their relatives involvement in the making of these decisions.
- There had not been regular and consistent training for staff with regards to the introduction of new documentation and procedures that were rolled out across the trust for patients deemed to be at end of life. An end of life care facilitator post had been funded for twelve months until July 2014 but then not renewed. This had led to inconsistent practice and understanding from ward staff, many of whom had received no training about the new guidance and forms to be used. There had been insufficient support and training to ensure that the trust wide strategy on end of life implemented in 2014 could become embedded into practice.
- There was limited advance care planning in place for patients. There was very limited recording of a patients personalised end of life wishes, for example a patients preferred place of dying.
- The End of Life Care group, which was chaired by the end of life lead and had some oversight responsibilities for the trust strategy, was not effective. This was due to limited attendance from senior medical staff and a lack of trust board representation and support.

However.

- We found the palliative care team responded quickly to referrals and provided good support to ward staff. The team and the palliative care consultant were highly regarded for the expertise and support they provided.
- Anticipatory medicines were always available and patients being discharged home had their medications provided promptly

End of life care

Are end of life care services safe?

Inadequate

We rated this service as inadequate for safety because:

- We found there were shortfalls in the frequency of recording the monitoring of the syringe drivers for some patients. This, coupled with inconsistent staff training and the lack of a formal syringe driver policy, put patients potentially at risk.
- On some wards there were occasional delays in accessing syringe drivers.
- There was inconsistent completion of patients records with respect to mental capacity assessments and resuscitation. This meant that patient safety was potentially compromised by resuscitation being attempted against either a patient's wishes, or not in their best interests.
- We identified concerns about the extent of trust wide medical cover for palliative care and the robustness of the cover arrangements for evenings, weekends, annual leave and sickness.

However :

- Staff were aware of how to report incidents and their responsibility to be open and transparent.
- Staff in the areas we visited had completed all the required mandatory training.
- Anticipatory medicines were always available and patients being discharged home had their medicines provided promptly.
- There were processes in place to assess and respond to patient risk. Staff were able to contact members of the palliative care team for advice about deteriorating patients. Nursing and medical staff on the wards told us that the team were responsive and supportive to urgent requests for input.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses and reported them appropriately. Staff were aware of the process to follow to complete the recording of incidents. For example in the bereavement office they had been recording on the incident system the occasions when death certificates remained unsigned for longer than 24 hours. The monthly collated figures were being were used by the manager of the mortuary service to identify how these could be improved. There had been identified concerns about a high number of certificates taking longer than 24 hours to be signed and relatives not being able to collect them.
- There had been incidents reported regarding the transferring of patients to community hospitals without the correct medicines for their syringe drivers. The policy, a copy of which was kept on the wards in the end of life resource pack, was amended. It was now required that all medicines required for end of life care were transferred with the patient on discharge to community settings.
- It was reported in the end of life care group minutes there had been 57 reported incidents between April 2015 and September 2015. The end of life lead received a report on incidents where "end of life" had been identified on the form and was also kept informed of any complaints that were made in respect of this area. It was unclear the full extent of incident reporting in relation to end of life care. For example staff did not record as an incident when a side room was unavailable for end of life patients and also when it was not possible to achieve the preferred location of death for a patient.

Duty of Candour

- Staff we spoke with in the mortuary service and palliative care team were aware of the new duty of candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new 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. We saw the details of a serious incident that was reported in the mortuary area following an accident. We saw that prompt action and recording was completed and action taken. Training was provided to the staff and additional guidance put into place. The manager of the mortuary was in contact with relatives immediately following the accident to apologise and was transparent and open.
- Staff we spoke with said they thought the reporting culture for incident was positive and not punitive. Staff said openness was encouraged.

End of life care

Cleanliness, infection control and hygiene

- The bereavement and mortuary areas appeared clean and hygienic. The cleaning staff had a cleaning schedule to follow for the office area and the public areas and the mortuary area was cleaned by the mortuary technicians. The technicians had a schedule they followed and the area was regularly checked by the manager in charge.
- There were hand hygiene dispensers in place and written reminders for visitors to clean their hands in the wards we visited. We observed staff and visitors following the correct procedures and wearing the appropriate protective clothing.

Environment and equipment

- We found there were shortfalls in the frequency of recording and monitoring of the syringe drivers for some patients. This, coupled with inconsistent staff training and the lack of a formal syringe driver policy, put patients potentially at risk.
- The National Patient Safety Agency recommended in 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by the end of 2015. An alternative had been provided across the trust. However we found that there was no syringe driver policy in place, though one was in draft form ready to be presented to the governance committee in January 2016. We also found inconsistent practices in place across the wards we visited with regards to the frequency of checking the drivers once in use. On one ward we found that a driver had not been checked and recorded for 16 hours. On another ward we were told there was an expectation that the drivers were checked every medicine round. There was not guidance provided as to the frequency that the checks should be completed. Three nurses on three wards we spoke with said they had not received formal training about the new drivers but had been shown how to use them by other staff. On one ward staff said they were required to complete training before using the equipment and then complete yearly updates but on another ward the staff said they believed they had to complete updates every three years.
- The mortuary was well organised and appeared clean and well maintained. The staff completed their own cleaning schedule and audited regularly against this. There was an electronic record of equipment servicing and maintenance that was up to date and maintained by the mortuary manager. Building improvements had been undertaken to improve the mortuary area including new flooring in the corridor leading to the secondary storage area. Additional mobile, or temporary storage facilities, were in place to ensure the mortuary had sufficient capacity when required. The mortuary was also a community service and, combined with the hospital service, dealt with approximately 3000 deaths a year.
- Improvements and changes had been made to the bereavement service area. The space had been reconfigured through building work to improve the experience for relatives who no longer had to walk through the bereavement office to reach the viewing area for the deceased. There was now an additional quiet room, or waiting area, they could use whilst undertaking a viewing. There was an additional office in place intended for use by the local coroner's office. The bereavement manager was waiting to hear when this appointment would be made at the time of the inspection.

Medicines

- Patients receiving end of life care were prescribed anticipatory medicines. These were prescribed in advance to promptly manage any change in the patient's pain or symptoms. If however further advice was required this could be sought from the consultant Monday to Friday and the site practitioner out of hours.
- There was information and advice provided on the wards with regards to end of life care and medicines. On the wards were there was a link nurse for end of life care and they were aware of this information and the advice relating to medicines. However not all nursing staff we spoke with were aware of this information pack, some of which was also available online. On two wards we looked at the storage of medicines and saw that all the normal end of life medicines were there. We saw that the controlled drug book was securely located and completed correctly. In the patient records we looked at medicines were correctly and clearly recorded.
- Staff told us there was a sufficient supply of syringe drivers and generally this equipment was provided promptly when requested. However on one ward we were told that it could sometimes take between 10

minutes and three hours to access the syringe drivers. These occurrences had been reported as incidents, but the nurse in charge told us there had not yet been an improvement.
- The discharge team said the preparation of medicines for rapid discharge patients was done effectively and did not cause delays. This included weekend discharges.

Records

- We found there were inconsistencies in the completion of records for patients who were considered to be on an end of life pathway. This was in relation to the recording of mental capacity assessments around a patient's ability to make decisions regarding whether to attempt patient resuscitation. We found patient safety was potentially compromised by these records not being completed. We were told of two recent examples were elderly patients had resuscitation attempted as the relevant treatment plan regarding the decision had not been completed. Both of these patients had neither the mental capacity assessment completed or the recording around resuscitation. We also saw records for much younger patients who were diagnosed with terminal conditions that did not have these records completed.
- Following the withdrawal of the LCP paperwork new documentation had been introduced. This included a symptom observation chart for the dying patient, in July 2014, and the Treatment Escalation Plan (TEP) during July 2015. This included information about nutrition, hydration, pain management and oral hygiene. On the reverse of some but not all there was a chart to assess and record skin condition. Some of these forms were completed but in other patients records this information was recorded elsewhere. The TEP form recorded the ceilings (limits) of patient care The TEP document also recorded the mental capacity assessment of a patient, the Do Not Attempt Coronary Pulmonary Resuscitation (DNACPR) guidance, and the patient and relatives involvement in this discussion. This form replaced a previous form Allow a Natural Death which had been widely used across the whole county.
- We found there were inconsistencies in the completing of records. There was variable documentation of clinical multi-disciplinary decisions, or any discussions with patients and relatives that had occurred. We looked at twenty-two sets of patient records. In ten of these we found the recording in the TEP was incomplete, including the resuscitation sections. In two we found that notes had been written by the consultant but had not been signed or dated. Three nursing staff on different wards commented that doctors were not always efficient at identifying end of life patients and completing the TEP form. Four members of nursing staff we spoke with said they often had to remind consultants to complete the TEP forms and they found some consultants were sometimes reluctant to complete the forms.
- We looked at 22 sets of medical notes across 12 wards. There were two specific documents used for patients who had been identified as being in need of end of life care. The first was a symptom observation chart, which had been introduced in October 2014, primarily as a replacement for the Liverpool Care Pathway documentation and also, since July 2015, a treatment escalation plan (TEP). The TEP contained the recording for a mental capacity assessment of a patient and also the instructions regrading resuscitation, the Do Not Attempt Cardio Pulmonary Resuscitation form (DNA CPR). The symptom observation chart also provided for other recording such as pain management and hydration. We found there were inconsistencies in the completing of these forms. Of the 22 forms we looked at 10 did not have the DNACPR section completed.
- There were no individualised care plans in place. For example, relating to patient's spiritual needs, or a preferred place of dying. If this information was obtained it was entered in the general nursing notes and not in either the specialist end of life forms that were in use. There was no allocated space on the forms to record detailed personal wishes and limited space to record any discussion which had taken place with the patients and/or their relatives.
- We saw that on the wards and office we visited the records were stored securely and patient confidentiality was maintained.
- We saw there were efficient and safe recording systems in place in the mortuary that followed national guidance. This included a new electronic recording system which identified deceased patients using a bar coding system as they were received into the mortuary storage. The checks in place ensured the correct identification of a patient, their location in the mortuary and the process that was being followed until they were

collected by a funeral service. We saw there were system in place to ensure the correct recording of personal items. All information was securely stored and accessible to the mortuary staff

Safeguarding

- Systems, processes and practices were in place to keep people safe identified, through policies, procedures and training for staff. Staff were able to explain the process to be followed if they needed to make a referral. Each ward had a designated link nurse for safeguarding who other staff could use as a point of reference if they needed to.
- All of the palliative care team, the bereavement and mortuary staff and the chaplaincy staff we spoke with had undertaken the trust's mandatory safeguarding training. We saw that safeguarding information was available on all the wards we visited and staff we spoke with was aware of how to contact the hospital safeguarding team. On one ward a nurse described how they had a made a referral to the hospital team following an admission of an elderly patient with a broken neck of femur. They said the hospital team were responsive and supportive.

Mandatory training

- The trust overall figure for the completion of mandatory training was reported as being 80.1%. However the staff in the bereavement and mortuary service were all up to date with their mandatory training as were the members of the specialist palliative care team. We saw the evidence to support this.

Assessing and responding to patient risk

- On every ward there was a daily ward meeting where concerns about patients were discussed. Nursing staff would discuss patients with the medical staff and a referral could be made to the palliative care team. The specialist palliative care team responded promptly to referrals, we were told that this was usually within short time frame but always within 24 hours.
- Staff contacted members of the palliative care team for advice about deteriorating patients and nursing and medical staff said the response for urgent input was good.

Nursing staffing

- The specialist palliative care team constituted of one band 7 wte, a band 6 wte and a band 5 0.5 wte staff member. This last post had been vacant for several months but was being filled from February 2016. We were told that competencies and training would be developed for the band 5 post. The team were managed by the lead cancer nurse specialist and all were based in the same office. This helped with information sharing and team work. For instance we were told that it helped avoid making inappropriate visits to patients.
- The hospital palliative care team provided a five day service between 9am and 5 pm. In the evening and at weekends there was access to a 24 hour advice line run from a local hospice. Calls were answered by nursing staff on duty in the hospice who could then contact an on call consultant if they felt they could not deal with the enquiry satisfactorily. The majority of staff we spoke with in the ward were aware of these arrangements and how they should make contact.
- For a year up until October 2014 the trust had employed a nurse as an end of life care facilitator. They had an educational role with ward staff, including the introduction of new documentation and process. At the time of the inspection this post was being reintroduced for a further 12 month period with interviews taking place in January 2016.
- There was a rotational opportunity for band 5 nurse to work with the palliative care team for a three month period at a time. Whilst this had been suspended for approximately 12 months we were told that this was restarted in February 2016. This programme was funded by the Macmillan charity. In theory these nurses returned to be the link person for end of life care on the ward they worked. However we found that on only three wards we visited there were nurses performing this role who had completed this placement. Also on other wards there were staff undertaking the link nurse role who had undertaken no specific end of life training. On two wards staff were not aware if they had a link nurse or who this was.
- The palliative care team also had daily electronic board meetings where they discussed and reviewed ongoing and new referrals. This weekly meeting was also attended by members of the discharge team and the chaplaincy department.

Medical staffing

End of life care

- Medical staffing levels did not meet the nationally recommended guidelines. There were poor cover arrangements for medical staff absence. Medical cover for palliative was provided by one consultant. There were also four hours of palliative care input from a hospice consultant but this was restricted to the outpatients department. The trust consultant was also the lead for end of life care in the trust. This person was allocated 4 hours per week for this role. Guidance for medical cover for palliative care produced in 2012 by the Association of Palliative Medicine of Great Britain and Ireland, suggests that minimum cover should be 1 whole time equivalent to 250 beds. The trust had 743 beds, meaning there should have been an additional two consultant posts to comply with these recommendations. Having only one consultant made delegation of tasks difficult and nursing staff told us they were aware that at certain times it was harder to access medical input due to the limited cover provided during annual leave periods. There was also a wide range of changes being implemented in respect of end of life care over the previous two years, including new documentation and practice initiatives. This represented a large workload to be covered in 4 hours per week.
- In the event of sickness absence and annual leave cover was provided by a consultant working in two local hospices. This was done through an honorary contract system and there was no service level agreement in place for this arrangement. During annual leave cover was provided on two days of the week on a pre-arranged basis for face-to-face reviews of patients, and telephone advice was available at all other times.
- At weekends we were told there was no face to cover provided though we were told by the end of life lead that theoretically the consultant could be called out via the hospice help line. This was not advertised because of concerns of being inundated with inappropriate calls.

Major incident awareness and training

- There was a major incident plan in place in the mortuary department. This was reviewed every year and updated if required. The mortuary manager explained how the plan linked into local authority contingency plans. The capacity of the mortuary had been increased in the previous two years from 74 to 100 with the addition of mobile storage capacity that could be utilised either in the mortuary area or, if required, in the community.

Are end of life care services effective?

Inadequate

We rated this service as inadequate for effectiveness because:

- We found that a combination of inconsistent provision of training and guidance to staff had led to varied understanding and implementation of the trusts end of life strategy and guidance.
- There was inconsistent understanding of the new documentation being used. There was a lack of guidance for how the new symptom observation chart was to be implemented.
- There was little evidence of advance care planning being undertaken. Many staff we spoke with did not recognise and define end of life as relevant during the last twelve months. There was staff emphasis on end of life care as relevant in the last weeks or days or hours.
- There was a lack of evidence to show care was person centred or that all needs were appropriately identified and met. There was no recording of a patients spiritual needs, preferred place of dying or any personalised wishes. There was little evidence that these discussions were initiated with patients.
- There was inconsistency in the referral process to the palliative care team. Some ward staff referred all patients considered to be receiving end of life care to the team, other wards only referred patients with complex needs.
- There was a lack of training and support for staff in the use of the end of life treatment escalation plans and the symptom observation charts. Training was not consistently delivered and there was no record of which staff had completed training.
- There was an inconsistent approach to the training of the link nurse for end of life on the wards.

- There was no assessment tool being used for the monitoring and managing of pain. Nursing staff were not provided with training in the use of any formal assessment tool. We found inconsistencies in the recording and monitoring of nutrition and hydration.
- We found patient's mental capacity was not being consistently assessed and recorded. There was little recorded evidence of patient or relatives involvement in the decision making around whether resuscitation was to be attempted.

However:

We found the palliative care team responded quickly to referrals and provided good support to ward staff. The team and the palliative care consultant were highly regarded for the expertise and support they provided.

Evidence-based care and treatment

- Following the withdrawal of the Liverpool Care Pathway (LCP national guidance) the trust had implemented a number of initiatives to replace this methodology. There was a strategy developed by the end of life lead. This took into account core recommendations for care of patients in the last few days of life in the Department of Health End of Life Care Strategy (2008). The recommendations from "One chance to get it right" published by the Leadership Alliance for the Care of the Dying were also represented in the strategy.
- Following the withdrawal of the LCP paperwork new documentation had been introduced. This included a symptom observation chart for the dying patient, in July 2014, and the Treatment Escalation Plan (TEP) during July 2015. This included information about nutrition, hydration, pain management and oral hygiene. On the reverse of some but not all there was a chart to assess and record skin condition . The TEP form recorded the ceilings (limits) of patient care The TEP document also recorded the mental capacity assessment of a patient, the Do Not Attempt Coronary Pulmonary Resuscitation (DNACPR) guidance, and the patient and relatives involvement in this discussion. This form replaced a previous form Allow a Natural Death which had been widely used across the whole county.
- An end of life symptom observation chart had been introduced in July 2014 and some training had been provided across the trust by an end of life care facilitator. We found there were inconsistencies in the use and implementation of this documentation and variable understanding of it by staff.
- There was no a policy in place for when the symptom observation chart was to be used, we found some were initiated by the nursing staff and some by consultants. Two nurses we spoke with said they understood a consultant needed to make the decision to start the chart while other nursing staff said it could be a nursing led decision. Some nurses said they believed they could start the chart but a consultant would then make the decision about identifying end of life care. On two wards we visited two nurses and a doctor who were unaware of the end of life symptom management chart.
- There was little advance care planning being undertaken and we saw no evidence of Advance Decision to Refuse Treatment (ADRT) in place. Advance care planning is a process of discussion between and individual and their care providers. The process is to make clear a person's wishes and will usually take place in the context of an anticipated deterioration in the individual's condition in the future, with attendant loss of capacity to make decisions and/or ability to communicate wishes to others. Many staff we spoke with did not recognise and define end of life as relevant during the last twelve months. There was staff emphasis on end of life care as relevant in the last weeks or days or hours.
- The trust had until October 2014 piloted the Amber Care bundle on two wards, and the palliative care team told us this was no longer in use in the trust. The Amber care bundle is an approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It enables patients to receive consistent information from their healthcare team. It helps people and their carers to be fully involved in making decisions and knowing what is happening with their care. However we found that this care bundle was still being used on two of the wards we visited and the documentation was also present on another though not in use. Some staff were aware of the Amber care bundle and that it was no longer in use but other staff told us they had never used this documentation. One member of nursing staff thought the Amber care bundle was the same as the

end of life symptom observation chart. In two of the TEP forms we saw reference to the bundle. This meant that patients were potentially receiving an inconsistent approach to their end of life care.
- The trust was not working towards any nationally accreditation or framework such as the National Gold Standards Framework in End of Life Care.

Pain relief

- Patients identified as requiring end of life care were prescribed anticipatory medicines. Records showed anticipatory medicines had been prescribed. Palliative medicines (which can alleviate pain and symptoms associated with end of life) were available at all times. Some wards had an adequate supply of syringe drivers. Other staff reported delays in the provision of the drivers.
- In one patients notes we saw it was recorded there had been a delay in providing pain relief, which had resulted in a complaint being made by a relative. No incident report was completed in respect of this incident. The reason for the delay was the consultant was not available to prescribe the medicines. The family complained at 2.30pm to the nursing staff on the ward and by 3pm the driver was in place. Two patients we spoke with said they had their medicines checked regularly by the doctors and nursing staff. They said they had not experienced delays in receiving medicines.
- The nursing staff were not trained to use a pain assessment tool. The symptom observation chart had three categories of mild, moderate and severe pain that could be recorded. Staff explained how they supported patients to manage their pain through observation and conversation and through discussion with the medical staff. Pain scoring was completed for patients every time their observations were recorded.
- The trust was part of a county wide collaborative project looking at guidance and teaching for anticipatory medicines. Feedback had been provided to the palliative care team that one area of identified improvement had been the prescribing for respiratory symptoms.

Nutrition and hydration

- We found there were some inconsistencies in the recording and monitoring of nutrition and hydration.
- Nutrition and hydration needs were included in patient's individual care plan. We saw examples in three patient records where the nutritional assessment had not been completed correctly. For example in one record the assessment was not completed until 10 days after their admission. It was then assessed that they had high risks. In another record we saw the assessment had not been reviewed as guidelines said it should have been. In the other records we saw that assessments and updates had been completed and dated.
- In four records we looked at we saw assessments used to measure skin tissue vulnerability, and pressure care risk assessments were incomplete.

Patient outcomes

- Ward meetings and communication between medical and nursing staff was the process to ensure patients requiring end of life care were identified
- Staff in the haematology department described how they often knew patients for several years and when it was identified a patient may be in the last twelve months of life, they worked with local GPs and the medical secretaries to ensure communication was consistent. Due to the long term working with the patient they said they would often know what there end of life wishes or needs were. The said the TEP form was making them more rigorous over developing medical plans for inpatients and over planning a discharge if this was required.
- The trust had taken the decision not to take part in the most recent National Care of the Dying audit. The reasons were lack of resources. A decision was taken to do something that could be completed more quickly. An audit had taken place over one month against the Five Priorities of Care. The full report from this was not available at the time of our inspection visit but the interim report had identified shortfalls against all the standards. These included delays in the recognition of the dying patient, lack of recording and assessment of capacity, lack of recording and identifying of spiritual needs, lack of recording regarding nutritional needs and a lack of recording of the how frequently observations should occur. The interim report also commented upon the inconsistency of knowledge around the new documentation that was in place.

Competent staff

End of life care

- Training had been provided for staff around the TEP when it was introduced in July 2015 and staff who had undertaken this told us they felt well prepared for its use. Training had been provided for nursing and medical staff. Some staff were only aware of the new form through the trust safety brief which required all nurses to sign that they had read the briefing. However we spoke with six nursing staff that were unaware of how to use the TEP form, or where it was located. Training for the TEP form was being undertaken by the trust resuscitation team. This had taken the form of "tool box" talks. These were short power point presentations done at ward level, matron meetings and ward nurses meetings. There were also drop in sessions, input on the junior doctors induction, and other staff induction held every two weeks, We were told that TEP training was also part of the mandatory consultant training. However there was no record of who had completed the training or a plan to ensure that all staff would eventually complete this.
- On each ward there was a designated link nurse for end of life care. However on four of the wards we visited the staff we spoke with were not aware who their link nurse was. Also some of the link nurses had undertaken training in end of life care and some had not. There had been an ongoing Macmillan Nurse funded rotational post which enabled nursing staff to work for three months with the palliative care team. Staff who had completed this had then become the link nurse for the ward they worked on. There were link nurse meetings arranged every three months. Of the twelve wards we visited there were three link nurses who had completed this rotational placement. One link nurse we spoke with said they had provided teaching and feedback to other staff on their ward following attendance at the link meetings. However this training was not documented to ensure all had received it. On other wards staff had not had this training, either because there was no link nurse to provide it or it had not taken place when they were on shift. We spoke with 4 band 5 nurses who had received no formal end of life training at all. One nurse working in the emergency department told us she had requested to go on a course but had been told it was not relevant to the department.
- Two of the palliative care nurses had completed the necessary additional training to be able to prescribe medicines.
- There was inconsistency regarding staff understanding and access to syringe driver training. This meant patient safety and well-being were compromised as plans were not fully understood. Some staff told us they were required to do syringe driver training and complete an update every three years. However two staff we spoke with said they had been shown how to use the drivers by other competent staff and not completed the formal training. In the emergency department we spoke with a band 5 nurse who had been "talked through" putting up a driver the previous day
- There was no mandatory training provided for end of life care for trust staff. Some nurses had received training from the end of life care facilitator. This person had been in post for a year until October 2014. No formal training had been provided since this date. This lack of training had been highlighted on the trust risk register. The previously submitted business case for formal training, submitted in June 2014, had not been successful. This was being resubmitted to the board. At the time of the inspection a new end of life care facilitator was being appointed and part of the role would be the provision of training to ward staff. The rotational appointment of a staff member seconded to the palliative care team for a period of three month at a time was also due to be restarted in 2016.
- Junior doctors could undertake palliative care training session as part of their post graduate learning. This included training on symptom management and identifying the dying patient. This was a one hour session. We spoke with four junior doctors who explained they were required to complete 80% of the training overall and that the palliative care training was not mandatory. Two of the doctors we spoke with had done the training.
- Staff we spoke with in the bereavement and mortuary service, the chaplaincy team and in the palliative care team had all had appraisals completed within the previous twelve months.

Multidisciplinary working

- We saw that staff worked effectively together within the hospital and with services in the community.
- We found there was inconsistency in the referral process for the palliative care team. Some ward staff told us they referred all patients considered to be receiving end of life care. On two wards we were told patients were only referred with complex needs. On one ward the nursing

staff told us that only doctors or consultant could refer to the palliative team whereas on other ward nursing staff told us they could make referrals. We observed the morning palliative care team board round, which was done electronically. The team reviewed all the patients that had been referred. Staff commented that some referrals came with insufficient information and some arrived as a result of a referral being made to several teams simultaneously. The palliative care team discussed referrals to ascertain whether they were appropriate and also whether the correct information had been provided from the ward. We observed professional and effective multi-disciplinary working between medical and nursing staff on the wards. We saw staff discussing the care needs of patients, considering decisions, including whether to complete TEP forms or contact the palliative care team.

- Staff in the bereavement office said they worked well with the local coroner's office. This would be further improved when the coroner's office took up the office space that had recently been provided for them in the bereavement and mortuary area.
- The discharge team had two nurses who would co-ordinate any rapid discharges for end of life patients. The discharge team was an integrated team of social care and nursing staff. The team said they worked well with community services, including GPs, to coordinate the discharge of patients and organise their care packages. The team could coordinate some care with the district nursing team, who capacity permitting, could provide up to six weeks of palliative care in certain areas of the county.
- The chaplaincy service were represented on the trust end of life strategy group and also the weekly palliative care multi-disciplinary meetings.

Seven-day services

- The hospital palliative care team provided a five day service. At weekends and out of hours, hospital staff had access to a 24 hour Specialist Palliative Care Advice Line, hosted by Cornwall Hospice Care. The majority of staff we spoke with were aware of this service and how to access it. However on two wards nursing staff we spoke with were unsure about out of hours palliative care advice and how this could be accessed. One ward sister and a doctor we spoke with were unaware they could contact the local hospice helpline for out of hours advice on sub-optimal symptom management.
- The palliative care team had trialled seven day working for two months in 2014 and we were told they found it to be underused. This was done over a two month period. However we were also told the trial was run using the existing staff compliment and that the changed service was not widely advertised. A business case was being put forward to run a seven day service from 2020. No formal audit or evaluation of the effectiveness of this trial had been undertaken.

Access to information

- Staff had access to the information they required to provide good patient care.
- Every ward had been provided with an information folder about the new documentation to be used for end of life patients. This included copies of relevant forms to be used. There was also information provided on the hospital intranet about palliative care support that was accessible on every ward. Staff had access to all hospital policies and guidance via the trust intranet. Guidance was available about transfers and discharges and also documentation to support anticipatory medicine prescribing.
- Information was also accessible on the wards about the chaplaincy service and there was a booklet provided for staff and patients providing help and advice following bereavement.
- There was a 24 hour advice line that was manned by the hospice staff team that hospital staff could use when required.
- On every ward there was an information booklet called the Bereavement Directory. This provided bereavement and other information to staff, patients and relatives regarding a wide range of services and support locally and nationally. This included Leukaemia Care, Mesothelioma UK and the Meningitis Trust. There was also information about support available from within the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Peoples consent to care and treatment was not always sought in line with legislation and the appropriate guidance. The new TEP form introduced in July 2015 contained the information to be completed to record the assessment of a patient's capacity. Of the twenty-two records we looked at for patients who were considered to be on an end of life pathway nineteen

(86%) had not had mental capacity completed. On two of the forms we looked at it was recorded the patient did not have capacity but there was no record made of how this decision had been reached and, whether relatives had been included in the making of this decision.

- In one patients records we saw reference to a relative not wishing a patient to return to the nursing home they had been admitted from. The capacity assessment had not been completed to determine the patients ability to make a choice, and the nurse in charge said in their opinion the patient had capacity and should be involved in this decision.
- The TEP form also contained the DNACPR information, which we found was incomplete in ten of the records we looked at. There were patients who had information recorded about resuscitation that had not had an assessment of their capacity completed. It was not possible to be assured patients or relatives had been involved appropriately about decisions about whether they would have resuscitation attempted if this became a possible action.
- On some wards the TEP form did not appear to be fully embedded into practice. On another ward staff were unsure when the TEP form was to be used. However, on the trauma ward we were told the form was widely used with all patients admitted with broken neck of femur. On some of the TEP forms we saw there was recording of the discussions with the patient and their family. However on the majority of completed forms, there was limited detail. We also observed some descriptions could be deemed insensitive or inappropriate. For example, on one form where it was recorded a patient did not have capacity and was not to be resuscitated due to "medical futility". This patient's medical record also recorded limited information about the discussion between the staff and the relatives.
- There was some reviewing of the effectiveness of the use of the forms and the extent of their use. We were told that all incomplete TEP forms were returned from the bereavement office to the resuscitation team. Every patient who went through the mortality review had their TEP form investigated to see if it had been completed correctly. However no report or action plan was yet available from this data. We were told that a ward based audit of TEP forms was planned to be done in February 2016 by the Resus team.
- Medical staff we spoke with were positive about the TEP form and nursing staff we spoke with considered that it had been well received across the trust. It was also understood in the community and used when a patient was discharged.

Are end of life care services caring?

Good

We rated this service as good for caring because:

- Compassionate care was provided to patients who were treated with respect and dignity by staff.
- Patients and relatives were kept informed about their treatment and prognosis.
- Patients and their relatives were involved and informed about their care and any decisions that were required to be made about treatment. However two patients we spoke with felt they should have had more involvement and information from the medical staff.
- Patients and relatives received emotional support from staff but there was limited follow up following a bereavement

Compassionate care

- We spoke with five patients who were receiving end of life care and all were positive about the staff that provided their care and treatment on wards. Staff were described as "brilliant" and "really caring" and one patient explained how friendly and helpful everyone had been. We spoke with another patient who was being discharged home. They said this was their second visit to the hospital within in a year and that the all the staff had been "brilliant" on both occasions. They were pleased to be spending their final days at home. They said they would miss all the staff as "nothing has been too much trouble and they were so helpful as well".
- On several wards we saw examples of recent cards that had been sent in by relatives thanking the staff for the care they had provided. For example one card stated "there are no words to express how grateful we will always be for the care and kindness" and another said "thank you for making my mother's last few days so comfortable and pain free."
- The bereavement service had not undertaken any survey of relatives or been included in the national

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"Voices" survey. However, they provided comment cards for relatives to complete and return. We saw a sample of returned forms and these provided positive comments about the environment and the approach of the staff.

Understanding and involvement of patients and those close to them

- We spoke with five patients and two these told us they felt they could have had better communication from the medical staff. Three patients told us they were happy with their involvement in decision making around their treatment.
- One patient described how they had been involved in decisions about their treatment, part of which had involved being part of a clinical trial. They told us they were fully involved and had consented formally to all their treatment. They said the medical staff had fully explained the potential benefits and risks of the course of treatment they were undertaking.
- We spoke with a patient who was being transferred to a residential home near their family. They felt they had not had enough discussion and support from the consultant about their end of life care. Their relatives, who we spoke with, also said they felt they could have been given more detailed information and emotional support. However, both told us nurses on the ward had been caring, kind and helpful.
- We spoke with one relative who told us they were unhappy as they had been waiting for three days to have a discussion with a consultant. They said that palliative care had been mentioned by the nurses but they had been told they were unable to discuss anything in detail. They said they were unhappy because they were unclear as to what the plan of care was likely to be.

Emotional support

- We found that while ward staff and the chaplaincy service provided emotional support there were limited proactive measures to ensure patients and relatives had access to the emotional support they needed.
- Staff we spoke with said they thought the ward staff were good at providing emotional support to patients and relatives. Some staff said that at times the pressure of work meant they could not spend the time they would like too. Two nurses we spoke said they had not done any training around end of life care. They thought when they had completed this they would feel more confident about supporting end of life patients and their relatives.
- There was no follow up contact for relatives after following the death of family member. Relatives were provided with leaflets on the ward and from the bereavement office which signposted to counselling services in the community. Information was provided about the hospital chaplaincy service.
- Some nursing staff told us they would make a referral to the chaplaincy service if they felt a patient needed emotional support. The chaplaincy service did not routinely visit the wards to enquire of the staff if there were patients they could support. The service tended to wait for referrals to be made. As there was also limited recording to evidence personalised care and assessment of spiritual needs. This did not support staff to identify unmet emotional needs of patients.
- If requested, psychiatric support could be provided for patients. At the palliative care board meeting we saw how this need was identified for a patient and the appropriate referral made. We were told that the response for this input was prompt.
- The chaplaincy service was available seven days a week and provided a service to patients, their relatives and staff. The service provided spiritual, pastoral and religious support. Staff in the bereavement office and mortuary told us they felt well supported by the chaplaincy service.

Are end of life care services responsive?

Good

We rated this service as good for responsiveness because:

- There had been an increase the use of the palliative care team over the previous two years with an increase in the referral of non-cancer related patients.
- The chaplaincy staff regularly attended multi-disciplinary meetings but were not proactive in offering any engagement.

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- Leaflets and information was available for patients and relatives to inform them of the chaplaincy service. The bereavement service responded promptly and appropriately to relatives and arranged weekend access to the mortuary.
- Complaints were investigated and responded to appropriately.

However:

- The trust recorded little personalised information regarding a patient's end of life wishes such as a preferred place of dying or any spiritual needs or requests.
- On some wards there was limited availability of a side room for increased privacy and respect for the dying patient and their family.

Service planning and delivery to meet the needs of local people

- During the period July 2014 to June 2015 the trust reported there had been 1594 deaths in the hospital. Between April 2104 and March 2015 there were a total of 830 referrals made to the specialist palliative care team. Of these 72% were cancer related and 28% non-cancer related. This represented an increase on the previous year of 4% on non-cancer referrals. The increase in referrals overall was an additional 159, which was an increase of approximately 25%. The team had responded to 80% of referrals within 24 hours.
- The trust did not audit the number of patients who achieved their preferred location for dying. There was also no specific part of the end of life documentation where this would be recorded. If it had been identified that a patient wished to die in their own home or a nursing home we were told this could be arranged quickly. The delays to this were caused by accessing funding for patients who required extensive care packages. However the trust could not provide data to show how many patients had been rapidly discharged.
- There was a new initiative being started in the community hospitals where there would be a number of designated end of life beds available. This was due to begin in April 2016 and would enable some patients to be hospitals nearer their homes and make it easier for visiting relatives.
- A new Macmillan information centre was being built on the trust site and was due to be open and in operation by the summer of 2016. This would provide extensive support to patients and their relatives.

Meeting people's individual needs

- It was evident from the number of TEP forms that were incomplete that there were delays identifying patients approaching or at the end of life. Two nurses we spoke with said they believed there could be delays in identifying the end of life patient. The audit conducted by the end of life lead in April 2015 also identified there needed to be improvements in this area. Also whilst some staff were aware of considering end of life as patients who may die within the next twelve months, staff we spoke with also thought it only referred to the last few days or even hours.
- There was no evidence of patient's spiritual needs, any personalised end of life wishes and preferred place of dying being recorded. On one ward (haematology) we were told that on the "rare occasion" a patient requested it could be accommodated. There was no evidence that medical or nursing staff were routinely or proactive in seeking this information.
- Patients receiving end of life care were not always able to access a side room on the ward due to these being occupied by patients who required to be isolated for infection control reasons. This was difficult for staff to be able to promote privacy and dignity for a dying patient being visited by a number of relatives on an open ward. There was more availability on some wards than others. For example on Lowen ward we were told that they could nearly always provide this facility. There were no audits of the number of patients who had died on open ward as opposed to a side room.
- There were open visiting hours for relatives of patients receiving end of life care but there was limited space on the ward for relatives to stay. This varied according to the ward the patient was on. We were told on one ward they would sometimes get a Z bed from the children's ward for relatives to use, but that sometimes this was not available. On another ward the staff explained how they tried to make relatives comfortable and would help with providing blankets, refreshments or let them use the ward day room to sleep in at night. On two of the

wards staff were unaware of how they could access Z beds as there was no central store for these. In critical care and the coronary care ward there was a relative's room that had a bed and a fridge.

- Patients told us the food was generally good and they were provided with a certain amount of choice. One patient said they were grateful for the free radio they were provided with, as they thought the charge of £3 per day for the television was expensive. Two patients commented that it would have been useful to have internet access whilst in the hospital.
- The bereavement office was located next to the mortuary with both areas sharing the same manager. The staff worked closely to ensure that relatives were treated with compassion and received an efficient and professional service. After receiving a deceased patient's notes the bereavement office would wait for the family to contact them. If this had not happened within 48 hours they would make contact themselves. If there was a delay in receiving a certificate or in getting it signed, the office contacted the family on a daily basis to provide an update. The bereavement office had identified a problem with the completion of death certificates and taken action to address this. The office was concerned about the number of delays in receiving certificates and had begun a process of auditing the delays and reporting these as incidents when a delay of more than 24 hours occurred. Staff arranged viewings if requested and these were provided in one hour appointments. The bereavement office provided a five day service but if requested weekend viewings would be arranged in conjunction with an on call mortuary technician. The viewing area was comfortable and well maintained.
- The mortuary was also a community resource and dealt with an average 3000 deaths a year in total. The bereavement office had recently finished reorganising their office space to provide a permanent office for a member of the coroners department who would be based at the hospital. This would provide an improved and more responsive service for relatives of deceased patients admitted to the mortuary from the community and also improve the communication between the bereavement office and the coroners department.
- The chaplaincy service provided a seven day 24 hour service with two full time staff, two part time chaplains and three chaplain's assistants. There were also 25 volunteer pastoral visitors. The chapel was arranged as a church and there was a side room that was designated for use as a multi-faith area. However, as this room was quite small the chapel was used for Muslim prayers on a Friday. There was also a room that had been adapted to provide an ablution facility. Patients could self-refer to the chaplaincy service, be referred by relatives or by ward staff. The chaplain attended the weekly multi-disciplinary palliative care meetings. However the team did not routinely enquire to ward staff of all end of life patients and were limited in how proactive they were in seeking engagement. The chapel itself was located on the first floor of the tower block at one end of the hospital. There was limited signage about the chapel and its location and also limited information displayed around the hospital about the services of the chaplaincy service. This was particularly true of the multi-faith, pastoral and spiritual services. Staff we spoke with also said they felt the location of the chapel and multi-faith area was not utilised as much as it could be. Staff said chaplaincy services would be more accessible if they were located more centrally or prominently in the hospital.
- We were told that members of the chaplaincy service did not routinely visit all the wards and talk to staff about patients who may benefit from contact. Two nurses we spoke with told us that whilst the chaplaincy service was excellent in communicating with patients it was to some extent underused. They felt it could be more proactive in seeking out patients who may benefit from a visit from the service. They were required usually to make a referral from the ward in the first instance.
- The chaplaincy provided a session on the trust induction course for new staff, this was run every two weeks. This was a relatively new initiative and it was hoped this would raise awareness with trust staff of the range of the services and support they offered to staff, patients and relatives.
- The chaplaincy service had produced a leaflet that was available on the wards which promoted and explained the work they undertook and the services they provided.
- We were told that information about end of life care resources were located on every ward, both in folders and also online. However on three of the wards we visited some of the nursing staff we spoke with were unaware of the folders and unable to locate them.

Access and flow

End of life care

- The trust had a designated discharge team of community nursing and adult social care staff. Two nurses were responsible for organising discharges or transfers of care for end of life patients. They provided a seven day service. There was no auditing of the numbers of rapid discharges that were organised in order for the trust to assess the responsiveness of the process and it was meeting peoples needs. At the time of our inspection staff were organising the discharge arrangements for five end of life patients
- Rapid discharges, that are those organised within a few hours, were not a regular occurrence. Discharges were organised as quickly. The delays to discharge were the result of funding issues and/or complex care needs.. The team told us that discharge arrangements had improved over the previous two years as staff on the wards were now providing better information prior to requesting a discharge to be arranged.
- Information was provided on the wards about the discharge process to be followed and the information that was required.
- There had been concerns identified around end of life patients being transferred in ambulances with other patients. In response, a new policy had been put in place which required that patients deemed to have four days or less to live were transported on their own.

Learning from complaints and concerns

- We saw that complaints were responded to appropriately and that learning was sought and disseminated to staff.
- All end of life complaints and incidents were being collated and sent to the end of life lead. This person reviewed for any recurring themes or staff learning. There were few formal complaints related to end of life care. We saw two complaints which related to the lack of availability of a side room. There were two other complaints related to delays in discharge and transport and funding complications. We saw that the follow up contact with the relatives had been undertaken to explain the reasons behind the issues.
- We saw an example from a board round where an issue following a complaint had come through. The consultant contacted the PALS office and was able to quickly resolve the issue.
- We spoke with staff from the PALS team. They told us the most frequent concerns they dealt with in relation to end of life care was the lack of availability of side rooms for patients. They also received regular concerns regarding relatives feeling they were not fully informed about the cause of death and the details that were recorded on the relevant certificate. There were also occasional issues when the relatives were unhappy about which next of kin had been informed of a death. They explained how they were able to resolve the majority of all these concerns. They said often it was case of arranging for relatives to talk to staff on the wards. Staff could explain why relatives were not able to have a side room and also why for example they had not been able to explain fully a patient's diagnosis. This would be due to staff having to respect the confidential wishes of a dying patient. The PALS staff said the nursing and medical staff were very responsive to requests to talk to relatives and these meeting would be arranged as quickly as possible.

Are end of life care services well-led?

Requires improvement

We rated this service as requires improvement for well led because:

- The End of Life Care group, which had the oversight of the trust strategy, had become ineffective due to a lack of attendance and a lack of leadership and input from the trust board.
- The trust had a comprehensive and detailed end of life strategy in place which was due to reviewed with consideration of the latest national guidance by April 2016. However the strategy had not resulted in a cultural change within the hospital and there had been insufficient monitoring and auditing against the objectives.
- There was a reliance on one consultant, who had four hours allocated weekly for end of life care.
- There was limited engagement with bereaved relatives to gain feedback about their experience of the service they received.

However:

End of life care

- There was evidence of good individual leadership from the palliative care lead and other managers of the services we inspected but there was limited leadership at board level.

Vision and strategy for this service

- The trust had an end of life strategy that had been ratified and put into place in January 2014. The strategy was due to be reviewed in April 2016. We found the vision and strategy for end of life care across the trust was not embedded. This was evident from the inconsistency which the new documentation was being used and understood.
- The strategy was based on national guidance and set out a vision for the trust of "end of life being everyone's business and everyone's responsibility". The documents stated a "cultural change was needed" and looked for ownership of the responsibility for the changes to be from every individual staff member and every clinical area to board level. Oversight of the trust strategy was from the End of Life Care Group which was chaired by the end of life lead who was the trusts palliative care consultant. The board representative on the group was the director of nursing. However, we saw that attendance at the meetings, which took place every two months, had fallen over time and the last two meetings in July and September 2015 had been non-quorate. There was limited evidence that the cultural change needed was being considered and achieved and that the trust board was driving through changes.
- There was a suggestion that the core group membership of the end of life group could be reconfigured to around ten people. The trusts own evaluation of delivery of end of life care was that too much reliance had been placed on the efforts of a few people. The trust had only one palliative care consultant and they had the trust wide lead role for end of life. This person was allocated four hours a week to achieve this. This was not realistic; there was an excessive amount of work which was not achievable within the suggested timescales. There were also limited options for delegation.
- We found that the End of Life Care group had become ineffective in driving through and embedding change. This appeared to be primarily due to a lack of resources and a lack of representation and support at board level to ensure trust wide support for the cultural change they were trying to make.

Governance, risk management and quality measurement

- The divisional governance structure and arrangements for the areas we inspected were clearly organised and understood by the managers and staff. There were regular team and management meetings were information was shared. These departments sat within their own divisions and the senior staff were clear about their governance arrangements.
- We found that the governance processes for end of life care had some shortfalls. There was a structure for governance reporting for end of life care that was laid out in the strategy plan. This included the end of life group submitting a report to the board on a quarterly basis and also a report to the clinical governance committee. The end of life lead was also to complete a quarterly report on incidents, complaints and compliments in relation to end of life care. These reports had not always been completed and presented to the relevant committees.
- There was a lack of evidence to show quality measures and improvements had been completed such as monitoring rapid discharges. There were shortfalls in the collection and auditing of data to establish any progress that was being made against the strategy plan for end of life. It had also been identified that individual clinical areas, specialities and wards should complete their own audits and reports on end of life care but these had not taken place. The planned audit of the TEP forms was due to be completed in February 2016.
- The end of life group, which had oversight of the trust strategy, met bi-monthly and had a falling attendance with the two most recent meetings being non-quorate. There was no representation from senior clinical staff apart from the end of life consultant at the most recent meeting. Due to the limited attendance the strategy and progress against it was not being effectively reviewed and monitored.
- There was not a specific end of life risk register, as risk registers were held within the individual areas or divisions. Two end of life risks had been placed on the trust wide register. One related to the lack of training for staff and the potential impact this could have for patients. The board wished to downgrade this risk as it

considered the support and training from the palliative care team was a mitigating factor. The end of life group were not in agreement with this and was challenging this recommendation.

Leadership of service

- End of life care was given positive and clear direction by the lead palliative care consultant. The written strategy they had produced was comprehensive and gave a clear picture of the direction and objectives. Whilst not all staff we spoke with were aware of the strategy those that were could explain the changes that were being made. The majority of nursing staff we spoke with were clear who the lead palliative consultant was. However the effectiveness of overall trust leadership to drive improvements in end of life care was affected by the ineffectiveness of the of the End of Life Care group, which was being poorly attended.
- There was a lack of priority and commitment to end of life care services. The End of Life Care meeting in October 2015 was attended by only five people. The group was supposed to have attendance from across the trust including senior medical and nursing staff and a board representative. At this meeting the only senior medical representative present was the end of life lead. At the most recent meeting in January 2016 there had been attendance from ten staff including the Director of Nursing and the trust Chairman. A need to focus on leadership for end of life had been identified in November 2015 with a plan to work more closely with Cornwall hospice to take this forward.
- The end of life group were due to review the strategy and consider the latest national guidance, for example the NICE Guidance for Care of Dying Adults which was published in December 2015. The end of life lead told us they intended the revised strategy would focus on "The Five Priorities of Care" developed by the Leadership Alliance and published in 2014. The end of life lead had completed an audit against these criteria in May 2015 and their initial report showed a number of shortfalls. The original strategy stated that an educational post, the end of life care facilitator was needed to be funded for five years to embed the new learning and practice but this post was only run for one year, ending in July 2014. A lead cancer nurse post is being recruited to which the trust advised us will have a role to play in leadership of end of life care.
- Staff within the palliative care nursing team said they were well supported by their manager and were given clear leadership and direction. Staff in the mortuary and bereavement service were positive about the leadership they were provided with. All said their managers were approachable and supportive and clear about the priorities of their respective areas to provide excellent service to patients and relatives.

Culture within the service

- Staff spoke of the supportive and friendly culture they worked in. Nursing staff said they occasionally saw senior trust staff and that they were approachable and asked questions about their work. Staff told us they felt proud to work for the trust and provide a service to the local community. Staff told us the trust was a friendly workplace. Staff in the areas we inspected all spoke positively about their colleagues and the working environment.
- We spoke with two volunteers who were involved with supporting patients and relatives. They were positive about their induction and the help they had from staff. One volunteer was working in the bereavement office. They told us the staff had helped them to understand their role and been very supportive and made them feel part of the team.
- We visited a number of wards in the hospital and found there were varying degrees of awareness of the end of life strategy and engagement with the service. However where staff had made referral to the palliative care team they spoke positively about the palliative care team and the support and input that was provided. There had been an increase of 30 % of non-cancer related referrals to the team in the previous 12 months.

Public engagement

- There had been limited engagement with the public to gain feedback about the service from bereaved relatives or patients receiving end of life care. No survey had been undertaken for several years. There was also no formal or informal follow up contact with bereaved relatives.
- The bereavement office had started providing comment cards for relatives to complete if they chose to.

Staff engagement

End of life care

- Information was distributed from the trust to staff through a regular newsletter and also from email updates from members of the board.
- There had no recent specific staff surveys carried out or feedback sought about the trust from within the palliative care team, the bereavement and mortuary and the pastoral care service.
- The most recent friends and family carried out amongst trust staff reported that 95% would recommend the hospital as a place to receive treatment.

Innovation, improvement and sustainability

- A Macmillan advice and support centre was being built as part of the hospital. This was a large building and would provide a service to patients from July 2016.

Outpatients and diagnostic imaging

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

Information about the service

The Trust had both generic and dedicated specialist clinical areas for outpatients. Dedicated facilities were available on the Royal Cornwall Hospital site for paediatrics, cardiology, rheumatology, ear nose and throat, oral Surgery, dermatology, maternity and gynaecology. These areas were staffed by nurses with specialist interests and supported by specialist diagnostics for example ultrasound in gynaecology, oral X ray in oral surgery clinic, dedicated equipment for ophthalmology and minor operating facilities in dermatology During 2014/2015, there were 189,194 referrals to the outpatient service (including paediatric referrals).

There were 496,000 outpatient attendances (172,000 new and 324,000 follow up). Approximately 40,000 patients were seen in the main generic outpatient clinic each year. Outpatient services were delivered from three Royal Cornwall Hospitals Trust sites and at several community hospitals run by another local providers. One stop clinics such as dermatology were provided at the Royal Cornwall Hospital site. Virtual clinics were provided in several specialties such as trauma and orthopaedics.

Diagnostic Imaging services consisted of x-ray, computer tomography scans, magnetic resonance imaging scans, ultrasound scans, nuclear medicine. These were delivered from three Royal Cornwall Hospitals Trust sites and community hospitals across the county. The Trust delivered approximately 350,000 examinations and interventions per annum.

Acute, general and trauma imaging services were delivered 365 days a year and 24 hours per day, seven days per week on the Royal Cornwall Hospital site, X-ray units at the Royal Cornwall Hospital were Digital Radiography. There was a 24 hours per day, seven days per week interventional radiology service. Interventional radiology refers to a range of techniques that use radiological image guidance to target therapy as an alternative to open or keyhole surgery. Breast screening services and breast imaging were delivered as an integral element of the breast care pathway.

Patient Services provided outpatient support across all clinical divisions and comprised of outpatient booking and reception services; health records; non-emergency patient transport and paying patients and overseas visitors (including general office).

Outpatients and diagnostic imaging

Summary of findings

We rated outpatient and diagnostic services to require improvement overall because:

- In the general outpatient clinic, two bags of intravenous fluids plus ampoules of normal saline were not stored securely in locked cupboards.
- Some facilities, particularly in diagnostics, were not adequately maintained and this posed a risk to staff and patient safety from radiation exposure. Staff were not consistently following local rules to protect other staff and the public from accidental irradiation.
- We saw in several clinics that patient records were not stored securely.
- Best practice in hand hygiene was not consistently applied in outpatient and diagnostic services and risks of cross infection were not always well controlled.
- Teams were competent regarding safeguarding procedures. However, not all staff had received adequate training in safeguarding children at level three as recommended by the guidelines published by the Royal College of Paediatrics and Child Health in March 2014.
- Some specialties within the outpatients and diagnostics service collected outcome data but this was not used to benchmark the performance of the service against similar providers or to monitor performance over time.
- There was not a reliable system in place for the supervision or mentoring of staff.
- Referrals were not triaged in a timely or consistent way
- Patients did not always have timely access to appointments. There were long waits for some specialist therapies and for follow up appointments.
- A new system to reduce the impact of cancelled clinics had been introduced but significant numbers of clinics were still being cancelled.
- The outpatients improvement board was not fully effective in ensuring progress against the planned changes and projects which it was set up to improve.
- Teams described feeling well supported in their immediate teams. However, both in the outpatient's service and the diagnostics service we saw there were examples of a disconnection between the senior management of the services and the day to day operational running of the clinics.
- There was also a separation of administrative management and clinical leadership within the outpatient services. This meant that understanding of key risks was not well integrated. Data and administration systems did not give clear oversight of the factors causing clinic cancellations and this had not been adequately addressed.
- The safety and well-being of some teams was not always prioritised, as seen in the inadequate accommodation for the staff of the medical physics team.

However caring was rated as good and we found:

- Staff reported incidents and these were investigated and they were aware of lessons that were learnt as a result of incidents. However, this learning was not always shared beyond the affected teams.
- The imaging service had improved staff compliance with completion of the World Health Organisation five steps to safer surgery.
- Audits were completed and these led to changes in practice that benefitted patients.
- There were good examples of multidisciplinary team working and staff had good access to the information they needed to provide effective care.
- Staff understood their responsibilities under the Mental Capacity Act 2005.
- We saw that staff in outpatients and diagnostics services did everything possible to maintain patient's dignity and privacy within the busy clinic environment.

Outpatients and diagnostic imaging

- Some clinic facilities were better designed than others to meet patient's individual needs. The learning disability service completed preliminary assessments of outpatients in order to identify requirements for reasonable adjustments.
- The trust had implemented a programme of ongoing improvement in the outpatient service.
- We saw examples of good practice regarding the promotion of a safety culture for staff. Staff told us they felt valued, respected, and proud to work for the trust.
- When staff raised concerns, leaders acted upon this, although we were told of examples when this action was delayed.
- Immediate action was taken by the trust following concerns raised during our inspection.
- Teams used surveys and other forums to engage with patients views.
- We saw good examples of innovative practice.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated the outpatients and diagnostics service as requires improvement for safety because:

- In the general outpatient clinic, two bags of intravenous fluids plus ampoules of normal saline were not stored securely in locked cupboards.
- Some facilities, particularly in diagnostics, were not adequately maintained and this posed a risk to staff and patient safety from radiation exposure.
- In the nuclear medicine service, the layout of the blood labelling area did not follow best practice guidelines and this posed a risk of contamination.
- We saw in several clinics that patient records were not stored securely.
- We saw that best practice in hand hygiene was not consistently applied in outpatient and diagnostic services and risks of cross infection were not always well controlled.
- There were variations in compliance with mandatory training including staff working with children who had not completed safeguarding level three training.

However:

- Teams were competent regarding safeguarding procedures.
- Staff reported incidents and these were investigated. However, learning was not always shared beyond the affected teams.
- The imaging service had improved staff compliance with completion of the World Health Organisation Surgical Safety Checklist, five steps to safer surgery.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. Staff consistently reported incidents and demonstrated knowledge of how to do this. The audiology outpatient's team had reported an incident involving a patient who had become aggressive when required to wait longer

than expected in the hearing aid repair clinic. The security team gave the clinicians feedback that the incident report had been appropriate and they would be aware of the patient for future appointments.

- When things went wrong in the outpatients and diagnostics department, thorough and robust reviews or investigations were carried out. Serious Incidents were investigated. Four serious incidents had occurred in outpatients and diagnostics in the twelve months preceding our inspection and these had all been comprehensively investigated. When things went wrong in the outpatients and diagnostics service, lessons were learned. For example, following an incident in computer tomography with a diabetic patient, the letters describing the pre-hydration process were being revised.
- Action was taken a result of investigations. Following an incident of wrong site surgery, the dermatology service introduced body mapping to their recordings of patient consultations. However, a near miss incident occurred at the beginning of 2015, and as a result, the service introduced photographs as a necessary component of the assessment and preparation process. These photographs were then uploaded to the electronic record storage system. More cameras had been purchased to allow this practice to be used in clinics at peripheral sites.
- There were examples of incidents where lessons were shared to ensure action was taken to improve safety beyond the affected team or service. In therapy, a set of notes was left on top of a clinician's car when she drove away from a patient's home following a home visit. Because of this incident, therapists instigated use of the orange notes bag and were supplied with a smaller orange carry case for community work. This standard operating procedure was shared with all therapy teams.
- However, in ophthalmology, when a serious incident occurred, this was investigated within the ophthalmology team but staff in other outpatient teams were not aware of learning from this incident.
- There had been no never events in the outpatients department in the twelve months preceding our inspection. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death. , has occurred in the past and is easily recognisable and clearly defined.
- The Ionising Radiation (Medical Exposures) Regulations 2006 (IR (ME) R) are specific regulations that are intended to protect patients from unintended, excessive or incorrect medical exposures. These regulations ensure the benefits outweigh the risk in every case and make certain patients receive no more than the required exposure for the desired benefit, within technological limits. An IRMER reportable incident had occurred in June 2015 when a patient received a computer tomography scan of their abdomen and pelvis in error due to confusion regarding the surname of the patient referred for the procedure. An additional lifetime cancer risk of 1 in 1000 was calculated as a result of this error. Staff in the department were aware of this incident and following that incident, staff now used a system that required an automatic 'type surname' check.
- The imaging service ensured that radiation incidents were fed into the risk management process. The imaging service ensured 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 IRR99 requirements. However, there was no system for flagging IR (ME)R related incidents on the incident reporting system.
- There were systems in place to minimise the potential risk of harm for radiation exposure. For example, a radiation risk assessment had been completed and was reviewed annually. There was a trust level document detailing protocol for doses much greater than intended. This protocol had been reviewed in January 2015. However, we noted that these systems were not as comprehensive or proactive as they could be.
- For example, during our inspection, staff told us about a flooding incident that had occurred in the nuclear medicine department. This incident was reported, and relevant professionals were given copies of the incident report. However, the trust Radiation Protection Advisory Committee were not informed of the event at the time of its occurrence. The trust indicated that this was because there was a negligible radiation hazard. The radiation at the time of the incident was low because the event had occurred at 0730 on a Monday morning. The incident report stated that this type of sewerage blockage was not uncommon due to the age and type of pipework and the inappropriate disposal of items via the sluice and macerator and toilets. Although there was a generic risk assessment written covering the risk of

flooding at the Royal Cornwall Hospital site, there was not a clearly identified action plan or safe operating procedure for staff to enact if such an event were to re-occur, potentially when the radiation levels were not as low.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a new regulation, which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds Staff we spoke with were aware of and demonstrated good understanding of their responsibilities under this legislation. Serious incident reports showed that this requirement had been considered.
- Staff at all levels were able to describe what the duty of candour involved and the actions required, even if they did not understand the terminology. Staff were also aware of the trust guidance and how to access this. More senior level staff, for example ward sisters and matrons were clear about the trusts responsibilities and how they were involved in the duty of candour.

Cleanliness, infection control and hygiene

- The cleanliness of outpatient and diagnostic facilities was audited on a regular basis. For very high risk areas, such as oral surgery and endoscopy, this audit occurred weekly and scores indicated that standards reached between 90% and 100% for all areas. For high risk areas, such as the haematology clinic, cleanliness was audited monthly and scores indicated between 88% and 100% compliance with standards. In significant risk areas, cleanliness was audited quarterly, and scores here were lower, for example 63% for the foot clinic and 71% for the electromyogram clinic in October 2015. Despite these low scores, these clinics had not been re-audited.
- Staff explained how standards of cleanliness and hygiene were maintained. We saw evidence that cleanliness and hygiene checks were regularly carried out. We saw that equipment such as commodes were labelled as clean. However, other equipment was not regularly cleaned. The white cells isolator in nuclear medicine was used most days, but it was cleaned once per week. The decontamination kit in nuclear medicine was not regularly checked. The public toilet next to the ophthalmic outpatient clinic had not had working hand-washing facilities for two days at the time of our inspection. There was no alternative hand gel made available to patients or visitors in this toilet.
- Good practice guidelines for decontamination of hands were not consistently followed. Hand gel was available in all outpatient clinic areas. However, in the ophthalmology clinic, there was a table placed in front of the hand gel and this prevented wheelchair users from reaching the hand gel. This hand gel dispenser was not clearly visible and we observed that no patients or visitors used this gel during our visit to this clinic.
- During our inspection, we rarely witnessed staff using hand gel or washing their hands. When we observed treatment sessions in two separate clinics, the staff we observed did not wash their hands or used hand gel before or after touching the patient.
- In some clinics, there were insufficient or inadequate hand washing facilities for staff. In the medical physics department, it was necessary for staff to wash their hands, due to the biological hazards present and the need for decontamination of radiation. Due to the location of their office and temporary nature of this accommodation, this was only possible using water from a fire hydrant. In the fracture clinic, there was only one hand-washing sink for all the consultation cubicles. This sink was also used by staff to fill their kettle for drinks.
- Reliable systems were not always used to prevent and protect people from a healthcare-associated infection. We saw in one clinic that a communal plastic jug was used to provide water for all patients waiting for their appointment. We saw in the general outpatient clinic, the fracture clinic and the oncology outpatient clinics that fabric armchairs were used in patient waiting areas. Some of these contained rips. Staff told us that there was no money available to purchase wipe able chairs.
- In the fracture clinic, there was a fault in the ventilation, which made the department very hot, especially in summertime when patients had been known to faint in the clinic. To improve the environmental temperature, there were a number of fans used in clinical areas where patients were seen for plaster care and dressings. When these fans were turned on, the airflow from the fans encouraged the spread of airborne pathogens which posed a risk to infection control.
- In nuclear medicine, the layout of the blood labelling room and laminar flow cabinet did not conform to the

guidelines for the safe preparation of radio labelled blood cells produced by the UK radio pharmacy best practice group in 2009. This presented a risk of cross contamination of blood and contamination of blood samples.

- However, some precautions were taken in the outpatients and radiology settings to prevent the spread of communicable diseases or infections. For example in nuclear medicine and in x-ray, patients who were known to have an infectious condition were seen at the end of the day and then a deep clean was undertaken of the room and equipment used.
- Infection control performance indicators for October 2015 recorded that hand hygiene compliance and commode cleanliness compliance was below 90% in several outpatient departments including deep vein thrombosis, respiratory, fracture clinic, oral surgery, ear nose and throat, pre-operative assessment clinic, genitourinary, pain clinic, gynaecology, and therapy services. These indicators also recorded below 90% compliance for commode cleanliness for the imaging department. The same indicators recorded that aseptic non-touch technique compliance was below 90% in the fracture clinic, the pain clinic, the deep vein thrombosis clinic, oral surgery, gynaecology outpatients and the Mermaid Centre. Data indicated that compliance with hand hygiene had been above 90% since July 2015 in all clinics audited
- In therapy services, patients had conducted monthly 'secret shopper' hand hygiene audits. These results were positive, with 100% compliance with bare below the elbows except for November 2015 when it dropped to 94%. Compliance with cleaning hands at least once during treatment session was 100% until September 2015 when it dropped to and remained at 94%.
- Some staff were aware of their team's performance with regards to hand hygiene. Hand hygiene audits were displayed in the waiting area of the ophthalmology department. In the fracture clinic, health care assistants completed the weekly hand hygiene audits. In nuclear medicine, regular hand hygiene and infection control audits occurred, and the results were disseminated to staff. However, one team felt that they were not given practical help to improve their infection control performance.
- Several outpatient and diagnostic clinics had participated in an environmental audit of infection prevention and control within the twelve months prior to our inspection. Areas for improvement highlighted in these audits included availability of protective eyewear, staff awareness of cleaning schedule, cracks in wall covering, waste bins not correctly labelled, patient chair cover ripped and cluttered cupboards. The main outpatient department had not been audited since August 2014. The cardiology outpatient clinic area had participated in an environmental audit 31 December 2015 to 11 January 2016. This audit gave an overall score of 60% for the department, and identified several areas of concern including ripped chairs and pillow, dusty equipment, hand-washing sinks being used for decontamination purposes, and unavailability of personal protective equipment.
- Action had been taken to improve patient and visitor compliance with best practice hand hygiene. In September 2015 a patient ambassador was commissioned by the outpatient improvement board to undertake a survey of the availability of hand gel in outpatient clinics. The results indicated that seven outpatient clinic areas had no hand gel available and the majority of those without hand gel also did not display posters on the importance of hand washing. In four locations, there were insufficient dispensers in relation to the size of the waiting rooms. Only one outpatient area had a dispenser that was accessible to wheelchair users. Following this audit further dispensers and posters were provided

Environment and equipment

- The facilities and premises of the diagnostics service were designed in a way that did not always keep people safe. For example, in nuclear medicine, there was a section of the plaster on the wall approximately two metres square that was loose/bubbling with damp. All facilities where staff are using unsealed radioactive sources should have sealed walls and floors to enable effective decontamination if a spillage or spray of radioactive material occurs. The bubbling plaster posed a risk of radionuclide being absorbed and decontamination being ineffective. The lead radiographer had reported this to the estates department but no remedial action had been taken. This had not been reported to the radiation protection committee.
- Equipment was not always regularly and adequately maintained to keep people safe. For example, the white cell labelling isolator in the nuclear medicine

department was due to be serviced in November 2015, but this had not occurred. A service had been scheduled for February 2016. Without regular servicing, the effectiveness of this machine could not be guaranteed, and there was no quality assurance in place for this isolator. We were told that the trust had not completed leak tests for the blood labelling isolators. There was a risk that the blood isolator may not have been working to manufacturers specifications because the room where it was situated did not conform to guidelines that recommend a positive pressure environment. This resulted in a risk of contamination of the blood sample and radiation exposure to staff. When requested, the trust did not provide evidence of monitoring or maintenance of this equipment.

- The imaging service ensured that ionising radiation premises had arrangements in place to control the area and restrict access, but these systems were not consistently adhered to. In nuclear medicine, we saw that there was a safe system of work in place for entry into restricted areas. There was adequate signage in place to restrict access where required. However, in the acute radiology computer tomography department, a controlled area had been left unattended with the door open. In x-ray, a controlled area had been left unattended with the door open. In another x-ray room, a damaged ventilation grille could have potentially compromised the safety of patients and staff as radiation was not entirely prevented from escaping from the room.
- The trust had a service level agreement with a neighbouring trust for the provision of medical physics expert cover and management of the medical physics staff and service. The diagnostics service risk assessments for all new or modified use of radiation were comprehensive. The assessment of the diagnostic testing completed in the medical physics department had considered the exposure pathways and included reference to the negligible security threat and had addressed occupational safety as well as consideration of risks to people who use services and public. However these assessments were not always completed promptly. Our inspection prompted the initiation of a risk assessment of diagnostic testing undertaken in the hut used as temporary accommodation for the medical physics team. This testing had taken place in this accommodation for several years.
- Resuscitation equipment was readily available in all clinics we visited. This equipment was stored securely, in tamper evident packs. However, in the ophthalmology clinic, the crash trolley was stored in a clinic room and this room was not labelled to indicate that this was where the trolley was located.
- In the same area, we saw eleven sterile haemorrhoid injection sets that were out of date, six of these had expired in 2011 and five of these had expired in 2012. When these items become out of date, it is not possible to guarantee they are sterile and this introduces a risk of infection to patients.
- Staff in outpatients departments assured us that personal protective equipment was readily available and this was evident in clinic rooms. However, in the nuclear medicine department where x-ray computer tomography is used for hybrid imaging, there were no lead aprons available to be worn by staff or visitors that enabled them to stay in the room at the time of the x-ray exposure to support a patient with special needs during their scan
- There were safe systems for managing waste and clinical specimens but these were not always used. For example in the ophthalmology clinic, we saw discarded used urine bottles were stored in a plastic bucket in an unlocked utility room. Although the lid for the bucket was available, we observed this was not used.
- Systems for managing waste were monitored and improved when required. For example, one of the physicist staff had designed an innovative software package for staff to use to account for and manage the storage and decay of radioactive waste products. This helped staff to decide how long to keep waste, when it was safe to dispose of and which route for disposal was safest.

Medicines

- There were not consistently reliable systems for storage of medicines. In the general outpatients department, we saw some medicines stored in an unlocked utility room. These included ampoules of normal saline and 500ml bags of 10% dextrose.
- We saw in the dermatology clinic that liquid nitrogen was stored in an unlocked room. The control of substances hazardous to health risk assessment referred to storage of cylinders of liquid nitrogen in external cages but did not identify the storage method required for the smaller quantity within the clinic

environment. There was a risk of cold burn or frost bite from this gas and in high concentrations it could cause asphyxiation. In ophthalmology, anaesthetic providine iodine was stored in a refrigerator that included an integral thermometer but was not locked.

- Prescription pads were stored securely. In the main outpatient department, the FP10 prescription pad was stored in the locked controlled drug cabinet. However, records of FP10 prescriptions were not pad specific. This meant that prescriptions might not be traceable. There were patient group directions (PGD) used within the dermatology service for anaesthetics, metrics cream, steroid cream and trial packs of moisturising cream. These documents were seen to be correct. In ophthalmology, the band 7 nurse was in the process of writing PGDs for several medicines. It was hoped that these PGDs would enable nurses to complete some clinical tasks, which would free up consultant time for more appointments.
- The outpatient departments we visited did not administer controlled drugs.

Records

- People's individual care records were not stored securely in the outpatient's service. We saw evidence of this in all of the clinics we visited except for one. For example, in the cardiology outpatient's clinic, we saw that in excess of 3074 patient identifiable records of cardiac pacing tests and approximately 80 sets of patient's medical records were stored in an office adjacent to the waiting room, with the door open, with no lock on the door and fully visible to patients in the waiting room. The cardiac pacing test records had been stored on unlocked bookshelves for several months. The medical records were stored in orange bags on the floor or loose on shelves and tables. We were informed that up until the week before our inspection visit, this room was also being used as a clinical area for seeing patients.
- In the same clinic, we saw an echocardiogram report left on the reception area, with full patient identification details and clinical history within vision of public. We saw patient medical notes left on the desk in the corridor where patients were brought to be measured and weighed. We saw several orange bags of patient notes stored on the floor behind the reception area with door open and visible to patients seated in the waiting room. The reception area was not attended at all times.
- In one outpatients department, we saw approximately twenty used specimen bottles with patient identifiable details unattended in an unlocked utility room. We saw eight patient identifiable urine specimen bottles containing urine left in a tray on a shelf in an unlocked utility room
- In several other clinics, we saw that patient medical records were stored in rooms that were not secure. These rooms were left unattended at times. In some clinics, patients medical records were left unattended in areas used by other patients. In one room used to store patient medical records, the door was left open and staff supervising those records did not have sight of the records.
- People's individual care records were accurate, complete, legible and up to date. We looked at ten patient records from a selection of different outpatient clinics. All notes contained a copy of the referral, a treatment plan, and a discharge summary, which had been communicated to the patients GP. Alert stickers highlighting allergies were visible on the relevant records and details contained within the inside cover of the notes.
- There were systems in place for managing records. These systems were monitored and improvements planned when required. For example, space for storage of medical records had been a significant pressure for the outpatient's service. The Trust had a mix of paper and electronic records; there remained a heavy reliance on the provision of hard copy notes across all of outpatient's services. There were plans to improve the records management with the implementation of electronic records as standard, but this was not yet available. There was a reliable system for ensuring medical records availability for clinics. This system was audited regularly. One week in every four weeks, the availability of records was audited for outpatient clinics. These audits indicated that during January 2015 to October 2015, an average of 95.3% of notes were available at the start of clinic, and an average of 98.9% of notes were available at the end of clinic. An average of 2.2 patients were not seen for their appointment during the week of the audit due to their notes not being available. The worst performing audit week was in October 2015 when only 88.9% of notes were available at the start of clinic, and although 99.2% of notes were available at the end of clinic, six patients were not seen for their appointment because of missing notes.

- Records were available electronically when paper records were unavailable. All staff were aware of the system to follow if records were not available, which involved making a temporary folder and extracting available information from the electronic system. In the oncology outpatient's clinic, all patient records were electronic. In radiology, there was a picture archiving system, which was an electronic database for storage of all clinical images that was accessible to relevant staff trust wide.
- Measures had been taken to increase compliance with notes availability. There were 'runners' available each day to transport patient records to clinics when needed. There had been eight incidents reported during July 2015 to December 2015 related to unavailability of patient records for clinics.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse that reflected the relevant legislation and local requirements. There was a reliable process in place for the identification and management of people at risk of abuse. This included the need to safeguard women and children with, or at risk of, female genital mutilation and people at risk of domestic violence. Staff in gynaecology outpatients had attended female genital mutilation training. Patient information leaflets about this topic were available in the department.
- Staff told us they had a good relationship with the Trust Safeguarding lead and felt well supported by them. Staff in gynaecology outpatients were able to explain their understanding of domestic violence. These staff referred to a named link person within the safeguarding team. Staff in the fracture clinic knew how to escalate concerns regarding abuse. The safeguarding flow chart was on display in the waiting area of the fracture clinic. Staff gave an example of when they had noticed the non-attendance of a child for an appointment. They had followed the trust policy and had escalated this to the social services and to the trust lead for safeguarding.
- There were processes in place to ensure the right person received the right radiological scan at the right time. Protocols for Imaging were written in October 2015 and were comprehensive. The trust protocol for scans of paediatric patients with non-accidental injury stated that two radiographers must be present to carry out this kind of scan, but these staff did not need to be specifically trained in non-accidental injury scans. This protocol did not conform to national guidelines. The trust informed us that these protocols were soon to be reviewed following the outcome of an investigation into a serious incident. Future plans included the appointment of a lead paediatric radiographer.
- The imaging service was focussed on ensuring that the World Health Organisation Five Steps to Safer Surgery was used as a checklist when carrying out non-surgical interventional radiology. During 2012/13, an audit of this checklist revealed that 90% of patient records contained completed checklists. During 2013/14, this rate had reduced to 59% with 24% incomplete and 17% missing. A further retrospective audit completed in June 2015 for the period January 2015 to May 2015 identified that 33% of patient records contained omissions, and in 2%, the checklists were missing. All of the omissions were related to computer tomography or ultrasound guided biopsies. The resultant action plan recommended that monthly audits be instigated. The data from these audits indicated that there had been significant improvement with the checklist being used consistently in all specialties with compliance in October and November 2015 reaching 99%.
- In dermatology, the team had adapted the World Health Organisation Five Steps to Safer Surgery checklist for use in their specialist area. In radiology, the teams completed this checklist for all 'needle to skin' procedures.
- There were some inconsistencies in the numbers of staff who had level two safeguarding training. In some teams, all staff were up to date with this training. However, poor compliance was particularly evident in the diagnostics service, for example, 71% of allied health professionals in the magnetic resonance imaging service, 53% of allied health professionals in the Mermaid Centre, but also in therapies where only 64.7% of staff were trained in safeguarding to level two. Eleven consultants were not up to date with this training. Not all staff who worked with children in outpatients and diagnostics were not trained to level three safeguarding as recommended by the intercollegiate guidelines published by the Royal College of Paediatrics and Child Health in March 2014

Mandatory training

- Not all staff received regular mandatory training updates in outpatients and diagnostics teams

Compliance with dementia training was good at 98.8% and there was almost 100% compliance with non-patient manual handling. However, on average, 87.6% of staff in outpatients and diagnostics services had completed their mandatory training. Medical and dental staff had the worst compliance rate at 77.9%. Allied health professionals fared better at 91.3%. Only 69.4% of outpatient therapists and 11.1% of consultants had completed patient moving and handling. Compliance with fire safety was varied.

- Twice yearly, the imaging service provided bespoke mandatory training sessions for all staff, half the team attended each date.
- Some staff told us that they had difficulty keeping track of training requirements. As part of the listening into action programme, the trust had identified the need for an increase in communication and user guides for staff advising how to identify training requirements, compliance and enrolment procedures.

Assessing and responding to patient risk

- There were clear processes for the assessment of people within outpatient clinics or radiology departments who were clinically unwell and required hospital admission. Staff in outpatients and imaging clinics were aware of these pathways. For example, in cardiology outpatients, a patient with pleural effusion attended the outpatient clinic. The member of staff contacted the 'cardiologist of the week' who was able to bypass the emergency department and admit the patient directly onto the cardiology ward. Staff in the cardiology outpatient department read the 24-hour tapes and if anomalies were evident, they acted upon this immediately.
- Staff in dermatology were aware of the potential for patients to burn during phototherapy and a patient group directive was in place for nurses to administer a steroid cream to the affected area. They felt confident to ask the patients to receive a prompt review from the doctors in clinic in these instances.
- All staff in radiotherapy were trained in adult life support in order to manage patients who reacted to the contrast media in radiotherapy planning. In clinical imaging, 43% of the registered nurses had completed a university accredited course 'care of the critically unwell patient in non-critical care areas'. Training using a simulator for anaphylactic shock and sepsis had been completed by 18.7% of middle grade and senior grade doctors attending patients in the outpatients and diagnostics departments.
- When staff were presented with a patient who displayed challenging behaviour, they could request assistance from the security team if required. However, in the fracture clinic the nurses did not have a clear line of sight of patients waiting for their appointments. The clinic was very hot and on occasions, patients had fainted in the clinic. The receptionist used an emergency bell to alert staff if patients became in need of urgent assistance.
- There was a designated radiation protection advisor. The imaging services had appointed radiation protection supervisors in each clinical area. The role of the radiation protection supervisor was to observe staff practice and ensure local rules were followed consistently. However, there was only one radiation protection supervisor for the large nuclear medicine service; this person was a medical physicist who was not working as a clinician in the department, overseeing radiation on a daily and practical basis.
- The imaging service ensured that the 'requesting' of a radiation diagnostic test was only sanctioned for authorised persons, in accordance with IR (ME) R. The referrals were requested via an electronic system that was password protected. Only persons who were deemed to be appropriately trained were given access to such a password. There also were written clinical guidelines and imaging referral protocol to authorise appropriately qualified non-medical practitioners such as the nurses in the chest pain clinics to request x-rays. These guidelines stipulated that all practitioners must have achieved competency within cardiology clinics assessed by the consultant and completed IR (ME) R training.
- There was good signage and information displayed in the radiation department waiting area informing people about areas where radiation exposure takes place. The required signage for radiation controlled areas was in large format and clearly visible.
- We saw evidence that the risks of contrast induced nephropathy were mitigated. Patients were sent a pre-appointment letter advising them to attend their GP surgery for a blood test to check kidney function
- The imaging service did everything possible to ensure that women (including women using the services and

female staff) who were or may be pregnant always informed a member of staff before they were exposed to any radiation. The radiology service used a form that females of child bearing age completed prior to their examination. Then staff checked the form for issues relating to pregnancy. However, the intrusive nature of the questions on the form did not follow the best practice recommendations in terms of how to take possible pregnancy into consideration when undertaking medical radiation exposures

Nursing staffing

- The trust reported that there was no specific acuity and dependency tool used for the outpatient day treatment areas. Team leaders reported that patient safety was at no times compromised by lack of staff. When there were insufficient nursing staff available, staff were transferred from a ward to cover the shortfall. Outpatient staff were not aware if this resulted in shortfalls of staff on the wards. Staff who worked in the clinics told us there was enough staff on duty when clinics were running.
- There was infrequent use of nursing agency in the outpatients and diagnostics service. The exception to this was the gynaecology outpatients service that reported a rate of 10.7%.
- The data submitted regarding staffing vacancies and turnover in the outpatients and diagnostic service was not recent. At the end of November 2014, vacancies were 16.7% for registered nurses, 16.3% for occupational therapists and 11.3% for health care assistants. The pathology directorate had staffing deficits for other staff). We were told by staff that the haematology service were only just managing to cover the on-call night time rota for blood transfusion. Rheumatology had deficits of 38.9% for qualified nurses and 10.1% for unqualified nursing staff. Medical Physics had an overall deficit of 13.2%.
- Turnover in outpatients and diagnostics was 17.6% for physiotherapists, 13.2% for health care assistants and 10.2% for dietetics. The main areas of turnover were outpatient booking and health records with turnover across the whole of patient services running at 11.09%. We were informed by booking staff that 70% of their staff were new. The teams had restructured in order to provide more opportunities for career progression in an aid to improve retention of staff.
- Sickness rate was 6.1% for clinical services, 5.9% for nursing and midwifery and 3.9% for allied healthcare professionals. This compared to a national average of 4.4% for NHS staff as a whole.

Medical staffing

- Some specialties reported high vacancies for doctors. At the time of our inspection there were 38 medical vacancies in surgery. In respiratory care, there were vacancies for three whole time equivalent doctors which equated to 21.2% of their team. The pain clinic had a vacancy of one whole time equivalent doctor which equated to 24.7% of their medical staff. Trauma and Orthopaedics had vacancies for four members of the medical team which equated to 9.5% of the doctors working in this specialty, the head and neck specialty had vacancies for five whole time equivalent doctors which equated to 7.8% of their team, the surgical outpatients doctors team reported vacancies for three whole time equivalent doctors which equated to 4.2% of their team. There were vacancies of one whole time equivalent doctor in rheumatology, endocrinology, gastroenterology and neurology.
- The trust relied heavily on the use of locum medical staff to cover staffing gaps. Some medical specialties recorded high use of agency staff. These included the older persons care team at 33.8%, cardiology at 24.1%, respiratory at 17.8% and trauma and orthopaedics at 12.3%. When there were gaps in medical staffing that could not be covered by agency, the clinics were cancelled.
- In November 2014, the sickness absence rate was only 1.1% for medical staff. This compared to a national average of 4.4% for NHS staff as a whole.
- In radiology we were told that it was difficult to recruit consultant radiologists, however due to increased training places in the region, and high retention rates once employed, the lead radiologist was optimistic about recruitment and retention at the time of the inspection.

Major incident awareness and training

- Staff told us there were reliable arrangements in place to respond to emergencies and major incidents. For example, in the main x-ray service, the clinical imaging assistants had volunteered to be responsible for putting up the biological chemical decontamination tent in the event of such an incident requiring this equipment. The

contingency for failure of the information technology systems in radiology involved reverting to paper records and a flow chart was available for staff to follow for each eventuality.

- Although the matron of one outpatient service was aware of the key role of the department as a hub for the 'walking wounded' and pre-discharge patients during a major incident, she explained that there had been no table top exercise to practise this during the 18 months prior to our inspection

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

- Some specialties within the outpatients and diagnostics service collected outcome data but this was not used to benchmark the performance of the service against similar providers or to monitor performance over time.
- There was not a reliable system in place for the supervision or mentoring of staff.
- Audits were completed and these led to changes in practice that benefitted patients.
- There were good examples of multidisciplinary team working and staff had good access to the information they needed to provide effective care.
- Staff understood their responsibilities under the Mental Capacity Act 2005.
- Staff in radiology used diagnostic reference levels and local rules were available. However these local rules contained omissions and staff did not follow these rules consistently.

Evidence-based care and treatment

- The outpatient's service and diagnostic service incorporated some relevant and current evidence-based best practice guidance and standards, to develop how services, care and treatment were delivered. For example, we saw in cardiology that echo cardiology guidance posters were on the walls in examination rooms and guides to optimal views for echocardiograms were available in all treatment rooms. The standard operating procedures had been reviewed in August 2015. We were told that a new senior manager was due to commence in the department and their role was to incorporate best practice guidance into existing standard operating procedures.
- The imaging service and the nuclear medicine service used diagnostic reference levels as an aid to optimisation of medical exposures. In computer tomography, these were displayed beside each scanner and were available on the electronic document storage system for radiology. Diagnostic reference levels and exposure charts were in place for non-accidental injury scans. There had been no occasions when staff had not followed dosing guidelines for occupational radiation exposure.
- Local rules were available on the electronic governance system in radiology and in nuclear medicine. There was a paper copy in every room 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. However, there were some omissions within these local rules. The clinical imaging protocols in computer tomography did not provide sufficient technical detail of operator exposure factors. This meant that if a radiographer needed to query the automatic settings or if the equipment memory failed, there would be no technical factors within the agreed local protocols to refer to for safety.
- We saw that local rules were not always followed by staff. Local rules stipulated if an x-ray room was left unsupervised, the person in charge of the last examination must leave it so that others may enter without risk of accidental irradiation. However, we saw in several imaging departments that controlled areas were left unattended with the doors open.
- The outpatient's service used NICE guideline 66/87, management of type 2 diabetes to identify and implement best practice. The teams treated patients according to individual risk factors and encouraged primary care management of glucose, lipids, hypertension and neuropathic pain as recommended by the NICE guidance. The consultants in the pain clinic saw those patients for whom primary care intervention had not been successful.
- The outpatients and diagnostic service used NICE guideline 101, management of COPD to identify and implement best practice. For example the service participated in the national chronic obstructive airways

disease audit in April 2014and used this data to benchmark their performance against this guideline. The trust was working with the local commissioning group to improve services for this patient group.

- The nuclear medicine had worked in conjunction with the cardiology lead and the chest pain nurse specialist to integrate NICE guidelines into the chest pain pathway. Staff in the rapid access chest pain clinic were aware of the NICE guidelines for chest pain. They had developed their service to ensure that patients were assessed by chest pain nurses who checked whether a myocardial perfusion-imaging test was required and scheduled this within 40 minutes if required.
- Staff in some clinics such as ophthalmology and pathology told us that there was very limited time available for audit of quality of care and treatment because the priority was always given to patient contact.

Pain relief

- The outpatients and diagnostics service had used the Faculty of Pain Medicine's Core Standards for Pain Management (2015) to inform clinical practice. The Pain Clinic collected outcomes related to patient experience including three yearly participation in Consultation and Relational Empathy (CARE) Audit which was last completed in October 2014.Pain services collected outcomes related to the clinical effectiveness of pain management techniques and used this to make changes where required. For example, the Brief Pain Inventory was used to measure patient outcomes and this data highlighted potential outlier scores for patients seen by GP trainees in the pain clinic. The service planned to ensure closer supervision of these staff members. There was an on-going pain and palliative care audit on the effectiveness and complications of intrathecal medicine treatment for cancer pain.
- The level of pain in adults and in children was assessed using informal methods, no pain assessment tool was utilised. In some clinics, there were no protocols for pain relief. During the 2014/2015 cancer patient experience survey, it was identified that only 73% of patients felt that hospital staff did everything possible to control their pain all of the time. There was no action plan identified to address this result.
- Staff demonstrated a good understanding of methods available to them for management of patient's pain. We heard consultant staff explaining to patients how to manage their analgesia effectively. We saw that consultant staff encouraged patients to request their GP to refer them to the pain management service.

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected and monitored. Staff were involved in activities to monitor patient's outcomes. In the audiology outpatient service, the Glasgow Questionnaire was used to measure the progress of individual patients but this was not used to benchmark or measure the performance of the service in comparison to similar services or to monitor outcomes over a period.
- The outpatient and diagnostic services participated in local audits, national audits, benchmarking, accreditation, and peer review. Staff in radiotherapy reported that they were informed of the results of the annual audit completed by a private pharmaceutical company. These staff also participated in a six-month internal audit that focussed on any areas of concern identified in the annual audit. Action plans were written and re-audited one month later
- Reception services worked with the clinical coding team to undertake three outpatient coding audits a month. These audits ensured that the outcome forms in use agreed with the background tables on the electronic patient administration system therefore securing the correct tariff and that both clinician and receptionist had discharged their duties accurately in terms of outcome form completion and the updating of PAS.
- Outcomes, as measured by activity levels, for people using diagnostic services showed a varied picture over time. In the diagnostics service the 2014/15 activity for computer tomography had increased by 2082 or 4 4.4% from the previous year, although data showed a 2.4% drop in activity during April 2015 to August 2015 when compared to the same period in 2014. A similar pattern had emerged regarding the activity trend for ultrasound. This had shown an increase of 709 or 2.9 % increase in use from 2013/14 to 2014/15, but the activity for April 2015 to August 2015 showed a 5.2% drop when compared to the same period in 2014. Activity trend for magnetic resonance imaging had increased by 787 or 5.6% since 2013/2014 and continued to show an increase in activity from April to August 2015 of 15.9%.

- 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 diagnostics service within the twelve months preceding our inspection. These included, among others: documentation of written consent in imaging completed September 2015; documentation of world health organisation checklist in imaging completed September 2015; audit into the use of chaperones during breast care clinics in accordance with general medical council guidance completed June 2015; audit on clerking proforma completed April 2015; radiologist knowledge of contrast reactions completed June 2015; radiographer changes to vetting undertaken by radiologists for outpatient computer tomography scans completed April 2015.
- Action was taken to make improvements as a result of the outcomes of audits. For example, following the audit of the use of chaperones in the breast care clinic, teams now used a 'chaperone declined' stamp to identify patients who did not want to have a chaperone with them for their appointment. This had resulted in an improvement in the percentage of patients who were asked this question by staff
- The trust had completed a mock IR (MER) inspection in December 2015. This review had identified key areas for improvement related to staff ability to locate standard operating procedures, location of training records, provision of continuous professional development, staff awareness of the trigger list for reporting of incidents and review of diagnostic reference levels. There was an action plan in place to address these shortfalls. In interventional radiology, all staff participated in an internal interventional radiology audit group
- The imaging service were in the process of applying to be accredited with the imaging services accreditation scheme. At the time of our inspection, the trust did not participate in the Improving Quality in Physiological Services (IQIPS) programme. The audiology outpatients department were in the process of preparing for applying for accreditation.

Competent staff

- All staff administering radiation were appropriately trained to do so. However, none of the staff working in computer tomography, including the lead for this service, had completed a postgraduate qualification accredited by the Society and College of Radiographers. This was unusual because although this type of qualification is not a necessary requirement under IR (ME) R, it is recognised as assurance of a level of specialised knowledge that is required for complex scans. One reporting radiographer had recently completed the chest-reporting master's credit module. It was hoped this would ease the workload for reporting of images.
- Those staff that were not formally trained in radiation administration were adequately supervised in accordance with legislation set out under IR (ME) R. However, there was some discrepancy regarding the level of supervision provided to assistant practitioners. The lead radiographer told us that assistant practitioners were always supervised and that treatment decisions were made only by qualified radiographers, and assistant practitioners did not make decisions to undertake additional views or discharge patients. However, we were told by frontline staff and the written scope of practice confirmed that assistant practitioners who worked in the trauma radiology department did practice unsupervised, passed their own films, made decisions to discharge patients and ended episodes of care.
- In some services, availability of appropriately trained staff had been a challenge. We were told that this had affected pharmacy, pathology and bookings teams. This was hindered further by the recruitment process, which we were told could take up to eight months. In haematology, there was a lack of staff that were suitably competent to work alone covering the on call night time blood transfusion service.
- In a mock IR(MER) inspection in December 2015, the trust identified that not all staff training records were accessible, up to date, and signed. This inspection also identified that not all staff were able to locate relevant IR(MER) documentation on the electronic governance system. The medical physics expert for the trust told us that training for radiology staff needed to be given greater priority and that there were gaps in training records that had resulted from having too large a team to oversee. However, when we asked a staff member to explain the relevant IR(MER) documentation, they demonstrated good awareness of the relevant guidance. We checked the training file of a band 7 staff member in radiology. This was very extensive and up to date. There were clear records showing detailing who was entitled

to administer radioactive medical products. There were clear records detailing which staff had the necessary certificate from 'The Administration of Radioactive Substances Advisory Committee' (ARSAC).

- In audiology, we spoke to a member of staff who was enrolled on the neurosensory pathway of the modernising scientist framework specialist training programme. This was funded by the strategic health authority and time out for study was granted by the trust. This training had enabled the service to cultivate an experienced clinician to take on the band 7 role. In July 2015, the department was an accredited training centre for clinical technologist training to diploma level until December 2016.
- The learning needs of staff were identified using the appraisal system. All staff told us they were up to date with their appraisals. However, data provided by the trust indicates that compliance with appraisal completion was below target for all staff groups except professional scientific and technical staff. On average, 80.4% had completed an appraisal within the 12 months preceding our inspection. For nursing and midwifery, the percentage completion rate was 67.4%, for healthcare scientists 73.2%, for clinical services, 78.2%, administrative and clerical 83.1%, allied health professionals 83.9%, medical and dental 87.9%. Professional and scientific staff achieved 100% with a staff group of three. In radiotherapy, all staff had an up to date appraisal. The band 7 nurse for the main outpatients department had not been replaced and this was impacting upon the completion of appraisals
- Some staff received appropriate training to meet their learning needs such as regular access to study days. Other staff told us that access to training courses was very limited. There was a comprehensive policy for clinical supervision in place. However this policy did not include expectation of frequency of clinical supervision and the operation of the policy had not been audited. Arrangements for supporting and managing staff did not include a robust system of supervision or mentoring. In four different outpatient clinics, staff we spoke with were not receiving one to one supervision or mentoring. In therapy, a programme to investigate staff awareness of supervision was underway with the intention of introducing supervision standards in the future. No audit of supervision had taken place because the leads recognised that staff had very different understandings of what was expected of supervision.

Multidisciplinary working

- Staff in different teams and services were involved in assessing, planning and delivering people's care and treatment. Staff in radiotherapy operated a rota system to facilitate staff to attend the multidisciplinary meetings held fortnightly with clinical oncology team and the radiation physics team. Nurses, radiographers and doctors attended monthly audit meetings in interventional radiology. The radiology service reported that their attendance at multidisciplinary meetings was almost 100%.
- Care was delivered in a coordinated way.There was an advanced practice reporting radiographer who worked very closely with the stroke co-ordinator and the emergency departmentteam to ensure rapid computer tomographyimaging and onward care of stroke patients. In the emergency department there was a radiologist based in the emergency department. This enabled the occupational therapist based in the emergency department to be able to progress quickly with discharge planning and rehabilitation plans.
- The radiology service had instigated a change to the imaging pathway in order to make this more coordinated for patients. Previously, when a patient attended for a scan but the staff member ascertained that that person required a more specialist scan, the referral was returned to the referrer who was then required to request funding for the more specialist scan. The radiology service had challenged this process and had succeeded in securing automatic approval of funding for such occurrences.
- Staff worked together to assess and plan on-going care and treatment in a timely way. This included when people were due to move between teams or services, including referral, discharge and transition. For example, there was a project to develop more efficient consultant-to-consultant referrals using the electronic system. The oncology team explained how the cancer nurse specialists worked closely with the district nurses to plan ongoing care, and GPs were encouraged to contact the consultants to discuss patient care. In the urology service, we were told that referrals were taken directly from the outcomes of the multidisciplinary meetings in order to expedite this process.
- One-stop clinics involving different disciplines of staff working together were available. For example, there was a 'hand clinic' held within the main outpatients

department and this included input from the doctor, the occupational therapist and imaging services. An outline business case had been submitted to the board in January 2016 for a specialist physiotherapist based in the fracture clinic.

Seven-day services

- There were evening and weekend clinics held in some specialties. The computer tomography service ran clinics from 8 a.m. until 8 p.m. Monday to Friday, with some clinics on Saturdays and Sundays. The interventional radiology service was available on call 24 hours per day staffed by five consultants. The ophthalmology service offered all day clinics on Saturday staffed by existing nurses who were given overtime. The oncology outpatient service did not provide weekend or evening appointments but there was an out of hour's oncologist available 24 hours per day, seven days a week. There was also emergency radiotherapy available throughout the weekend. In the main outpatients department, there were occasional clinics set up to run on a Saturday to meet a rise in demand for a specific speciality such as colorectal.
- Some clinics used/ telephone appointments as an alternative to face-to-face appointments. In some specialties such as surgical and gastroenterology outpatients, the outpatient services used videoconferencing to consult with residents of the Isles of Scilly. There was a chemotherapy helpline available 24 hours a day, which was manned by, trained nurses. The audiology clinic provided a telephone follow up service.

Access to information

- The information needed to deliver effective care and treatment was available to staff in a timely and accessible way. For example, the preparation team for medical records included a 'runner' who retrieved patient records and distributed them to clinics at short notice when required. Staff in all outpatient clinics were able to access the referral letter and the discharge summary via the electronic system. The outpatients / diagnostics service provided electronic access to diagnostic results
- The systems that managed information about patients supported staff to deliver effective care and treatment. We observed the consultation with a patient in fracture clinic who the consultant suspected required surgery. The consultant in the fracture clinic was able to check the electronic schedule and instantly be informed when a surgeon of that specialty would next be available in the hospital for consultation and when space would be available to perform surgery if this was deemed the right course of treatment. The patient was advised of an appointment time for this consultation prior to leaving the fracture clinic.
- However, the bookings staff explained that the patient administration system did not always provide the information needed. For example, when patient's relatives telephoned the service for information, this system did not identify whether that relative had permission to receive updates on the patient's behalf.
- Systems for storing patient information were not always easily accessible. In cardiology, echocardiogram images were stored on computer disks, only one copy of this information was retained, and in order for clinicians to view old images, they were required to locate and upload these disks.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff demonstrated understanding of consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. The procedure for gaining consent in the imaging service had been re-audited in August 2015. This audit concluded that insufficient written information was given to patients prior to their procedures and the patient copy of the consent form was not consistently given to the patient. The service recommended that use of procedure specific consent forms should be expanded to address this.
- Patients were adequately supported to make decisions. We observed a patient consultation in the ophthalmology department and the clinician gave comprehensive explanations. The nurse checked the patients understanding. Another patient in the ophthalmology clinic told us that the clinician he had seen had clearly explained the consent procedure and explained the treatment options available to him.
- Staff told us that if a best interest's decision were required, the specialist link nurses for learning disability or dementia were involved in that process.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services caring?

Good

We rated the outpatients and diagnostics service as good for caring because:

- Staff introduced themselves by name and role.
- We saw that staff in outpatients and diagnostics services did everything possible to maintain patient's dignity and privacy within the busy clinic environment.
- Patients were routinely offered chaperones.
- Staff gave consideration to the psychological needs of their patients.
- Patients were empowered to manage their own health.

Compassionate care

- We heard staff introduce themselves when meeting patients. These professionals explained their roles and responsibilities as recommended in NICE QS15.
- A patient survey of the imaging services in 2015 identified that 90.7% of patients reported that staff introduced themselves by name and role.
- Patients told us they were treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty as recommended in NICE QS15. Staff understood and respected patient's personal, cultural, social and religious needs. One patient in dermatology told us "I feel they talk to me as a person. I am not just a number". Staff took the time to interact with people who used the service and those close to them in a respectful and considerate manner.
- Staff showed an encouraging and supportive attitude to people who used services. When patients experienced physical pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way. For example, a patient told us that a member of staff had offered to hold their hand during a procedure.
- Staff did everything possible to ensure that people's privacy and dignity was respected within the busy environments of the outpatients and diagnostics clinics. However, in some clinics, patients were not always able to speak to the receptionist without being overheard. In one clinic, cubicles were divided by curtains which resulted in consultations being overheard.
- Staff always ensured that patients were offered a chaperone when intimate personal care and support was being given by a member of the opposite sex or when being examined by a member of the opposite sex. Sometimes this resulted in delays to the clinic if there were a shortage of staff in clinic. Where possible, staff ensured that this chaperone was the same sex as the patient.

Understanding and involvement of patients and those close to them

- We observed that patients were supported by healthcare professionals to understand relevant treatment options as recommended in NICE QS15. However, patients told us that staff did not always communicate with patients so that they understood their care, treatment and condition. We interviewed twenty patients and two of these patients expressed that they were not given full explanations of their diagnosis and treatment. Staff told us they made sure that patients and those close to them were able to find further information and ask questions about their care and treatment. A patient survey of the imaging services in 2015 identified that 97% of patients reported they were told what their examination would involve and understood the explanation given by staff. 99% of patients felt able to ask questions
- Following their appointment, patients told us that they understood how and when they would receive test results. A patient survey of the imaging services in 2015 identified that 99% of patients reported that the staff member explained when their results would be ready and who would discuss the results with the patient. Outpatients we spoke with gave a mixed response regarding whether they had received copies of letters sent between the hospital and their GP. Staff told us that this occurred regularly. The Management of Clinical Records Action Plan dated December 2015 identified that patients were not routinely being sent copies of their correspondence. This risk had originally been identified in March 2015. When this was reviewed in December 2015 there was no clear way forward identified. Patients told us they knew who to contact if they were worried about their condition or treatment after they left hospital.
- We saw in only one outpatient's clinic that information regarding safeguarding from abuse was displayed where patients would see it.

Outpatients and diagnostic imaging

Emotional support

- Staff considered the psychological needs of patients attending the outpatients and diagnostics service. We saw that the consultant in the fracture clinic considered the mental health needs of a patient when planning how quickly the patient could be followed up by the surgeon. In the ear nose, throat, and audiology outpatient's service, a hearing therapist was available for patients following the fitting of their hearing aid to work with them on improving their communication skills and to maintain work and social contacts.
- Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. In interventional radiology, staff used a separate exit away from the main thoroughfare for patients who were emotionally distressed.
- Patients were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. For example in the oncology outpatients department, patients who had completed their treatment were given open access to the clinic and advised to return directly if they experienced symptoms. Staff discussed treatment options with patients and patients were encouraged to be part of the decision making process. For example, in the fracture clinic, we saw that a patient was encouraged to express his preferences about surgical treatment and his reluctance to proceed with surgery was acknowledged by the consultant. The risks associated with conservative treatment were explained to the patient.
- A small-scale evaluation had been completed in the cystic fibrosis service in October 2015 entitled: 'Transition: a cycle of further development in the adult cystic fibrosis service'. This study looked at the effectiveness of a project called 'Yes! I can do it' that aimed to motivate teenagers with cystic fibrosis to self-manage their condition incorporating a home exercise programme and use of the habitual activity estimation tool to enable individuals to analyse their activity levels.
- Staff were aware of the written information available that could to be given to patients, but patients told us that they were not routinely offered information. The vision for the patient's services division included a plan to improve patient information, revise the leaflets available in outpatients and introduce a website.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated the outpatients and diagnostics service as requires improvement for responsiveness because:

- Referrals were not triaged in a consistent or timely way for all specialties
- Short notice planning of clinics meant that patients with the most urgent need were not always able to attend appointments offered to them.
- Patients experienced delays for new appointments. Three specialties were not meeting the 92% target for referral to treatment within 18 weeks, namely trauma and orthopaedics (86.8%), cardiology (84.5%) and thoracic medicine (88.8%). The delay for womens health physiotherapy was 29 weeks in November 2015, and 25.6% of patients who were booked an appointment had waited more than 18 weeks.
- There were long waits for paediatric dietetics service, women's health physiotherapy service, and paediatric musculoskeletal physiotherapy.
- In some specialities, such as respiratory, ophthalmology and cardiology, there were significant delays to follow up appointments.
- Despite the introduction of a new system to reduce the impact of cancelled clinics, significant numbers of clinics were still being cancelled for avoidable reasons
- Although the trust was meeting the majority of the 'cancer wait' targets, patients waiting for treatment in some specialities had waited longer than 62 days for non-urgent treatment. Performance against this target was as follows: sarcoma at 50%, colorectal at 53.8%, head and neck at 66.7%, obstetrics and gynaecology at 75%, lung at 81.8% and breast at 84.2%.
- Patients did not always receive a copy of letters sent about them to their GP.
- There were no options to ease the stress of car-parking for patients attending outpatient appointments
- In some clinics such as cardiology, the facilities did not maintain patient privacy
- The waiting room for the magnetic resonance imaging department was isolated with no facilities for patients and no staff presence

However:

- . Some clinic facilities were better designed than others to meet patient's individual needs.
- There were 'advice and guidance' facilities in specialties such as dermatology, rheumatology, haematology, renal, and cardiology. There were virtual clinics in ophthalmology, trauma and orthopaedics and the fracture clinic
- The learning disability service completed preliminary assessments of outpatients in order to identify requirements for reasonable adjustments.
- Lessons were learnt from complaints and practice was changed to improve care.

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. Demand for the ophthalmology service had grown and in response, the specialist nurses were focussing on ways to free up consultant time to see patients such as extending their role to include eye injections and administer patient group directions for medicines. There were several non-medical prescribers in clinics such as ophthalmology, oncology and dermatology.
- Relevant stakeholders were involved in planning services. For example, in radiology the trust was working together with neighbouring trusts across the South West to make use of the limited resource of paediatric radiologists for provision of advice and cover when required.
- The outpatient services tried to ensure flexibility, choice and continuity of care. There were virtual clinics occurring in the trauma and orthopaedic, the fracture clinics and ophthalmology. In these virtual clinics, the consultants reviewed the diagnostic information such as x-ray images and the patient records and decided whether a face-to-face consultation with the patient was necessary. In the audiology clinic, the team recognised that their patients needed support following the provision of a hearing aid. To meet this need, they had employed a team of volunteers.
- There were 'advice and guidance' facilities in specialties such as dermatology, rheumatology, haematology, renal, and cardiology. GPs were able to send an email to the advice and guidance service and the consultant of the relevant specialty would respond with a suggested management plan.
- In August 2015 the clinical chemistry laboratory became the first laboratory in the United Kingdom to go live with a programme designed to use estimated glomerular filtration rate graph surveillance for the early identification, support and treatment of people with progressive kidney disease. This project involved a weekly download of the prior weeks reported creatinine results which were used to identify patients at risk as having deteriorating renal function and at risk of requiring future dialysis. Between August 2015 and December 2015, a total of 3804 patients were included in the searches, 60% of those under 65 years were flagged and 54% of those over 65 years were flagged.
- The advice and guidance service in the renal specialty aimed to reduce unnecessary outpatient attendances through provision of specialist renal consultant advice to potential referrers. As a result, 59% of the patients discussed were managed in the community with no requirement for outpatient referral to the clinic.
- The service was evaluated using an online survey to those healthcare professionals using the service. This indicated that 100% of respondents agreed that the service was prompt, the advice was excellent, the service had improved patient care and they would use the service again.,
- In cardiology, the advice and guidance service had not yet been evaluated. In haematology, initial evaluation showed that in December 2015, there were 56 patients discussed by referrers, only three patients went on to be referred to the haematology outpatients service.
- In some clinics, the environment of the outpatient and diagnostic clinics were appropriate and patient centred. We saw that in the audiology clinic there was a room available with a nursing chair for breastfeeding mothers and infant changing station. Staff in gynaecology were able to access a free clinic room when patients required emotional support following a consultation or examination. However, in cardiology outpatients, the environment was not well designed to maintain patient privacy. Staff measured patient's height and weight in a corridor that also served as an area where staff read

echocardiogram tapes. Patients were required change into hospital gowns in curtained cubicles. There were no call bells in these cubicles and male and female patients were obliged to change in adjacent cubicles.

- For people living with hearing impairment and/or dementia, there were variations in the quality of facilities design to meet their individual needs. There were hearing loops available and identifiable in all the outpatient clinics. In the computer tomography service, if a patient was 'flagged' to have hearing impairment they were given a longer appointment slot.
- However, the fracture clinic was cramped and very busy, with no quiet areas. The waiting room for the magnetic resonance imaging scans was in an isolated area of the hospital. There was no reception cover and no toilets nearby. Patients were required to locate instructions on the wall that directed them to telephone the department to advise of their arrival. For patients with additional needs such as visual impairment or dementia, these instructions may have been challenging to locate or to implement.
- The facilities for children in clinic waiting rooms were adequate except for the fracture clinic that offered a very small curtained area for children. Staff described this as inadequate for their needs. A patient survey of the imaging services in 2015 identified that 34% of patients visiting the imaging clinics needed children's facilities to be available, and of these 81.3% found the facilities to be suitable.
- There were no options to ease the stress of parking for patients. One patient in the ophthalmology clinic explained that if your appointment was delayed, you were required to run back to add money to the meter and then return, hoping that meanwhile you had not missed being called for your appointment. Patients were not given pagers so they could leave the waiting room for a break.
- Outpatients departments were not always clearly signposted. The route to the ophthalmology department was not well signposted from the main entrance. Closer to the clinic, signage improved and within the clinic signs were clear using white on blue background to aid visual clarity. In x-ray, there was clear signage to the x-ray rooms. A patient survey of the imaging services in 2015 identified that 96.4% of patients found the clinics easy to find.
- Information was provided to patients before appointments. This could be requested in different accessible formats. A patient survey of the imaging services in 2015 identified that 54.4% of patients received an information leaflet; all of those patients who received the information reported that it was accurate and easy to understand.
- Information was provided to patients to help them to remember advice given during clinic appointments. In the fracture clinic, a quick response code that could be read by personal mobile phones was attached to patients plaster casts. When scanned, this provided information specific to the individual regarding their plaster care. In nuclear medicine, information was available for breast feeding mothers explaining precautions following radioactive administration. In the ophthalmology clinic, there was a representative from a Cornwall based charity available in the clinic 3.5 days per week. This representative spoke to patients, shared information, and demonstrated equipment.

Access and flow

- Referrals were not always triaged in a timely way. The trust access policy stipulated that consultant triage of new referrals should be completed within 48 hours. The trust did not audit against this standard, but bookings clerks advised us that the triage process could take up to two weeks for some specialties. Snapshot data for 14 January 2016 indicated that on 14 January 2016, there were 69 patient referrals to oral surgery that had not been triaged within 48 hours, there were 13 patient referrals to gastroenterology that had not been triaged within 48 hours.
- While all specialities were carrying out triage of new referrals there was not a consistent approach to how each specialty did this, which lead to inconsistency of monitoring these referrals.
- Care and treatment was not always prioritised for people who needed an urgent referral to a clinic. We were told by booking staff that it was not always possible to accommodate patients with most urgent needs because clinics were arranged at short notice making it difficult to plan the clinic list. We were told that in some specialties, there was a disconnection between the bookings service and the clinical teams planning clinics which impacted on the planning.
- For many specialities, patients follow up appointments were delayed later than their agreed date to be seen

Outpatients and diagnostic imaging

- On 3 January 2016, 5380 patients had experienced a delay to their follow up appointment and 23.5% of these patients had been delayed more than three months past their agreed date for follow up. The maximum delay was ten months in respiratory medicine.
- There were also long delays for patients requiring follow up treatment in ophthalmology. At the time of our inspection, there were 2549 patients who had waited longer than one month past their agreed date to be seen. There were 73 patients who had experienced the longest delays of five months past their agreed date for follow up. In July 2015 there were over 3237 patients whose follow up appointment had been delayed, with the longest waits reaching twelve months.
- In cardiology, in February 2016, there were 296 patients whose follow up appointment had been delayed.
- The risks associated with delays for follow up appointments were comprehensively assessed. In cardiology and respiratory medicine specialties, all delayed follow up appointments were validated and reviewed by the administration teams. All patients whose follow up appointment was more than two months overdue were reviewed by the service lead and risk assessed using the 'wait-risk' coefficient method. Which did not take account of patient's condition. In cardiology this equated to 42% of overdue appointments, in respiratory medicine this was 74%. All patients whose follow up appointment was more than three months overdue were reviewed by the consultant specialist and risk assessed. There was a weekly meeting to discuss the progress of individual specialties performance against referral to treatment targets, which included discussion of ways to reduce risk to patients in general, such as provision of extra clinics
- The waiting times for patients needing cancer treatment were described in relation to the 'cancer wait' targets set by NHS England. These were: a maximum two-week wait to see a specialist for all patients referred with suspected cancer symptoms and for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected; a maximum 31-day wait from the date a decision to treat is made to the first treatment for all cancers; a maximum 31-day wait for subsequent treatment such as surgery; radiotherapy or anti-cancer medicines (three separate pathways); a maximum 62-day wait for the first treatment from the date of referral from an NHS cancer screening service, from urgent referral for suspected cancer or from a consultant's decision to upgrade the priority of the patient (three separate pathways).
- There was a dedicated administration team for those patients who required consultation within two weeks for suspected cancer diagnosis. This team focussed on liaising with patients and booking their appointments. The trust was meeting the targets for this group of patients.
- For the most part, the trust was meeting the cancer wait targets but there were some exceptions. During the period April 2015 to October 2015, the trust had consistently met three of the cancer wait standards these were:
  - the percentage of patients receiving first definitive treatment for cancer within 31 days
  - the percentage of patients receiving subsequent medicine treatment for cancer within 31 days
  - the percentage of patients receiving subsequent radiotherapy treatment for cancer within 31 days.
- Data showed that, on average, all targets had been met, but both of the 62-day cancer wait targets had dropped below target for two months or more during this period. The specific specialties that did not meet the 85% standard for these targets were:
  - sarcoma at 50%,
  - colorectal at 53.8%,
  - head and neck at 66.7%,
  - obstetrics and gynaecology at 75%,
  - lung at 81.8%
  - breast at 84.2%.
- The main reasons identified for these breaches included delays to outpatient appointments and magnetic resonance imaging scans for breast care; delays for high dependency unit beds, anaesthetic assessments and repeat endoscopy procedures for colorectal care; and delays for oncology outpatient appointments for lung care. Some cancer pathways relied upon provision of services at other neighbouring trusts such as biopsies for lung cancer and positron emission tomography scans.
- In radiotherapy, staff told us that the trust target of 94% of patients to be treated within 31 days of referral for radiotherapy was not expected to be achieved in January 2016, the projected performance percentage was 85%. The service was not expected to achieve this

target in February 2016. There had been an increase in demand for radiotherapy together with an increase in complexity of radiotherapy delivered. In order to address this increase in demand the team had agreed to extend their working day and overtime agreements had been reached.

- There were effective mechanisms to monitor the risk to patients who had been delayed in their receipt of cancer care. Every time a patient waited longer than the national targets for cancer care, the cancer services team analysed the reasons for the breach and the possible harm to those patients. These breaches were discussed at weekly meetings. The trust also monitored those patients who had not received a diagnosis by day 42 and this data was used to warn of a potential breach. A review of the trusts validation procedures for the referral to treatment pathway was completed by the south and west commissioning support alliance January 2015 to March 2015. This review concluded that the validation process was working effectively.
- There were some delays for outpatient appointments for new patients. In November, the overall performance against referral to treatment targets of 18 weeks for incomplete pathways was 94.3%. Three specialties were not meeting the 92% target, namely trauma and orthopaedics (86.8%), cardiology (84.5%) and thoracic medicine (88.8%). At the end of November 2015, the trust had 1221 patients on incomplete pathways compared to a plan of 1041. This was due to lower than planned elective activity, on-going patient cancellations due to difficulties in emergency patient flow and recruitment challenges in some specialties, specifically orthopaedics and respiratory medicine. There had been two patients who had waited more than 52 weeks for their treatment during April 2015 to November 2015
- The outpatient's service had a key performance indicator of 18 weeks for all therapy specialties. For musculoskeletal physiotherapy, patients were consistently seen within five weeks of referral. However, for women's health physiotherapy the delay was significant, recorded at 29 weeks in November 2015. From August 2015, onwards the pending list for women's health service exceeded 18 weeks. In November, 25.6% of patients had waited more than 18 weeks. In December, this figure had reduced to 8.3%.The team expected the delay for appointments in the women's health physiotherapy service to have reduced to less than 18 weeks wait at the end of January 2016
- The delay for an initial appointment in paediatric musculoskeletal physiotherapy was recorded at 30 weeks in November 2015. In December 2015, there were 69 patients who had waited more than 18 weeks and still did not have an appointment booked. Paediatric dietetics had breached the 18-week waiting target in October 2015 and was recorded at 17 weeks in November 2015. Staff anticipated a reduction in the waiting list secondary to proposed staffing changes in February 2016. When patients were delayed for their initial assessment in therapy services, the professional lead sent a letter to the referrer to inform and explain regarding the delay. Future plans included a comprehensive service review to focus on the sustainability of the service.
- Clinicians in the paediatric dietetics service and the physiotherapy women's health service, did not assess the risk to patients who had experienced delays to their follow up appointment. Improvements to the waiting times for follow up appointments in these specialties were anticipated secondary to proposed staffing changes in February 2016
- The time taken for diagnostic images to be reported was sometimes delayed. In November 2015, 91% of x-rays were reported in 14 days with the longest wait 20 days. For computer tomography, 91% of images were reported within 11 days, with the longest time for reporting at 13 days. For magnetic resonance imaging, 96% of images were reported within 14 days, with the longest wait 18 days. When lists became too high, the mitigation was to outsource the reporting function.
- There was an effective telephone call management system within the outpatient bookings service. In June 2015, new contact centre telephone software was gradually introduced to allow calls to be streamlined and directed to the relevant available agent via a queuing and holding system. Whilst patients waited, they were told their position in the queue. Since the introduction of the system, the volume of calls handled by the system had exceeded 90,000. The average length of time to answer a call across all three sites was 1 minute and 4 seconds.
- Patients in the fracture clinic told us that the appointments system was not always easy to use. One patient reported that he had been told he would receive an appointment within four days, but when he telephoned after six days, there was no record of this requirement in the appointment system. Another

patient we spoke with in computer tomography told us that he had been given the expectation that his scan would be completed within one month of referral at his local GP surgery. This scan actually occurred at the main hospital site three months after his consultation with the GP.

- Sometimes care and treatment were cancelled or delayed due to avoidable reasons.
- During April 2015 to October 2015, at the Royal Cornwall Hospital site, 11% of clinic appointments were cancelled by the trust compared to an England average of 7% and12% of clinic appointments were cancelled by the patients, compared to an England average of 6%.
- Between July 2015 and December 2015, 32.8% of clinic cancellations were due to annual leave equating to 3056 appointments, and 22.2% of cancellations were due to bank holidays, which equated to 2071 appointments.
- There was no clinic brokerage service, so if a clinic was cancelled, those slots or room availability were not offered to another specialty. We saw in one outpatient clinic that many rooms were not being used and this was confirmed as a regular occurrence by the matron overseeing that clinic. The trust did not audit the use of clinic rooms.
- Following clinic cancellations, patients were not always supported to access care and treatment again as soon as possible. The trust access policy stated that outpatient "appointments must be rebooked before or as close to the original appointment date as possible". However, we were informed by booking staff that this was dependent upon the clinic capacity available. Booking staff informed us that patients were sometimes cancelled several times. However the trust did not collect data to monitor this. A serious incident occurred in December 2014 involving a patient who experienced pain and blurred vision following an operation to his eye. His appointment with the consultant had been delayed by five weeks due to staff shortage. This incident resulted in a permanent reduction in vision for this patient. The investigation of this incident identified that the glaucoma policy was not always followed by booking staff and this policy did not include an escalation process for booking staff to follow in the event of clinic cancellation.
- We saw that clinics did not always run on time. Patients told us that the waiting time for appointments was not always communicated. During our inspection, we saw that staff informed the patients verbally regarding these delays. There were no visual electronic communication systems functioning in any of the clinics.
- The trust had collected data for December 2015 for some clinics regarding the length of time patients were kept waiting once they had arrived in clinic. This data related to the pain clinic, ear, nose and throat outpatients, rheumatology outpatients, maternity outpatients. The data showed a variable picture regarding delays in clinic. In most clinics, patients were seen on time. However in rheumatology, 38.9% were seen more than 30 minutes past their scheduled appointment time and 1.7% of patients waited more than one hour. A patient experience survey had been completed in 2015 in the imaging services. This indicated that 34% of patients were seen on time and 29% of patients waited less than 15 minutes past their scheduled appointment time.
- The rates of non-attendance for appointments were higher than the national average in most specialties. During the period April 2015 to November 2015, overall figures showed an average rate of non-attendance of 7.27%. However, in some specialties, rates of non attendance was much higher, for example in September 2015 hepatology was 15.7%, paediatric surgery was 13.3% and oral surgery was 12.4%.
- Action had been taken to reduce the rate of non-attendance. The trust had introduced an appointment reminder service (text and voice messaging) to reduce rates of non-attendance. This was not available in the therapies service. At the time of our inspection, the impact of this system had not been evaluated.

Meeting people's individual needs

- Services were planned, delivered and coordinated to take account of people with complex needs, but some parts of this process were not working well. There was a flagging system within the trust that identified patients living with conditions such as dementia or learning disability. However, staff in several outpatients clinics were not aware of the system, or were not fully informed regarding what symbols might be seen, what they would mean, how they would 'flag' a patient.
- Staff considered the needs of patients living with dementia and their carers. Staff in gynaecology outpatients told us that the dementia care lead nurses

were usually available to attend clinics with patients known to be living with dementia. However, staff in some clinics were not aware of the existence of lead nurses for dementia care.

- We saw that the trust gave careful consideration to the needs of patients with learning disability and their carers. There was a separate assessment service for outpatient referrals for patients with learning disability. GPs referred into the learning disability assessment service that assessed the needs of the patient over the telephone and liaised with carers where appropriate. That team then forwarded referral to the relevant bookings team who processed the referral as normal and alerted the learning disabilities team once an appointment was made. The learning disabilities team then made any required reasonable adjustments for that appointment. For example, staff in gynaecology outpatients told us that the learning disability lead nurses were usually available to attend clinics with patients known to have a learning disability. During January 2014 to December 2015, the learning disabilities team arranged reasonable adjustments for 900 patients. These adjustments included extra staff 38%, minimal waiting time for 21% of patients, the first or last appointment slot for 14% of patients and a quiet area of the clinic for 13% of patients. Staff in interventional radiology completed a pre-treatment assessment that identified specific needs such as learning disability.
- Appropriate support was available for bariatric patients. For example, in computer tomography, their newest scanner was able to accommodate patients up to 33 stone in weight. Staff were able to access hoists suitable for bariatric patients.
- Translation services were readily available if required. Electronic self-check in kiosks were being trialled in some clinics including dermatology, audiology and rheumatology outpatients. Reception staff in one clinic explained how the instructions could be displayed in four languages. All patient information leaflets were in English but staff told us that they were able to request the leaflets in different languages.
- Booking staff told us that they arranged interpreters in advance of the patient's appointment. Clinical staff told us that this sometimes happened. Staff were able to arrange interpreters for follow up appointments. In gynaecology, staff told us about a female patient who had previously been arranged a male face to face interpreter. The patient had not felt comfortable discussing her health concerns in front of a male and so the clinic staff had used the telephone interpreter service to provide a female Bengali interpreter. This service could be arranged with minimum notice and the dual handset telephones were available from a neighbouring clinic.
- The environment of some clinics were not designed or adapted to meet the needs of people who use a wheelchair for mobility. In some clinics, there was not an area in the waiting room for wheelchair users to wait in their wheelchair. This meant that they were obliged to locate themselves in the corridor. In the Mermaid Centre, there was no fire exit that could be accessed by people using a wheelchair. A chair to lift patients down the steps had been provided but staff had not been trained how to use this.

Learning from complaints and concerns

- Patients told us that the staff had not explained the complaints process to them. Some patients felt able to find out how to log a complaint, others were not confident to do this. Patients told us they were not given written information about the complaints process.
- Staff in the bookings service reported that the main trend from complaints relating to their service was the short notice given for attendance at clinic appointments and cancellations. Lessons were learnt and action was taken to improve care because of complaints. For example, following a complaint in November 2015, an endoscopy leaflet was amended to reflect different options for stopping medicines prior to this procedure. In the audiology outpatient's service, the most frequent subject of complaints were the time taken for patient's telephone calls to be answered. The service offered the facility for patients to contact the team by text or email as an alternative. Reception staff told us that they were kept informed regarding the themes of patients complaints as these were often related to delays or cancellations.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated the outpatients and diagnostics service as requires improvement for well led because:

- The trust had implemented programme of ongoing improvement in the outpatient service led by the outpatient improvement board. This had made some progress but significant challenges remained regarding access to new and follow up appointments and clinic cancellations.
- In the outpatients service and the diagnostics service we saw there were examples of a disconnection between the senior management of the services and the day to day operational running of the clinics. This meant that understanding of key risks was not well integrated.
- The safety and well-being of some teams was not always prioritised, as seen in the inadequate accommodation for the staff of the medical physics team.

However:

- We saw examples of good practice regarding the promotion of a safety culture for staff.
- Staff told us they felt valued, respected, and proud to work for the trust. Teams described feeling well supported in their immediate teams.
- When staff raised concerns, leaders acted upon this, although we were told of examples when this action was delayed. Immediate action was taken by the trust to increase security of records storage following concerns raised during our inspection.
- We saw good examples of innovative practice.

Vision and strategy for this service

- The trust had a vision for the outpatient's service. This vision was to have lower levels of traditional outpatient and emergency activity, with a larger proportion of follow up work done in the community in primary care or by telephone and through virtual clinics and telehealth. The trust planned to develop new technologies and skills in the community to improve management of long-term conditions and reduce emergency admissions. This would include one-stop clinics in areas such as urology, gastrointestinal surgery, ophthalmology, therapies and the ear nose and throat specialties. Patient pathways were to be streamlined to reduce the need for follow-up outpatient appointments. Plans included improvement of diagnostic services in areas such as nurse cystoscopy, building on new technologies such as the digitisation of imaging, co-locating 'hot' services; improving patient flows and modernising equipment and facilities
- The plan to deliver this vision was being overseen by the outpatient improvement board and implemented by the outpatient improvement project team. The outpatient improvement board was set up to improve patient experience, quality and efficiency across all outpatient services, specifically the number of cancelled clinics resulting from non-sickness, the rate of non-attendances against the national benchmark, the spatial distribution of clinics across Cornwall and the variation in outpatient clinic administration and reliance on non-automated processes. In March 2014, a new work programme was established and a project lead appointed to co-ordinate delivery.
- This board was chaired by the divisional director of specialist clinical services, attended by the chief operating officer, the deputy chief operating officer, divisional managers, strategy manager, clinical representatives and the divisional finance manager. This board was not always effective at driving forward the improvement plan. This board had met four times in the six months prior to our inspection. One of these meetings was not quorate and actions against the improvement plan were not discussed.
- Some progress had been made including:
  - the introduction of the clinic cancellation database
  - improvements in outcome recording
  - use of patient ambassadors
  - a pilot regarding the scanning of referral letters for paediatrics
  - plus the creation of an interventional radiology suite and installation of improved diagnostic equipment.
- However, despite this progress there remained significant challenges around access to appointments and the high volume of clinic cancellations. Managers told us that the clinic cancellation database had not been successful at reducing the number of clinic cancellations.

- At the time of our inspection, some projects had commenced but were not complete. These included:
  - the roll out of the telephony management system for non-centralised booking teams such as therapies
  - customer care training for reception and outpatient booking staff
  - roll out of scanning of referral letters and electronic recording of patient attendances.
- There were some projects still to be delivered by the programme. These included the introduction of outpatient room booking software to support improved productivity. Minutes of meetings in July and August 2015 recorded that progress against this objective had halted. Future minutes did not record further actions.
- Other projects still outstanding included the review of outpatient vetting processes, and the ratification of the accessible communications policy. The oncology outpatients service had a vision for improvement looking at how the haematology and chemotherapy service might be delivered in 2020. This was in the early stages of development but progress so far had included the setting up of a mobile community chemotherapy service.
- Some staff were aware of the plan to improve the outpatient service. Staff in the medical records department explained that there was a vision for the outpatient's service to move to electronic records. Staff were aware that incremental steps were being taken towards this goal such as approval of funding to commence the scanning of notes. Staff in the administration services told us that they had been involved in determining the specification of this electronic system. However, progress had been halted due to financial constraints.
- At the time of our inspection, there were no formal plans for development of the cardiology outpatient's service although the need for development was recognised by the lead for the service. In radiology the long term strategy included the possibility of having a managed equipment service.

Governance, risk management and quality measurement

- Each clinical specialty that operated an outpatient clinic was responsible for the delivery of that service and the governance of that service was managed by the division that housed that specialty. There were separate management structures for each clinical specialty within the outpatient service. In some clinics, staff working in the outpatient clinics were line managed by the band 7 or band 8 clinician located on the inpatient wards serving that clinical specialty. In some clinics, this resulted in band 5 staff running outpatient clinics with very limited oversight from their line manager
- Staff in the outpatient service were clear about their roles and responsibilities. Clinical leads demonstrated clear understanding of their clinical specialisms and the challenges faced by frontline staff delivering care. Leaders clearly understood the governance framework.
- However, in some clinics, we saw there was a disconnection between the administrative management of the outpatient's service and the clinical leadership of the specialties. This resulted in a less than holistic understanding of performance. For example, clinical leads did not have an up to date knowledge of the waiting lists for their specialties or delays for follow up patient appointments. Staff in lead roles in some clinics told us they were not aware of infection control performance data such as the result of hand hygiene audits.
- There was a disconnection in the governance of the diagnostics service. The radiation protection advisory committee met every six months and a summary report was forwarded to the trust management committee. However, the membership of this committee did not include representation from the lead radiologist or from a lead radiation protection supervisor. This meant that frontline staff did not have an accessible route to escalate radiation protection concerns affecting the diagnostics service, such as the deteriorating physical environment of the nuclear medicine facility. The membership of this committee did not include representation of the trust executive to provide quick and accessible route for escalation to the board.
- This disconnection was evident in the supervision of assistant practitioner staff in radiology. The manager of radiology was not aware of the defined scope of practice of the assistant practitioners for whom they were responsible
- There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. Risks were identified on the divisional risk register for outpatients. These included the following risks rated as high severity: Failure to address sufficient follow up capacity in ophthalmology (identified in November 2012), lone working within ophthalmology

department during on-call hours when no chaperone or clerking system were available (identified in April 2015), staffing capacity resulting in ten hour overtime shifts on Saturdays (identified in April 2015). Action had been taken to address the shortfall in follow up capacity in ophthalmology such as use of locums, collaborative working with a local GP surgery and service improvements within the wet age-related macular degeneration clinics such as nurses providing injections.

- The risk of patient records not being stored securely was identified on the Management of Clinical Records Action Plan in October 2014 and removed in February 2015 following an audit that had concluded there was compliance in this area. Immediately following our inspection the trust were notified of our concerns regarding storage of records in the outpatients and diagnostics services. The trust had taken a proactive approach including provision of locks for doors, lockable storage cabinets and advisory notices for staff. There were high numbers of clinic cancellations in the outpatients service when compared to the national average. This concern was not identified on the risk register. A web-based clinic cancellation/request system had been launched during 2014/15. This system aimed to streamline the clinic change process, which had previously been fraught with difficulty, a lack of consistent approach and heavy reliance on significant email streams. We were told by staff that this system had simplified communication but had not impacted upon the volume of clinic cancellations. At the time of our inspection, this system had not yet been evaluated.
- There was a lack of clarity in the data collected on the clinic cancellation database which meant that managers did not have a clear understanding of the reasons for the cancellations occurring.
- A divisional manager identified locum turnover as the primary reason for clinic cancellations, however this factor was not identifiable on the clinic cancellation database..
- The database identified annual leave was responsible for 23.7% of clinic cancellations in November 2015 and 19.6% of clinic cancellations in December 2015. There was a trust policy for consultant annual leave to be approved eight weeks in advance and managers reported that this was generally adhered to. However, the administrative processing and recording of consultant annual leave was completed within specialties using separate information technology systems and this impacted negatively on divisional management oversight of this factor.
- The number of clinics cancelled in the outpatients and diagnostics service was raised at the outpatient improvement board in December 2015. Some progress had been made to address this problem. This included the trialling an absence tracking tool in the specialty of anaesthesia In January 2016, the trust had introduced new processes that required staff within clinical divisions to contact patients directly to cancel clinics if the notice was less than two weeks. NHS locums had been appointed in some specialties whilst business cases for more sustainable solutions such as substantive consultant posts were submitted. Specialty level data reports had been introduced to highlight areas of concern. Within ophthalmology, delays were being subcategorised to clinical specialty to allow further visibility and prioritisation of staff resources.
- There was a dedicated governance board for administration that met once a month and an information governance committee that met once every six weeks. The records team inputted data to these governance meetings relating to security, operational issues such as appraisals, turnover of staff, data protection, issues regarding the patient administration system and the data quality dashboard
- We saw that clinical and internal audit took place in the outpatient and diagnostic services. The data from these audits was used effectively to monitor quality and there were reliable systems to identify where action should be taken. However some staff told us that this aspect of clinical governance was often overshadowed by clinical priorities.
- The main issues of concern identified in the clinical imaging directorate performance report included: funding for the third magnetic resonance imaging scanner, lack of capacity for reporting to deliver GP and outpatient reports in less than 5 days, lack of radiologist capacity to cover all multidisciplinary team meetings, rising numbers of cardiac magnetic resonance imaging referrals which were exceeding commissioned activity, increasing unreliability of computer tomography scanner and magnetic resonance scanner requiring replacement. In radiology, an electronic quality

management system was in the process of being introduced. This system held all the essential governance documents required under IR(MER) regulations.

- With the support of the Trust Development Authority, the trust completed a pre-inspection review in December 2015, visiting 14 clinical areas including outpatients. Areas of notable good practice included band 5 leadership in the cardiac investigation unit. Areas of practice that required improvement included medicines management, equipment checks, cleanliness, and documentation completion. The trust planned to strengthen the matron daily rounds to address these concerns. Staff in leadership roles that we spoke with were aware of issues identified in their departments. However, when we asked staff in the outpatients teams how they had contributed to the trusts self-assessment of ratings prior to our inspection, no staff were aware of this process including those in a leadership role.

Leadership of the service

- Most of the leaders of the outpatients and diagnostics service told us they had the skills, knowledge and experience that they needed to do their jobs. Some leaders told us they did not have the capacity to lead effectively because they were required to cover clinical duties that were often prioritised over governance activities. Most leaders demonstrated a thorough understanding of the challenges to good quality care and were able to identify the actions needed address these challenges.
- Most leaders were noted as being visible and approachable, Staff described an 'open door' availability of clinical leads. However there were two clinics where band 6 leaders were not visible and staff at band 5 were leading clinical teams by default. Consultants were described as approachable.
- There was a mixed opinion amongst staff within the outpatients and diagnostics services about the visibility of the trust executive team. However, staff felt confident that their immediate line managers were able to escalate concerns and disseminate information to them effectively. Therapy leads felt that the therapy services had a strong voice when issues arose

Culture within the service

- The culture of the outpatients and diagnostics service centred on the needs and experience of patients. All staff we spoke with prioritised the needs of the patients and demonstrated a commitment to improving care for patients.
- However, in some outpatient teams, the safety and wellbeing of staff had not been prioritised. The medical physics team had been accommodated in a temporary structure since September 1997. The team used this area for the operation of a gamma camera to analyse specimens. At the time of our inspection the temperature in this cabin was 17 degrees, staff were wearing outdoor clothing and had wrapped polystyrene under their desks in an attempt to insulate. The windows were single glazed and leaked and moss was growing on the inside of these window frames. The carpet had worn thin and was taped together and there were gaps underneath the external door. Staff were required to transport equipment and their route took them on roads with no pavement and through a loading bay where vans reversed.
- The medical physics team had reported their concerns regarding the inadequacy of their accommodation but no solution had been found. The risks associated with transporting equipment had been reported but staff had not received feedback. These concerns were raised with the trust during our inspection and as a result, funding was approved for the speedy relocation of staff and equipment.
- However, we also saw examples of situations where the safety and well-being of staff were prioritised. For example, when patients attending outpatients or diagnostics were known to be aggressive towards staff or patients, the bookings team ensured that these patients were given appointments at main hospital locations where security was present. Staff in clinics told us of examples when the security service had provided support during an appointment.
- When individual staff members were involved in serious incidents, these staff were offered a meeting with their line manager, occupational health counselling, and support from their staff union representative.
- Staff told us they felt respected and valued. Staff told us they felt a shared responsibility to deliver good quality care and they were proud of the hospital and enjoyed their work. Staff described feeling privileged to work at the trust.

Outpatients and diagnostic imaging

Public engagement

- The outpatients and diagnostics service provided some forums for listening to the views and experiences of the patients in order to shape and improve the culture and the care in the outpatient's service. In the audiology outpatient service, the service leads had asked their team of volunteers to give feedback regarding patient's perceptions of the hearing aids being offered by the trust. This service had also engaged patients via a focus group and planned to progress this engagement with a smaller group of individuals to work collaboratively on service developments.
- The outpatients and diagnostic service engaged with patients, relatives and patient representatives to involve them in decision making about the planning and delivery of the service. For example, there was a cancer patient and carer group that performed several functions such as seeking volunteers to support new initiatives, advocating for patient access to services such as digital imaging magnetic resonance imaging, organising a health and well-being event and a focus group for breast cancer care.
- Outpatient surveys were used. In radiotherapy, patients were given a questionnaire on the last day of treatment to feedback regarding the quality of service. This data had not yet been analysed.
- The Friends and Family Test was introduced into Outpatients in October 2014. In 2014-2015, there were 514 responses received, of these 96% said they would recommend the trust as a place to receive treatment. Patient Ambassadors were used to engage with patients and help increase take up of the survey. We heard from several services that the friends and family surveys were not yielding useful results. To address this, the therapies service was planning to return to using a locally developed survey Into 2015/2016 the outpatients and diagnostics service planned to supplement the Friends and Family questionnaire with some quality related questions focussed on care and compassion.

Staff engagement

- There was a mixed response from staff when asked if their views were reflected in the planning and delivery of services and in shaping the culture. In December 2015, around 140 members of staff attended the trust's Listening into Action 'Pass it on' event.
- Staff told us that the senior executive team held an 'open door' drop-in programme where staff could arrive without appointment to talk to a senior manager. There was also a timetable of visits to clinical areas that included the outpatients and diagnostics service. An executive team had visited 'outpatient therapy' during November and more visits were planned for March 2016.
- When staff raised concerns, leaders recognised the importance of this and acted upon the concern. For example in the x-ray service, the clinical imaging assistants had identified a shortfall of bed poles for intravenous fluid drips on the wards and this had affected their efficiency regarding the transportation of patients to the x-ray department. Because the staff had raised this concern, the trust had purchased several more bed poles and this issue had been resolved.

Innovation, improvement and sustainability

- There was evidence that leaders and staff strived for continuous learning, improvement and innovation.
- There was a trust-wide 'innovation club' that met approximately every four to six weeks. A therapist lead we spoke with applauded this forum as a mechanism for sharing good ideas and networking.
- Staff focused on continually improving the quality of care. In ophthalmology, the lead nurses were administering eye injections, which reduced the patient waiting time from one or two hours to see the consultant to approximately 20 minutes for the nurse.
- One of the physicist staff had designed an innovative software package for staff to use to account for and manage the storage and disposal of radioactive waste products. This helped staff to decide how long to keep waste, when it was safe to dispose of and which route for disposal was safest.
- The trust recognised and rewarded improvements to quality and innovation. For example, staff in the interventional radiology team had won an innovation award for their success with the vascular access service. The vascular nurses used an ultrasound scanner to guide venous access for patients who were difficult to cannulate. They had extended this service to provide assistance to other teams within the trust where arterial access was difficult to achieve.

Outpatients and diagnostic imaging

- The British Society of Interventional Radiology had awarded the interventional radiology department 'exemplar' status following an inspection in April 2015 Staff in interventional radiology were also developing a nurse led paracentesis service.

Sexual health services

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

Information about the service

The main location for sexual health services provided by the Trust was at The Hub which is on the site of the Royal Cornwall Hospital Treliske. Services provided included contraception and sexual health advice, screening and treatment, HIV services and chlamydia screening and treatment.

Contraception and sexual health services were also provided in the following areas to provide ease of access for patients: Bude, Launceston, Liskeard, Helston, Redruth, Hayle, Penryn, Falmouth, Newquay, St Austell and Penzance. Not all of these clinics provided both sexual health and contraception services and patients were advised of this at the time of booking an appointment.

From April 2015 to March 2016 the trust recorded a total of 23,580 attendances at the sexual health and HIV clinics. There were 7953 new patients (those who had not attended the clinic before).

Patients were able to book appointments or to attend a walk in a clinic. A single booking telephone line was in operation and answered by the receptionists at The Hub. Information was provided to patients on their first contact to advise on the availability and location of appointments. The Hub was open six days a week with other clinics around the county being provided from Monday through to Friday.

During our inspection we visited The Hub and clinics held at Hayle and Penryn. We spoke with 19 staff and seven patients. We received completed comment cards from four patients who had attended the service which provided their feedback. We reviewed documentation and medical records for four patients.

Sexual health services

Summary of findings

We judged sexual health services as good overall because:

- Patients were protected from avoidable harm. Openness and transparency about safety was encouraged. Staff understood their responsibilities and were encouraged to report incidents and near misses.
- Safeguarding vulnerable adults, children and young people was managed proactively and effectively by staff trained to recognise early signs of abuse.
- Staff were employed in sufficient numbers to run the service effectively. A daily briefing ensured all staff were aware of any potential risks or concerns regarding the operation of the clinics.
- Patients' care and treatment was planned and delivered in line with current national recommendations and legislation.
- The service participated in local and national audits and used the outcomes to inform,develop and improve care pathways and patients' care and treatment.
- Staff worked well together as part of a multidisciplinary team to coordinate and deliver patients' care and treatment effectively.
- Patients were provided with sufficient information regarding their care and treatment needs to be able to give consent prior to procedures or treatments being carried out.
- The sexual health service provided a caring service to patients.
- The privacy, dignity and confidentiality of patients' was protected and they were treated respectfully by the staff.
- Patients we spoke with provided us with positive feedback regarding their experience of using the sexual health service.
- The service was planned and delivered in various locations and at different times of day times, in order to meet the needs of the local population.
- The facilities and premises we visited were fit for purpose.
- The booking system for appointments was easy to use and supported patients to attend an appropriate clinic to meet their care and treatment needs.
- Patients were advised on how to make a complaint, were listened and responded to and action was taken in response to complaints and suggestions received.
- Staff were aware of a clear vision and strategy for the service in that the aim was to become a fully integrated sexual health service. However, this was dependent on future commissioning arrangements which lay with an external organisation.
- There were effective governance systems within the service and the wider trust. The service was able to identify current and future risks and the actions required to address these issues.

Sexual health services

Are sexual health services safe?

Good

We judged sexual health services as good for safety because:

- Patients were protected from avoidable harm. Openness and transparency about safety was encouraged. Staff understood their responsibilities and were encouraged to report incidents and near misses.
- Safeguarding vulnerable adults, children and young people was managed proactively and effectively by staff trained to recognise early signs of abuse.
- The service employed sufficient staff to run the service effectively. A daily briefing ensured all staff were aware of any potential risks or concerns regarding the operation of the clinics.

Incidents

- Staff reported all incidents through the trust's electronic reporting system. Staff we spoke with said they were encouraged and felt confident to report incidents. The reporting system enabled staff to indicate if they required feedback about any action taken as a consequence of their report. Staff informed us that they always received feedback at staff meetings and individually regarding the outcome.
- All of the incidents reported through the electronic system within the sexual health service were reviewed by the unit manager and the clinical lead and escalated as necessary to the divisional general manager. We spoke with the divisional general manager who confirmed this system was effective.
- The reported incidents were monitored to identify any themes or patterns and, when necessary, they were reviewed at the divisional governance meetings.
- A record was maintained of all incidents. Since 2010 there had been 174 reported within the service. At the time of our inspection three recently reported incidents remained open as they were in the process of being investigated and actioned.

Duty of candour

- Staff we spoke with were aware of the Duty of Candour legislation which was introduced in November 2014. Duty of Candour 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.
- We saw evidence that the service had been open and honest with one patient who had been provided with an incorrect test result. This incident had been recognised by the service, investigated and action taken to reduce the risk of this happening again.
- The trust had recently made training available for staff regarding the Duty of Candour but we were told no staff from the sexual health services had attended this at the time of our inspection.

Cleanliness, infection control and hygiene

- We observed there were plentiful supplies of protective personal equipment (PPE), such as disposable gloves and aprons, for staff to use in consulting and treatment rooms and the clean and dirty utility rooms. There were handwashing facilities in all clinical areas. Patients we spoke with observed that staff had washed their hands before and after providing any care and treatment to them. We observed staff washed their hands and used the PPE when handling and testing patient samples. For example, when testing urine or handling microscope slides.
- Single use equipment was used, for example, speculums were used for cervical examinations and procedures.
- The treatment and consulting rooms were cleaned thoroughly at the end of each clinic. The patient examination couch was cleaned between patients and clean disposable paper towel placed over the surface between patients.
- There were cleaning schedules in place within the department and we observed all areas were visibly clean. Monthly audits were carried out of the cleanliness of the department and action taken where necessary.

Environment and equipment

- The Hub was a modern purpose-built building which provided light and airy patient and staff areas.
- The emergency resuscitation trolley was accessible to all staff and was placed in a central location within The Hub in an area accessed by staff only. Staff checked the trolley daily to ensure it was ready to use. At the community clinic in Hayle, staff had access to the emergency equipment in the outpatients department in

the event of an emergency. It was not clear where the emergency equipment was located in the newly set up clinic in Penryn which was located in a local pharmacy. However, staff stated that, should a patient become acutely unwell, they would telephone for an ambulance.

- The trust had installed panic alarms within the reception area and consulting and treatment rooms. Staff were aware of the location of the panic alarms. However, not all staff we spoke with were aware of the guidelines regarding the use of the alarms or the action to take should they hear an alarm sounding. The unit manager advised us of the training drill that had taken place regarding the response to alarms but not all staff we spoke with had attended this or heard the alarms sound. This meant that there was a risk at an appropriate course of action would be followed should a member of staff need to sound the alarm. The community clinics were housed in buildings managed by other providers and did not all have alarms in areas where staff would potentially be working on their own.

Medicines

- Medicines were stored securely throughout The Hub in locked cupboards within the treatment room and consulting rooms. Medicines which required cool storage were stored in refrigerators used only for this purpose. The temperatures of the refrigerators were recorded by staff on a daily basis to ensure they were maintained at the correct temperature to ensure the safety of the medicines. One refrigerator in the HIV clinic was not working properly and was not in use at the time of the inspection. The medicines were stored in the main clinic refrigerator to ensure they were kept at the correct temperature.
- A weekly top-up system was in operation through the trust pharmacy department and staff reported this worked well. If further supplies were required during the week staff told us that the pharmacy responded promptly.
- When staff held community clinics they took medicines for the clinic from The Hub. The medicines were placed in a cool box inside a sealed box when being transported. The pharmacy had undertaken an audit of the temperatures of the medicines when being transported, in situ at the clinic and on return to The Hub (if they had been unused and returned). The audit found that the medicines had remained at safe temperatures for use at all times.
- There was no written record in place to show which medicines had been taken from The Hub and then returned if unused in the community-based clinic. We discussed this with staff who would be able to identify which member of staff prepared the medicines for transport, who held the clinic and which member of staff returned the medicines to The Hub. Staff considered this was sufficient due to the low risk items that were used in community clinics. However, following discussions with the pharmacist and unit manager, there were plans to review this system.
- Medical gases were stored securely within The Hub. For example, nitrogen storage was in a secured area outside of the building to enable sufficient ventilation when refilling canisters. This was good practice and followed national guidelines. Staff were provided with a detailed policy and procedure on how to refill canisters and were trained to carry this procedure out. The policy stated that protective equipment should be worn during the procedure, including a coat or protective overalls. Staff confirmed this protective clothing was not available to them and they wore only goggles and thick gloves.
- A pharmacist was present in the department to support clinicians running HIV and sexual health clinics. Patients' prescriptions were prepared prior to the HIV clinic to ensure their medicines were ready for them to collect during or after their appointment. The pharmacist also met every patient to review their medicines, which ensured potential complications or adverse interactions were identified. One patient expressed positive comments about this pharmacy service, saying; "The pharmacist is amazing, goes above and beyond to work on the patient's behalf. Their knowledge is exceptional".
- Complex medicine regimes were discussed at the weekly HIV multidisciplinary team meeting prior to complex new or different medicines being prescribed. Staff followed patient group directions (PGDs) to dispense medicines to patients and those we spoke with were aware of their responsibilities in this area. PGDs are written instructions to enabled suitably trained health professionals supply or administer medicines to patients, usually in planned circumstances. The PGDs were in date and were due to be reviewed in March 2016.
- Electronic patient prescribing was used within the trust but not within the HIV service for patients HIV medicines.

- There were no risks on the pharmacy risk register relating to the sexual health services.
- Staff were provided with guidance and instruction on the safe management of medicines. The sexual health service antibiotics policy and procedure followed the British Association of Sexual Health and HIV (BASHH) guidelines and were regularly reviewed to ensure compliance with these national guidelines.

Records

- Patients' records were held electronically. The system used was not accessible to staff members outside of the sexual health service, ensuring patient confidentiality. Computers were password protected and access to the electronic records system required additional passwords.
- The information contained within the patient record was detailed and provided a medical and sexual health history, consent obtained from the patient for care and the care, treatment and advice provided to the patient. An assessment template provided staff with prompts to ask relevant questions to identify safeguarding issues, such as domestic violence, child sex exploitation and female genital mutilation.
- Paper records had been archived and were stored on site in a locked records cupboard. The cupboard was opened using the staff swipe access cards and this enabled an audit to be undertaken to show who had accessed the room and when. A system of ordering the archived records was in place and staff were able to locate archived records when required.
- The chlamydia screening staff recorded information relating to patient testing and results on a separate electronic system. However, they were able to access the sexual health records and shared information with staff in the sexual health service. This did however present a risk to clinicians in that they were not automatically able to see all of the patient's information relating to previous and current care and treatment needs.

Safeguarding

- Staff had access to the trust safeguarding policies and procedures for vulnerable adults and children, which were available on the intranet. The policies instructed staff on the action they had to take if they suspected any abuse had occurred.
- Staff were up to date with their safeguarding mandatory training. The level of training was role specific, with clinical staff receiving level 3 training and administrative and reception staff level 2. We were shown a training matrix which demonstrated staff were up to date or were due to attend training.
- Staffs demonstrated an understanding and awareness of safeguarding children and adults and were able to discuss the action they would take should they have concerns.
- The initial patient registration form and assessment documentation prompted patients to answer questions which would highlight safeguarding concerns.
- There was a named consultant who had additional responsibility for safeguarding children. As part of this role they saw vulnerable children and young people who attended the clinic. For example, looked after children (previously known as children in care) or those with a learning disability. Children and young people who attended a drop in clinic were identified to the consultant and followed up by a telephone call if necessary. Staff also had access to a named nurse who had additional safeguarding responsibilities. All staff we spoke with knew who this person was and told us they were provided support when any safeguarding issues were suspected.
- The chlamydia screening service was able to identify children under 16 who requested a testing kit on line. Face to face contact was arranged with the children to ensure their safety. If a child attempted to log in again and change their date of birth the system alerted staff that the patient may be under 16. The staff were clear that in this instance, they would discuss this with the children's safeguarding leads in the department.
- The child protection and safeguarding policy and procedure included information and guidance for staff regarding recognising and acting when child sex exploitation was suspected and indicated by the history and information provided by a young person attending the clinic.
- Staff had access to a detailed policy and procedure regarding female genital mutilation (FGM). This provided instruction for staff on when they were legally required to report any identified or suspected risk from FGM to women and children and how to make such reports. Staff had been provided with training regarding FGM, which we were told, had been informative and useful.

- Staff were provided with domestic abuse training to ensure they were able to recognise warning signs in order to safeguard patients.
- The service held a monthly meeting regarding the safeguarding of adults and children. At this meeting records of patients who had attended clinic were reviewed and concerns discussed. Children under the age of 16 who attended the clinic were reviewed to ensure there were no safeguarding concerns raised during their visit.

Mandatory training

- The trust required each member of staff to attend mandatory training which included fire safety training, health and safety, safeguarding, basic life support and infection control.
- The unit manager maintained a training matrix which identified that staff were up to date with their mandatory training or a training date had been booked to attend. The exceptions to this were staff who were on long term leave. The manager was aware of where the gaps in training were and which staff were due to attend training.
- The trust training department sent individual staff reminders prior to the expiry date of their annual mandatory training.
- Staff we spoke with said they found the reminder email useful and were aware of their responsibilities to book themselves onto a training session. Staff told us there were opportunities to attend the training and a variety of dates to choose from.

Assessing and responding to patient risk

- Emergency equipment was available within the department to provide treatment to patients who became unwell. However, staff told us that patients who deteriorated during care and treatment were transferred to the emergency department or emergency gynaecology unit in the main hospital. If necessary, an ambulance was summonsed to transport the patient safely.
- Clinical staff were aware of the risks of certain procedures and the action to take should a patient become unwell following the procedure.
- Some members of staff we spoke with had attended self-defence training but most had not had any training on conflict resolution or managing violence and aggression. They told us that, although they were on their own at times in some areas of the department, they had not experienced problems of this nature from patients. We were concerned however, that at times staff returned to The Hub alone to return equipment, medicines and patient specimens following community clinics. This required them to enter the building and then secure it again on leaving.

Nursing staffing

- The service had carried out a review of the skill mix and staffing establishment with a view to moving to an integrated service. This had led to a change in the skill mix and job roles and descriptions of staff.
- The sexual health department did not use agency nurses to cover any gaps in shifts. Staff told us that they covered additional shifts amongst themselves and on occasions used the hospital staff bank. We were told it was difficult for agencies and the hospital nurse bank to supply them with staff who were suitably trained and competent in sexual health and contraception. Two band 2 health care assistants from the nurse bank, had expressed an interest in working in the department and were undertaking a number of induction and training shifts to enable them to be able to work independently in the department.
- At the time of our inspection there were a number of vacancies across the nursing team. These consisted of a band 6 post to cover 30 hours per week, a band 5 nurse for 22 hours per week and band 2 health care assistants to cover 62 hours. A band 3 health care assistant had been recruited the week before our inspection and was completing the recruitment process prior to commencing duties.
- Three additional health care assistants had been identified as necessary to ensure the smooth running of the clinics. The chaperoning policy and procedure had been reviewed and changed which meant a chaperone was required for each patient who had an intimate examination. A business case had been put forward to the trust to recruit these additional members of staff.

Medical staffing

- The medical team within the sexual health services consisted of four consultants, three associate specialists, five doctors, a registrar trainee and two junior doctors who rotated every four months. We also saw medical students had placements at the service. Staff told us the medical team was adequately staffed to

ensure the smooth running of the service. However, there was a concern that due to a planned absence later in the year, there would not be sufficient consultant hours to operate the current level of service. This had been identified as a risk on the service risk register.
- Medical staff were available six days a week when clinics were open.
- Three consultants were part of the South West HIV network, with two being part of the on call arrangements to provide telephone advice to clinicians across the South West regarding the care and treatment of HIV patients.

Major incident awareness and training

- The trust had a major incident policy and procedure that was available to staff on the intranet. Staff were aware of this policy. The Hub was identified as the second incident command room in the event that this could not be located in the main hospital due to the incident.

Are sexual health services effective?

Good

We judged sexual health services as good for effectiveness because:

- Patients' care and treatment was planned and delivered in line with up to date national recommendations and legislation.
- The service participated in local and national audits and used the outcomes to inform, develop and improve care pathways and patients' care and treatment.
- Staff worked well together as part of a multidisciplinary team to coordinate and deliver patient's care and treatment effectively

However:

- It was not evident that there was a clear process for staff to speak with children under the age of 16 or young persons alone if they attended with their parent(s) or other person. This did not ensure the young person had the opportunity to speak confidentially with the clinician.

Evidence-based care and treatment

- Staff were knowledgeable about guidelines and recommendations provided by the British HIV Association (BHIVA), the British Association of Sexual Health and HIV (BASHH), the Faculty of Sexual and Reproductive Healthcare (FSRH) and the Royal College of Obstetricians and Gynaecologists (RCOG).
- We saw documentary evidence, including minutes of meetings and memos to staff, which demonstrated the service guidelines and policies and procedures were reviewed and amended when necessary to reflect updates to national guidelines.

Pain relief

- Patients who were experiencing pain at the time of booking an appointment were provided with an appointment on the same day where possible or referred to a clinician for a telephone conversation. This enabled a clinician to take a medical history and provide appropriate guidance.
- Patients were advised to take analgesia prior to attending the clinic for certain procedures, for example the fitting of an intrauterine device (coil). Analgesia was available in clinics for patients prior to and following certain treatments.

Patient outcomes

- Patients who required appointments for urgent services, such as emergency contraception, were seen on the same day. All staff we spoke with were very clear that patients were provided with appropriate care and treatment on the day they telephoned for an appointment or they attended a walk in clinic. At times this meant the clinics over ran. We spoke with one patient who had attended a clinic without an appointment. However, due to their clinical need they had been provided with care and treatment promptly.
- The trust contributed to and provided us with a south west sexual health quarterly outcome indicator report which was produced by Public health England (PHE) Field Epidemiology Service South West. This report provided comparative information to assist with improvement of sexual health services. (Epidemiology is the study of the patterns, causes, and effects of health and disease conditions in defined populations).

- The average rate of conception in females under the age of 18 was 18 per 1,000 in Cornwall and the Isles of Scilly. This rate was lower than the rest of the south west which was 20 per 1,000 females and the England average of 23 per 1,000 females.
- The rate of new diagnoses of gonorrhoea, syphilis and HIV was lower in Cornwall and Isles of Scilly compared to the rest of the South West and the England averages. Between April and June 2015 the rate for new diagnoses of gonorrhoea and syphilis was 8 per 100,000 population across the South West. Cornwall and the Isles of Scilly evidenced a rate of 5 per 100,000 population. The figures increased in the demographic of men who have sex with men but remained lower in Cornwall and the Isles of Scilly by 30 per 100,000 compared to the rest of the South West
- The sexually transmitted infections (excluding chlamydia in patients under 25 years old) testing rates and diagnoses were lower than the South West average in Cornwall and Isles of Scilly.
- The sexual health and contraception service participated in local and national audits, including those run by the British HIV Association (BHIVA) and the British Association of Sexual Health and HIV (BASHH).
- The service had participated in the BASHH gonorrhoea audit and following the outcome of the national audit the service had changed the assessment and consultation templates in patients' records. This was to enable the service to record that a patient had revisited the service for a further follow up test. The service planned to re-audit the data to ensure this was an effective measure.
- A further change had been made to the electronic patient templates to improve the detail of recording following an audit of a specific contraceptive method.
- The indicators for late diagnosis of HIV patients were slightly higher (worse) in Cornwall and the Isles of Scilly than the England average. The service had been proactive in seeking the reasons for this and had undertaken a 'HIV look back exercise' within the local service. This had entailed looking at patient records, including those from GPs, the acute hospital and sexual health clinic attendances. No themes or trends had been identified, although there were changes made to the recording and sharing of information following patients attending for dermatology care and treatment.
- A local audit had been carried out to look at current practices in Hepatitis C testing to ensure these were in line with recently amended BASHH guidelines. Following this audit, action was being taken to identify higher risk groups of patients, such as men who have sex with men, those who have sex while under the influence of drugs and also to trace contacts of these higher risk groups of patients.
- The service participated in the BHIVA audit regarding HIV in pregnancy and childhood survey and case audit of pregnancy. A number of actions were identified based upon the recommendations of this audit. This included a joint pathway with maternity services to ensure patients received appropriate medicines promptly.
- The service had put additional measures in place to reduce the risk of misdiagnosis when reading microscope slides. Health care assistants had been trained to prepare and initially read the slide and then once the clinician had seen the patient they reviewed the slide. This system provided a two-step check of readings.
- The chlamydia screening programme service followed national guidelines on contacting patients with a positive test result which stated three attempts were to be made. The service initially made contact by text asking the patient to contact the department. The next day if no response from the patient had been received, a voice mail and another text would be sent and if still no response, this would be repeated on the third day. If a patient registered on line for a self-test they would have left their address for the testing kit to be sent to them. The service would send a letter to the patient advising them to contact the service. Attempts would be made to contact patients through external organisations and venues such as GPs where their tests were carried out. Close monitoring was carried out of patients who had tested positive but not been contactable and therefore not received treatment. Figures for 2015 identified six patients had been unable to be contacted. This information was reported to the national screening programme for inclusion in national statistics.

Competent staff

- All staff took part in an annual performance appraisal with their line manager. Records showed these were up to date.
- Registered nurses are required to comply with a new three yearly revalidation process from April 2016. The

sexual health service had dedicated a team meeting to this process to ensure that all registered nurses were aware of the process and understood the action required.

- The service manager was provided with information from the trust regarding the registered nurses' registration dates with the Nursing and Midwifery Council (NMC). All nurses are required to be registered with the NMC to demonstrate they are fit to practice. We saw records which showed all trained nurses who worked within the sexual health service had an up to date PIN number which showed their registration was up to date.
- The service held educational meetings for the staff, to which external professionals were invited to deliver training and information sessions.
- Nursing and medical staff told us they had received a thorough induction when they commenced work at the service. We saw evidence of the induction programme which showed each new member of staff was allocated a dedicated mentor for their induction period. Medical staff we spoke with gave clear examples of how they were supported and encouraged to develop skills to enable them to work safely and independently in this specialist area.
- Nurses saw patients on a one to one basis and therefore were clinically autonomous, unless they sought assistance or a second opinion from a colleague. Therefore, to provide assurance of their competence, an initial period of shadowing and assessing of their skills and knowledge was in place. A 'training passport' had been developed for all registered nurses based on the British Association of Sexual Health (BASH) competencies
- Health care assistants were mentored and supervised by registered nurses.

Multidisciplinary working

- A daily clinic briefing took place each day at The Hub to discuss and plan the day's clinics, share information and highlight any potential issues. We attended a briefing session and saw that all staff took part in this and were included in the planning of the day's clinics. Changes were made to the planned allocation of staff to specific clinics due to suggestions made by the staff to promote the smooth running of the department. Staff listened to each other and demonstrated a cohesive team approach to ensure the department functioned effectively.
- All of the staff we spoke with were proud of the multidisciplinary team working which took place in the department. Everybody felt able to raise concerns and suggestions with other individuals and they were confident they would be received favourably. There was a strong team approach to providing holistic patient care.
- Written protocols were in place for the joint working with the sexual assault referral centre (SARC) in Truro, which was run by an external provider. Staff reported good communication with the SARC to ensure patients received a seamless service. Staff told us the organisation telephoned The Hub to advise them when patients required a sexual health or contraceptive service following a sexual assault. Staff offered a prompt appointment or advised patients to attend a walk in clinic as soon as possible and expedited the patient's access to a clinician on their arrival in the department. Staff were positive that when they had previously had a patient attend following a sexual assault that the SARC had been responsive in meeting the patient's needs.
- The service had developed good working relationships with other departments within the trust. Referrals made to the emergency gynaecology service were followed up promptly. Staff worked with the paediatric department and provided support when forensic testing was required for a child.
- Staff were proud to have been instrumental in setting up the South West HIV network. This network provided a dedicated on call HIV consultant rota to provide guidance and support to professionals caring for HIV patients at all times.
- There was a weekly multidisciplinary team meeting to review patients receiving HIV care and treatment. This was attended by doctors, nurses, pharmacists and social workers.
- We heard that at times patients rang the main booking line to return a call to a member of staff but were unable to state a name of who had telephoned them. Staff said this meant they were unable to transfer the call to the appropriate clinician because they had not been informed to expect the patient to call.

Seven-day services

Sexual health services

- Sexual health services were available six days a week from Monday through to Saturday.

Access to information

- The electronic patient records system meant that staff had the medical records available for each patient when they attended clinics. This ensured previous episodes of care and treatment could be reviewed, taken into consideration and they were informed of any ongoing risks or concerns.
- The electronic system alerted staff to known risks from individual patients. For example, if a patient had demonstrated violence or aggression to staff across the wider trust or when attending the sexual health department previously. The reception staff received general alerts from the trust and transferred this information into the system used by the sexual health department.
- The chlamydia screening staff recorded information relating to patient testing and results on a separate electronic system. However, they were able to access the sexual health records and shared information with staff in the sexual health service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Verbal consent was obtained prior to care and treatment. This was confirmed by staff and patients and it was recorded in patients' records.
- Written consent was obtained prior to the fitting of intrauterine devices (sometimes known as a COIL). An information leaflet was provided to the patient and on the reverse of this was the written consent to be signed by the patient and doctor. A copy was provided to the patient and one scanned onto the electronic patient records system used by the service.
- The electronic patient records system identified the need to obtain consent for procedures, care and treatment with a red dot to ensure clinicians were prompted to record they had discussed this with the patient. One set of records we reviewed did not evidence consent had been sought but all of the others did. A system of records peer review was in operation and where records had not been completed fully, this omission would be raised with the clinician concerned.
- Staff we spoke with were aware of Gillick competence. This is used in medical law to establish whether a child (16 years or younger) is able to consent to his or her own medical treatment without the need for parental permission or knowledge. However, it was not evident that there was a clear process for staff to speak with children under the age of 16 alone if they attended with their parent(s) or other person. For example, asking the parent to leave the consulting room for a period of time. Staff told us they would ask the child if they were happy to speak in front of their parent and if the answer was yes the parent would be permitted to remain in the room. However, staff commented that in these circumstances, they would seek an opportunity to speak to the patient alone, for example, when showing them where the toilet was.
- Staff were aware of the Fraser Guidelines when young people attended the clinics to obtain contraception. Fraser guidelines refer to a legal case which found that doctors are able to give contraceptive advice or treatment to under 16-year-olds without parental consent.

Are sexual health services caring?

Good

We judged sexual health services as good for caring because:

- The sexual health service provided a caring service to patients.
- Patients' privacy, dignity and confidentiality were protected and staff treated them respectfully.
- Patients we spoke with provided us with feedback which was positive regarding their experience of using the sexual health service.

Compassionate care

- Patients were treated with respect and their privacy and dignity was promoted. We saw the receptionist greeted patients in a friendly and professional manner.
- The waiting room was set out so that patients sat in smaller areas within a large room which enhanced people's privacy. A radio played so that patients speaking with receptionists could not be clearly heard by other patients in the waiting room. Screens were strategically placed so that the waiting area could not be seen from the main entrance or from outside.

- Patients were called into the consulting rooms by the clinician themselves who used only the patient's first name. A check was made by the clinician away from the waiting area to confirm the patient's full name. This promoted patient confidentiality.
- The service had received feedback from patients previously regarding the use of their full name within the waiting room. We were told that in response to this feedback reception staff were instructed to ask patients for their first name only. However, we observed that patients were asked for their name as opposed to their first name, and five patients we saw booking in gave their full name. This was confirmed by other patients we spoke with after the appointment. One patient told us they had been asked to speak up as the receptionist had not heard them so had repeated their full name in the reception area.
- Patients attending for the HIV service were able to access the clinic which was located on the lower ground floor through a separate door if they wished. This enabled them to avoid entering through the main reception area and waiting room.
- Patients commented to us that their experience at the clinic had been a positive one. Comments included: "this is a very caring, great service with fantastic friendly and professional staff", "the welcome is nothing less than tremendous" and "excellent service, compares well to previous clinics I have attended. I have never had a bad experience here".

Understanding and involvement of patients and those close to them

- We observed patients were able to be accompanied by their partner, parent or chosen representative. Staff spoke with patients on their own and together with their representative to ensure treatment options and care were fully understood.
- Staff provided patients with written information which was also explained verbally during their appointment. One patient confirmed this had taken place during their appointment.
- There was a telephone advice line in operation five days a week. We observed a registered nurse provided information to patients in response to queries regarding their care and treatment, request for information about contraception and advice about attending a clinic. The staff were polite, friendly and showed empathy and understanding to the patients who telephoned. Patients told us they were provided with sufficient information regarding their care and treatment. One patient commented: "great advice given which was really helpful",
- Patients who used the HIV service had access to a telephone advice line and an email enquiry service. Patients we spoke with said the nurses who responded to their telephone calls and emails were "amazing" and provided an excellent service, giving them detailed and relevant information.

Emotional support

- Health advisers who were registered nurses provided support to patients in each clinic. The health advisers were able to spend time with patients discussing their care and treatment plans and prognosis.
- Negative test results were provided to patients by text if the patient had agreed to this method. However, if a patient had a positive result and required further care and treatment they were asked to attend a clinic or ring the advice line. This enabled staff to support the patient when receiving the outcome of the test and provide reassurance about the treatment required.

Are sexual health services responsive?

Good

We judged sexual health services as good for responsive because:

- The service was planned and delivered in a range of locations and at a range of times to ensure that the service was convenient and accessible for the local population.
- The facilities and premises we visited were suitable for the delivery and effectiveness of the service.
- The booking system for appointments was easy to use and supported patients to attend an appropriate clinic to meet their care and treatment needs.
- Patients were advised on how to make a complaint, were listened to and responded to and action was taken as a result of complaints and suggestions received.

Service planning and delivery to meet the needs of local people

- Clinics were held in different areas around the county to provide convenient access for patients. The service

recognised there were deprived areas, rural areas and limited public transport services for patients to attend the main clinic and so had reviewed where outlying clinics would be best held.
- A new clinic had been started in Penryn. The decision to locate the clinic there was based on staff knowledge and data which showed the Falmouth clinic was always very busy and attended well by students from the local university. The Penryn clinic provided additional clinic time within the locality.
- There were no single sex clinics or young person's clinics were held at the time of our inspection. The waiting rooms were all mixed sex.
- The sexual health services were co-located providing sexual health, contraception and HIV services to patients. There was a 'hub and spoke' model of service provision. The main service operated from The Hub on the site of Royal Cornwall Hospital, Treliske, with supporting community clinics available around the county. Not all of the community clinics were co-located and patients were informed at the time of booking of suitable clinics for them to receive their care and treatment. The service was working towards getting as many co-located clinics as possible with dual trained staff in all clinics.
- The chlamydia screening programme was not meeting the commissioner's targets. In 2014 the diagnostic indicators showed that 1844 positive screens for chlamydia had been achieved against a target of 2,300. The data for 2015 was to be produced by April 2016 but staff told us they expected the outcomes would be lower (worse). The service had been affected by a reduction of five dedicated staff. The team now consisted of two members of staff and, as a result, the service had been restructured to best utilise their skills and expertise. This had impacted negatively on the patient management standards as there were insufficient staff to provide outreach work to target patients in the age bracket 16 to 25 years, which was a target the trust was measured against. The service had a number of actions in place to increase the number of positive screens, including the recruitment of a part time promotions worker to target young people, access them through the media and train testing organisations. A poster campaign was being developed which had involved working with local college students to design posters which would be appealing to young people, in particular, young men. These were currently being printed and once received by the service were to be displayed widely across Cornwall. The staff had attended local events and groups across Cornwall with information to hand out and to speak to young people regarding the importance of testing for chlamydia. These included work places and young mums' groups. Meetings had been held with the commissioning service regarding the unmet targets.
- Patients were provided with information about the service on the trust website. Patients we spoke with were positive about the website in that it was easy to use and provided detail on clinic times and venues and directions to The Hub. The service was also advertised on the Cornwall Sexual Health and Contraception (SHAC) website. This is an externally run website providing information to patients about all of the sexual health and contraceptive services in Cornwall.

Access and flow

- We observed that signs around the hospital site did not clearly identify to patients where the sexual health services were located. There were a number of signs that referred to The Hub but it was not clear that this was the sexual health service until the building itself was reached. Two patients we spoke with said they had difficulty finding the service on their first visit.
- The reception / entrance area had four touch screen computers in place for patients to book themselves in. Staff told us that these had been installed approximately two years ago but they were not operational. This was because the electronic system used by the department was not compatible to support this technology.
- The skill mix of staff and staff roles within the department had recently been reviewed. This was to support the registered nurses and doctors with the running of the clinics and patient care and treatment and reducing the waiting time for patients. For example, band three and four health care assistants were enabled, following training, to read and report on microscopy slides. Band two health care assistants were involved in the preparation of the slides. All significant results were checked by a clinician. This reviewed skill mix of staff meant the clinics were more streamlined and efficient which reduced the waiting times for patients and the length of the clinics.
- To make an appointment at a clinic, patients rang a central booking line. This was answered by the

receptionists. The receptionists were provided with an up to date list of which clinicians were competent to carry out specific procedures, care and treatment. This meant patients were booked into appropriate clinics for their needs.

- We observed the receptionists answering the telephone booking line calls. Patients received a polite, friendly and efficient service. Appointments were provided to patients in a timely way.
- The service complied with guidelines provided by the Faculty of Sexual and Reproductive healthcare and the College of Obstetricians and Gynaecologists regarding patients' access to care and treatment times. The guidelines recommend that patients can access non-urgent information, advice or services within two working days and that treatment methods for long acting reversible contraception (LARC) are provided within two weeks of the patient's request, if medically appropriate.
- At the time of our inspection nursing staff had not completed additional training to enable them to provide some long acting reversible contraception (LARC) methods. For example, where patients required the insertion of intrauterine systems. However, we saw patients who requested this were able to be booked into a doctor/consultant led clinic for this procedure within the recommended time frames.
- On arrival in the department, patients were prompted to present to the reception desk and were asked to confirm their name and complete a registration form if they had not attended a clinic within the last month. Personal details for returning patients were checked to ensure they remained correct.
- Patients were advised if there was more than one clinic running so that they realised they may not be called in turn of arrival.
- Reception staff advised patients if the clinics were running late and when they could expect to be seen. If a clinic was running more than 30 minutes late patients were offered an alternative appointment or informed when the walk in clinics were held. Staff told us appointment only clinics generally did not run more than 30 minutes late but that patients who attended walk in clinics could wait for up to one and a half hours. We were told that the waiting times for patients who attended drop in clinics was not audited or monitored.
- Reception staff entered patients' arrival on the computer system so that the clinicians knew who had arrived and was ready to be seen. This ensured patients were seen in the correct order and were not left waiting for their appointment. Clinicians used the electronic system to identify the time the patient started and finished their consultation. The waiting times for patients attending booked clinics were audited by interrogating the data recorded on the electronic system. We reviewed the data and found that from May to December 2015 between 92 and 94% of patients were seen by a clinician within half an hour of arrival. For the same time period between 99 and 99% of patients were seen within one hour of arrival. There were a number of patients (between 50 and 100 each month) who could not be included in this data as the time they initially saw the clinician had not been identified. This did not assure us the data was accurate.
- In the event that patients did not attend a booked appointment, protocols were in place to follow up vulnerable patients and those considered to be particularly at risk if they missed their appointments. For example, telephone calls were made to patients under the age of 18 who had missed their appointments to ensure they were safe and to encourage them to attend on another date. For patients who did not attend their HIV review with a nurse or a doctor, initial contact was made by telephone to rebook the appointment. If the patients were not contactable by telephone on two occasions and did not return any message which had been left a letter was sent to them.

Meeting people's individual needs

- Facilities were mostly suitable to ensure access for people with a disability. Toilets we suitable for disabled people at The Hub and at the clinics we attended in Hayle and Penryn. Parking for disabled people was available outside the clinic at The Hub and Hayle but not at Penryn, which was located in the town centre. The main entrance to The Hub was accessed through two sets of double doors, the first of which had the option for automatic opening but the inner doors required to be manually opened. This could be difficult for patients using a wheelchair or other mobility aid. One patient we spoke with said they had mobility issues and found the walk from the main car park required them to walk up a steep slope outside of The Hub which

they found challenging. They were not always able to park outside of the building as the spaces were often full. Other patients told us the cost of car parking was expensive and cost prohibitive to them.

- Toys were available in the waiting room and baby changing facilities were located off the reception area for patients attending The Hub with children.
- Interpreter services were available for patients whose first language was not English. Staff we spoke with were positive about this service and told us that in their experience it had worked well. A telephone translation service was available which staff said was accessible and useful for consultations. Staff told us that relatives were not routinely asked to provide a translation service due to the often confidential and sensitive nature of the service.
- The chlamydia screening service had access to specific leaflets in a large number of languages to explain the importance of testing and what it entailed.
- The trust provided support to staff from a specialist learning disabilities team. Staff were able to contact the team for support and guidance when necessary and were positive in their comments regarding this service.
- Patients were asked to provide a mobile telephone number to enable the outcome of results to be texted to them. If a patient had a negative test result this was relayed by text. However, if a patient had a positive result and required further care and treatment, they were asked to attend a clinic or ring the advice line.
- The service had made contacts with difficult to reach groups of clients. For example, travelling communities, homeless people and sex workers. There were limited specific outreach services in place at the time of our inspection as the service had been unable to identify communities of people in these hard to reach groups as people were diversely spread across Cornwall. There was a fortnightly clinic specifically for homeless people which was provided in day centre in Camborne.
- Leaflets were made available within clinics and waiting rooms for patients to take regarding a range of conditions and treatment options. Some leaflets were not able to be purchased by the department and staff printed some off for patients and also gave information on relevant web sites where patients could access the information at home.
- Patient's views were sought through friends and family test questionnaires being handed out at reception.
- The service monitored their rates of partner notification. Partner notification is the process of providing access to healthcare to sexual contacts who may have been at risk of infection. The success of partner notification varied from 0.6 to 1 against a target of 0.6, for patients who attended the service.

Learning from complaints and concerns

- We were provided with the complaints log which showed the sexual health service had received two written complaints over the past year. One complaint was in relation to patient having to wait for half an hour for medicines. The other complaint was in relation to a patient's negative perception of the receptionist's attitude towards them. Action had been taken as a result of the complaints. For example, staff had been reminded about the importance of positive interactions with patients.
- We also saw evidence of the response to a patient who had been provided with incorrect test results. Whilst this patient did not wish to formally complain, they were offered this opportunity and action had been taken regarding the incident as though a complaint had been made. An investigation had taken place to establish the reason the error was made and how the risk of this reoccurring could be reduced.
- We also reviewed a log of telephone conversations which was held in the nurse and doctors office. This identified that a verbal complaint had been received from a parent of a child who attended the clinic in December 2015. We were provided with assurances by the staff that the patient's care and treatment had been delivered appropriately and the correct procedures had been followed by the staff. However, there was a lack of written evidence regarding this and the concerns raised by the parent had not been included in the complaints log.

Are sexual health services well-led?

Good

We judged sexual health services as good for well led because:

- Staff were aware of a clear vision for the service which was to become a fully integrated sexual health service. However, this was dependent on future commissioning arrangements which lay with an external organisation.
- There were clear and effective governance systems within the service and the wider trust. The service was able to identify current and future risks and the action required to address these issues.
- The culture of the service was one of openness and transparency. Staff felt respected and valued by their colleagues and their managers.

Vision and strategy for this service

- The service was aiming to become an integrated sexual health service. This model aims to provide easy access to patients, through 'one stop clinics' where the majority of sexual health and contraceptive needs can be met at one location, usually by one health professional, with extended opening hours and accessible locations. The local commissioners had advised that there would be a review of commissioning in 2017/18 and a tender application would be required to secure the future funding of the service. At the time of the inspection the service was co-located and staff were being provided with opportunities to train and upskill to provide an integrated seamless service to patients.
- Currently patients had to book appointments by telephone. The service envisaged that online booking of appointments and self-check in at the department could improve the booking service and offer greater flexibility for patients. At the current time the IT system could not support this.

Governance, risk management and quality measurement

- The sexual health services sat within the gynaecology and sexual health division within the trust.
- A weekly operations meeting was held within the sexual health services that was attended by the division general manager, senior nurse, medical staff and the administration manager. This meeting provided the opportunity to discuss issues, concerns and to share information from the wider trust. Action points were taken from this meeting and the minutes identified who was responsible for following these up.
- The sexual health service held monthly governance meetings of which minutes were maintained. We reviewed the minutes for the past three monthly governance meetings. The minutes showed issues relating to performance, reported incidents and complaints were discussed and addressed.
- The divisional board held a monthly governance meeting at which issues identified from the sexual health service meetings were discussed and appropriate action and escalation taken as necessary.
- The service manager attended senior nurse meetings within the division which enabled risk management discussions and issues to be raised.
- The service maintained a risk register which identified risks rated low, moderate or high. The risk register identified a date each risk was due to be reviewed and the action which had been taken to reduce each risk. The risk register was reviewed at the divisional governance meeting where the decision was made if it was necessary to escalate the risk to the trust board.

Leadership of service

- Staff were positive about the local leadership of the sexual health service. All of the staff were fully aware of who their line manager was and the management structure within the service. All staff we spoke with said they would be able to raise issues with the senior staff in the department and were confident they would be listened to and action taken to address concerns. Staff commented that the matron, who they found friendly and approachable, often visited the department.
- Senior staff were aware of the management arrangements within the division and felt supported by the divisional general manager. Not all staff had met the divisional general manager but knew who they were.
- Staff were not as clear regarding the operation of the wider trust and the role of the hospital executive team. The acting chief executive had planned to attend a staff meeting but this meeting had been postponed by the service but was to be rearranged.

Culture within the service

- Staff informed us the service was a friendly and supportive environment to work within and that all members of the staff team were approachable. The service provided a learning environment for trainee GPs and junior doctors. Those we spoke with were positive about their experience and told us the service was well regarded and recommended by their colleagues who had previously worked there.

- Three members of staff told us they had applied for jobs as they liked the ethos of the team and believed that patients were provided with an excellent service.

Public engagement

- The service valued feedback from patients. We heard that the waiting room had been rearranged as a result of feedback from one patient where they did not felt that the environment was not conducive to the exchange of confidential Information. Changes had included the use of screens, layout of the chairs and introduction of a television and radio.
- Patients were encouraged to complete friends and family test surveys when attending the service. The completed surveys were monitored and Staff told us the most common issues raised were parking difficulties and expense, lack of refreshments in The Hub area and signage around the hospital site.

Staff engagement

- A whole team staff meeting took place once a month and was used as an opportunity to share and receive information from the team.
- Single discipline (role-specific) meetings took place once a month and we saw minutes from the nursing staff meetings and the doctors' meetings.
- The service had undergone a period of change and reconfiguration to become a co-located service. This meant that contraception, sexual health and HIV services were provided from the same premises to provide patients with a seamless service between the specialities. Another period of change was due to take place to develop into an integrated service which would enable patients to see one practitioner/clinician for all their care and treatment needs. Staff were fully aware of these plans and had been consulted regarding the proposed changes.
- Information was cascaded to the staff from the wider trust in a number of ways. A daily email from the trust board was sent to all staff each day. Staff confirmed they received this, although a number said they did not always get the opportunity to read their emails due to time constraints. Following the senior nurse meetings a team brief was cascaded to the staff at their team meetings verbally and also by email. Any information which was required to be shared urgently was presented to staff during the clinical meeting which was held each morning prior to the start of clinics.

Innovation, improvement and sustainability

- Staff were proud to have been instrumental in setting up the South West HIV network. This network provided a dedicated on call HIV consultant rota to provide guidance and support to professionals caring for HIV patients at all times.
- The chlamydia screening team included innovative methods to publicise the importance of testing for chlamydia. They were aware of which groups of patients they needed to target and had previously publicised their service on a music streaming facility. Streaming means listening to music in 'real time', instead of downloading a file to your computer and listening later. This method of listening to music is growing in demand and particularly popular with young people. Currently they were engaged in working with local students to design a number of posters which would appeal to young people, in particular, young men. Work had taken place to identify where these would be best placed across Cornwall.
- The sexual health service had been awarded the trust's 'extra mile innovation award' for good team working in 2013/14. The awards were to highlight and celebrate individual and team achievements.

Outstanding practice and areas for improvement

Outstanding practice

- Kerensa ward had been appropriately designed to provide a safe and suitable environment for patients living with dementia.
- Advanced nurse practitioners in acute oncology provided an effective 24 hour telephone advisory service for patients receiving chemotherapy treatment. There was an established pathway for patients with suspected neutropenic sepsis, who were seen promptly by an advanced nurse practitioner in the Acute Admissions Unit or the Ambulatory Emergency Care Unit.
- A system of escalating concerns had been introduced, comprising communication prompts which were used to alert clinician colleagues of concerns which required immediate attention. SBAR - Situation, Background Assessment, Recommendation is a nationally recognised communication tool. This had been adapted to include 'Decision'. SBAR-D information was recorded on bright yellow 'escalation of care' labels, which were affixed in patients' notes.
- Surgical services had a compassionate and caring approach to people with a learning disability. There was a team of experienced staff to support people with different needs, and an innovative approach to meeting their needs, which included carrying out procedures at home if this was safe.
- There was an outstanding example of individualised and multi-professional care for a patient who had been in the unit for 10 months. The critical care team, the ambulance crew, the family and community teams were all instrumental in enabling the patient to go home safely. A member of the team arranged what was described as a "huge meeting with all the people who needed to be there to formalise [the patient's] discharge." There had been the arrangement of two visits home for the patient to build their confidence before the permanent move.
- The medical simulation training program training provided to obstetrics and gynaecology services (and other specialties) was outstanding. Training was provided every month and could be arranged on any of the obstetric clinical environments, or within a dedicated simulation suite. There was an emphasis on learning through the debriefing sessions that immediately followed simulation sessions. Staff feedback was consistently positive stating it enhanced team working, learning and confidence.
- Training programmes for staff on the paediatric units which involves allied health professionals and the regular use of simulation training. A programme of training was organised for clinical staff and allied health professionals to take part in. This involved multi professional meetings with specialist speakers, reviewing cases to share any learning points and a programme of using simulation training on a fortnightly basis. The simulation training was shared across the hospital and alternated between neonatal and paediatric scenarios. The scenario was videoed for future reference and sharing with colleagues who were unable to attend. Discussion and critique was a valuable part of the process and staff valued these opportunities to improve their skills without patient risk.
- Processes to engage with patients and the wider community such as the use of Facebook for surveys, using schools to consult with how children would like to see the service improve, using a form of real time feedback and responding to comments. There was a trial where medical and nursing students consulted with patients and families and fed back results to staff immediately. Staff said they had found this motivating and could deal with issues as they occurred.
- The interventional radiology team had won an innovation award for their success with the vascular access service. The vascular nurses used an ultrasound scanner to guide venous access for patients who were difficult to cannulate. They had extended this service to provide assistance to other teams within the trust where arterial access was difficult to achieve. The British Society of Interventional Radiology had awarded the interventional radiology department 'exemplar' status following an inspection in April 2015

Outstanding practice and areas for improvement

- In the fracture clinic, a quick response code that could be read by personal mobile phones was attached to patients plaster casts that when scanned, provided information specific to the individual regarding their plaster care.

Areas for improvement

Action the hospital MUST take to improve

- Ensure all patients are clinically assessed by a competent member of staff within fifteen minutes of arrival in the emergency department.
- Ensure deteriorating patients are recognised and treated quickly and are monitored effectively in the emergency department.
- Ensure staff are trained to recognise sepsis and that sepsis guidelines are followed in the emergency department.
- Ensure patients presenting to the emergency department are not re-directed to primary care services before being assessed by a competent member of clinical staff.
- Ensure there are systems in place to prevent repeat doses of medicines being given in error in the emergency department.
- Ensure patients' pain is assessed on arrival in the emergency department, treated quickly and re-assessed regularly.
- Ensure there are systems in place to prevent repeat doses of medicines being given in error in the emergency department.
- Ensure systems and process for quality monitoring and governance in the emergency department operate effectively to identify risk.Results from clinical audits must be reviewed and lead to changes in practice to improve patient safety. Performance data must be collected and discussed at relevant governance meetings.
- Take action to improve substantive staffing levels across the clinical divisions and reduce reliance on temporary staff who may not be suitably skilled or experienced. This will reduce the risk that patients' care and treatment is delayed or compromised. Also ensure nursing staff levels enable managerial staff to fulfil their responsibilities.
- Strengthen the nursing levels and reduce the number of agency staff used in critical care to reduce pressure on substantive staff. Alongside this, ensure there are full time managerial supernumerary roles, including the role of the clinical nurse educator, in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards.
- Must ensure there are sufficient numbers of medical staff in obstetrics and gynaecology and the emergency department to provide care and treatment to patients in line with national guidance.
- Ensure there are sufficient staff in the clinical decision unit and children's emergency department.
- Take action to ensure that all staff are supported and enabled to undertake regular mandatory and professional training.
- Ensure staff working with children in the outpatients and diagnostic services are adequately trained in safeguarding children level three as recommended by the intercollegiate guidelines published by the Royal College of Paediatrics and Child Health in March 2014.
- Ensure that staff receive regular supervision and performance appraisal in all divisions.
- Ensure that staff who set up syringe driving equipment are appropriately trained.
- Ensure that medical patients are admitted to the most appropriate specialty ward, according to their clinical needs. This should include the review of the outlier policy and the consistent application of bed

management and escalation policies and processes designed to ensure that stroke and cardiology patients receive prompt and appropriate care and treatment.

- Take immediate steps to ensure that the backlog of patients awaiting cardiology procedures is eradicated.
- Continue to take steps to reduce the incidence of avoidable harm as a result of falls.
- Provide care and therapy to patients to enable them to receive an enhanced recovery from orthopaedic surgery.
- Improve bed management for elective surgery patients to ensure it is meeting the needs of all patients needing surgery in a timely, safe and responsive way.
- Ensure all patients whose surgery is unavoidably cancelled are treated within 28 days of their cancellation.
- Ensure the access and flow of patients in the rest of the hospital reduces delays from critical care for patients admitted to wards. Reduce the risks of this situation not enabling admission of patients when they need to be, or being discharged too early in their care. Reduce the unacceptable number of patient discharges at night. Ensure staffing levels safely support all commissioned beds. Reduce occupancy levels in critical care to recommended levels.
- Ensure that all patient's personalised end of life wishes are discussed and recorded. This should include their preferred place of dying and any spiritual needs. They should ensure that a patients unmet emotional needs are identified and discussions with patients and relatives around end of life wishes are appropriately recorded.
- Take further action to reduce the number of clinics that are cancelled for avoidable reasons
- Ensure critical care staff have sufficient understanding of the Deprivation of Liberty Safeguards so practice meets both the law in this regard and trust policy.
- Must take effective action to transform how midwives are supported and embed an open, honest, transparent culture across the maternity services.
- Ensure that patients considered to be need of end of life care have the designated documentation completed.
- Ensure that Do Not Attempt Coronary Pulmonary Resuscitation part of the Treatment Escalation Plan is completed when required and is signed by the appropriate person and that assessments about patients mental capacity are completed when required and that the reasons for the decisions are accurately recorded.
- Ensure that patient records are stored securely. Patient confidentiality must be maintained in accordance with the Data Protection Act
- Ensure the effectiveness of the blood isolators used in nuclear medicine are monitored and that this equipment is maintained.
- Ensure that the environments where diagnostic testing takes place are adequately maintained so as to enable adequate decontamination to occur.
- Ensure the outpatient improvement board is effective in addressing the challenges to ensure patients have timely access to first and follow up outpatient clinics for all specialities and that clinics are run and booked so as to reduce cancellations.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Ensure action plans following serious incidents occurring in the emergency department are monitored to ensure their effectiveness
- Ensure nursing staff have access to patient group directions in the emergency department
- Ensure there are sufficient consultant emergency medicine doctors
- Ensure immediate access to major incident equipment in the emergency department
- Ensure regular checks take place in the emergency department so that patients are comfortable, hydrated and adequately nourished,

Outstanding practice and areas for improvement

- Ensure effective escalation processes when the hospital is approaching full capacity
- Ensure a cohesive leadership team which is focussed on the needs of patients and staff in the emergency department
- Continue to monitor and improve compliance with systems designed to ensure that premises, equipment and medicines are maintained and used in a safe way.
- Continue to monitor and improve compliance with record keeping standards.
- Consider whether the operational capacity and the range of care and treatment provided by the ambulatory emergency care unit can be increased to support admission avoidance.
- Continue to work with partners in the wider health and social care community to reduce the number of delayed transfers of care.
- Continue to work with staff to encourage efficient discharge processes occur to facilitate patient flow seven days a week.
- Ensure feedback and learning from complaints is available for all levels and grades of staff
- Engage staff in developing a strategy and objectives which drive quality and improvement in the medical division.
- Work with specialties within the medical division to ensure that relationships with acute medicine are cooperative and supportive particularly where patients in MAU require decisions on transfer to other wards.
- Improve mortality reviews within surgery and critical care services so they demonstrate the implementation of actions, their monitoring, and lead to improvements in patient care.
- Ensure the cleaning of the floors is carried out to an acceptable standard at all times (particularly in the Surgical Assessment Unit) taking account of the raised levels of activity in some areas.
- Have all staff follow infection prevention and control protocols at all times and be bare below the elbow when in clinical areas.
- Review the cleaning checklists in surgery wards to ensure they have some meaning and used for their intended purpose.
- Relocate the flammable product cupboard away from a patient waiting area in the Tower Block theatres.
- Improve antibiotic stewardship on surgery wards to become compliant with the management of these medicines at all times.
- Ensure any patient records or information is confidential at all times on surgery wards and units.
- Be compliant with the use of the National Early Warning Score system on all surgery wards.
- Review elective readmission rates for surgical specialties so staff understand and report within governance how and why they exceed national averages. There should be plans developed to bring them in line with national averages.
- Ensure surgical services recognises and takes action to comply with the standards for emergency laparotomy surgery.
- Ensure there is an effective pain tool available to ward staff and used to help with patients who are not able to articulate how they are feeling.
- Review the competency training for newly recruited staff to ensure they are fast-tracked and able to use the skills they have brought with them.
- Ensure patients are not being accommodated in the corridor in chairs in the evening due to a lack of a bed after the closure of the Surgical Receiving Unit.
- Improve the use of the mental capacity assessments and associated forms used on surgery wards to capture consent decisions are in line with trust policy. All patients subject to a Deprivation of Liberty Safeguards' authorisation should have a care plan.
- Ensure there are enough pillows in the recovery areas at all times.
- Improve the trust website to ensure people can get access to appropriate helpful information online.
- Produce a strategic plan for surgery services showing how it will achieve its objectives.

Outstanding practice and areas for improvement

- Review the risk register in surgery services to ensure action plans are delivering the intended changes. The service should ensure actions are realistic to achieve objectives.
- Ensure staff are clear about what constitutes a reportable incident, and these should be reported at all times. Make improvements to the incident management system so critical care incidents can be categorised, graded and able to be analysed at local level to determine proactively any risks or developing trends.
- Return to displaying results on avoidable patient harm within the critical care unit.
- Ensure security of trolleys for resuscitation equipment in critical care to highlight if, between daily checks, they had been opened, used, or tampered with.
- Review critical care discharge paperwork to provide ward staff with a comprehensive uncomplicated summary that meets the requirements of NICE Guidance 50.
- Review and risk-assess the provision of the critical care outreach team service which was not being provided, as recommended in best-practice, for 24 hours a day.
- Ensure allied health professional staff are used or employed to meet the needs of patients at all times.
- Review all procedures and protocols within critical care so they are up-to-date and reflect current and best practice.
- Routinely screen for delirium for patients admitted to critical care.
- Revisit the National Confidential Enquiry for Patient Outcome and Death 'On the right Trach': A review of the care received by patients who underwent a tracheostomy (2014). This should include a review of skills and experience of other wards in the hospital for supporting patients with a tracheostomy.
- Ensure there is a review of equipment competence for nursing staff in critical care and training of approved numbers of staff.
- Provide clarity around the use of restraint for critical care staff.
- Review bereavement information in critical care services and look to improve the support provided to people faced with the death or a relative or friend on the unit.
- Look to provide an assessment for patients in critical care for any poor psychological outcomes or acute psychological symptoms, and provide support in line with National Institute for Care Excellence (NICE) guidance CG83. Provide patients with rehabilitation regimes when they leave the unit, in line with this guidance.
- Ensure critical care strategies and future plans are part of the overarching vision of the surgery, theatres and anaesthetics division.
- Review the risk register in critical care to ensure action plans are used to effectively deliver intended changes. Undertake audits of the physical environment under the Department of Health Building Note HBN04-02 2013 and include any shortcomings in the risk register. Include any gaps emerging from the audit of the service under the Faculty of Intensive Care Medicine Core Standards in the risk register.
- Ensure there is an effective review of acts of violence and aggression committed on critical care staff to look for learning and ways to prevent future occurrences.
- Look to return to regular unit or team meetings within critical care
- Should ensure all serious incidents identified prior to the newly revised monitoring system have evidenced that all necessary actions and learning has been completed.
- Should promote the use of antibacterial hand sanitiser on ward and clinical areas to prevent the risk of spreading infections.
- Should ensure the privacy of patients at all times on the ante natal ward (Wheal Fortune) at all times.
- Should ensure the delivery trolley is stored safely on the ante natal ward at all times.

Outstanding practice and areas for improvement

- Should ensure all necessary daily safety checks of required of resuscitation equipment in the maternity and gynaecology service is completed.
- Should ensure there is a range of supplementary equipment available to support pain and labour.
- Should ensure the community midwifery teams have local base rooms at all times in order to provide services to meet the needs of women living throughout the wide geographical area covered by the trust.
- Should ensure there is sufficient safe storage in the community for nitrous oxide.
- Should ensure any vehicle used to transport nitrous oxide has safety notifications in the event the vehicle is involved in an accident.
- Should review if the older and non-standard resuscitaire on the ante natal ward remains appropriate for use.
- Should review the storage of the resuscitaire on the ante natal ward so that it is easily accessible in the event of an emergency.
- Should ensure systems are followed to ensure medicines are not stocked for use beyond the stated dates.
- Should ensure there are beds available on the gynaecology ward for emergency gynaecology admissions.
- Should ensure all policies and guidelines are updated appropriately.
- Should ensure there is ongoing evidence of compliance with the WHO surgical checklist within the obstetric theatres.
- Should ensure the minimum standards in the National Neonatal Audit programme (NNAP) are met for women who require antenatal steroids as a result of premature birth.
- Should ensure all gynaecology cancer patients receive appointments in line with national standards.
- Should prevent the cancelation of elective gynaecology admissions and prevent gynaecology patients being admitted to other specialty wards.
- Ensure there are the correct protocols, guidance and a policy in place for the use of syringe driving equipment and that all staff receive updates on this.
- Ensure that all wards that require syringe driving equipment can access this without undue delay
- Ensure that all staff have training around end of life care, including training on the TEP form and the Symptom Observation Chart.
- Review the current provision of palliative care medical cover and consider whether it would be appropriate to increase this in line with national guidance.
- Ensure that the medical cover arrangements for palliative care are robust and clearly understood throughout the hospital.
- Ensure there is guidance and a policy in place for starting a patient on a symptom observation chart.
- Ensure there is a consistent approach for making referrals to the palliative care team.
- Provide training for nursing staff in the use of a pain management tool.
- Ensure that staff designated as the ward end of life link nurse have received training in end of life care.
- Ensure that nutritional and hydration assessments for patients are completed consistently and are routinely monitored.
- Ensure that all wards are aware of how to access portable beds to accommodate the relatives of end of life patients and review its provision of facilities and accommodation for relatives of end of life patients to ensure a consistent approach from staff.
- Audit the number of patients who achieve their preferred place of dying.
- Ensure that the pastoral care service is more pro-active in ensuring that all end of life patients have the opportunity of receiving support from the chaplains or volunteers.

Outstanding practice and areas for improvement

- Engage more with bereaved families to gain feedback on their experience.
- Ensure that the End of Life Care group is fully supported by senior staff and the board and is quorate in order to be effective. That the governance arrangements for end of life care laid out in the strategy are in place and the required reporting completed.
- Ensure that the layout of the blood labelling facilities in the nuclear medicine department to is arranged to minimise risk of contamination
- Ensure that soft furnishings, such as waiting room chairs, in outpatient clinics can be easily and adequately cleaned and decontaminated
- Ensure that 'local rules' include reference to the requirement for staff to restrict access to areas where radiation exposure takes place. Staff to adhere to this requirement wherever practicable
- Ensure that staff are provided with opportunities for protected one to one time with their supervisor
- Ensure that patients in outpatients are routinely provided with a copies of correspondence written about them
- Ensure that membership of the radiation protection committee includes representation from the executive team and from 'shop floor' clinical staff
- Ensure FP10 prescription pad records are specific to individual pads in outpatient areas.
- Should raise awareness amongst staff of the 'flagging' system to identify additional needs of patients attending the outpatients and diagnostics services
- Address the delays for initial outpatient appointments in some specialist therapy services such as women's health physiotherapy and paediatric musculoskeletal therapy.
- Ensure that the environments where staff work and carry out testing are fit for purpose, in particular this recommendation refers to the accommodation of the nuclear physics team
- Ensure information systems provide adequate data to inform and improve management of outpatient clinics
- Ensure there is an audit trail of the medicines which have been taken out of The Hub by staff and returned if unused at the clinic.
- Ensure staff in sexual health services are provided with appropriate protective clothing in accordance with the trust policy and procedure when dealing with canisters of medicinal gases from the main externally stored supply.
- Review the separate electronic patient record systems used by the chlamydia screening staff and the sexual health staff to record patient information to reduce the risk of important information being missed at future appointments.
- Review the way in which patients attending sexual health services are welcomed to reception and asked their name in order to protect their confidentiality.
- Review the action plan in place to support the chlamydia screening programme trajectory targets being met.
- Ensure signage around the hospital is clear in assisting patients in finding their way to The Hub.
- Review the main entrance to The Hub so it is fully accessible to patients with some disabilities.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** Staffing 18 (1) The provider had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed to meet the requirements of the fundamental standards. There were not always sufficient numbers of suitably qualified, skilled and experienced nursing staff in a number of areas including: Arrangements for the deployment of temporary staff in the medical division did not prove assurance that these staff were suitably skilled or experienced. The high level of nursing vacancies in critical care meant the supervisory nursing staff were not able to fulfil their managerial responsibilities at all times due to providing front-line care to patients. There were not always sufficient numbers of suitably qualified, skilled and experienced nursing staff in the emergency department in the children's and clinical decision unit.

This section is primarily information for the provider

Requirement notices

There were not sufficient numbers of medical staff in obstetrics and gynaecology and the emergency department to provide care and treatment to patients in line with national guidance.

There were too many temporary staff used to fill gaps in shifts, which added pressure to the substantive staff team.

18(2) Persons employed by the service provider in the provision of a regulated activity must –

(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The high level of nursing vacancies on surgery wards meant the supervisory nursing staff were not able to fulfil their managerial responsibilities at all times due to providing front-line care to patients.

Compliance with mandatory training was variable in many areas.

There was a lack of assurance that nursing staff had sufficient opportunities for clinical supervision, education or professional development.

Non-medical staff in surgery services had not met the trust targets for being provided with an annual performance appraisal.

Staff were setting up and operating syringe driving equipment without completing appropriate training.

Staff in the emergency department were not always competent to assess patients prior to referral to primary care services.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care 9(1)(a)(b) The provider had not taken adequate steps to provide appropriate care and treatment meet their needs Medical patients were not always admitted to the most appropriate specialty ward, according to their clinical needs. Cardiology and stroke patient did not always receive prompt and appropriate care and treatment because of the unavailability of specialist beds. Patients' cardiac investigations were cancelled at short notice, sometimes more than once, because of the unavailability of specialist beds. Due to poor patient access and flow, and demand for services leading to medical patients being accommodated in surgical wards, there was regular cancellation of surgery. Too many patients who had their surgery cancelled were not being re-booked within 28 days. Patients were remaining too long in recovery at times, some of whom required critical care admission. Some patients were being transferred to another area of the hospital when the recovery areas were full or needed a bed. Not all patients were able to receive critical care following their surgery due to a lack of beds in that service.

This section is primarily information for the provider

Requirement notices

Surgery services were not providing timely care and therapy to post-orthopaedic surgery patients to enhance their recovery.

Due to bed pressures, patients in the critical care service were not discharged in a timely way from the unit onto wards when they were ready to leave. Patients were also discharged too often at night and the occupancy in the unit exceeded recommended levels too often. Patients were prevented from accessing critical care due to a lack of beds. Elective surgery was regularly cancelled.

Take further action to reduce the number of clinics that are cancelled for avoidable reasons.

9(3)(a)

The provider did not ensure that patients were involved in an assessment of their needs and preferences

Patients in the emergency department did not always have their pain assessed on arrival, treated quickly and re-assessed regularly.

End of life patients did not have personalised care and treatment plans in place and their involvement in these discussions was not sufficiently recorded.

Information was not fully completed for patients considered for do not resuscitate assessments in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 13 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment. 13(5) A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Critical care staff were not following practice around the Derivation of Liberty Safeguards in accordance with the law in that regard, or the trust's policy.
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 1 and 2) Good governance 17(2)(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. In the emergency department Governance and quality monitoring processes did not operate effectively to identify risk. Poor results from clinical audits did not always result in a change in practice that improved patient safety. Performance data was collected and discussed at consultants' meetings but not at governance meetings.

This section is primarily information for the provider

Requirement notices

17(2)(c)

End of life patient care was not recorded consistently in a manner to ensure safety.

Assessments were not fully completed or recorded about patients mental capacity.

Patient records were not stored securely in outpatient departments. We saw evidence of this in all of the clinics we visited except for one. Patients medical records and other patient identifiable data were left unattended in unlocked rooms and on trolleys in corridors that were accessible to the public.

There had been no improvements following audits in 2011, 2013 and 2015 of the standard of documentation of consent.

17 2 (e)

The provider had not taken appropriate steps to ensure that systems and processes operated effectively to ensure compliance with the regulations in the Part. Such systems and processes must enable the registered person, in particular to- Seek and act on feedback from relevant persons on the service provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

Whilst systems were in place to seek and act on staff feedback, these were not effective in the maternity and gynaecology services. Staff remained feeling worried and anxious with regard to raising any concerns due to a lack of appropriate support

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

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

Regulation 12 HSCA 2008 (regulated activities) Regulations 2014 Safe Care and Treatment

12(2 (a) (b)

Assessing the risks to the health and safety of service users of receiving the care or treatment. Doing all that is reasonably practicable to mitigate risk.

Not all patients in were clinically assessed by a competent member of staff within fifteen minutes of arrival in the emergency department.

Deteriorating patients in the emergency department were not always recognised and treated quickly and monitored effectively in the emergency.

Staff in the emergency department did not always recognise sepsis and follow the sepsis guidelines.

Systems in place in the emergency department did not protect patients from the risk of repeat doses of medicine being given in error. This was due to both paper and electronic systems both being operational and not all staff having access to the electronic system.

12 (2) (e)

The safety of some equipment used by the provider for care and treatment was not assured. The white cell labelling isolator in the nuclear medicine department was due to be serviced in November 2015, but this had not occurred. A service had been scheduled for February 2016. Without regular servicing, the effectiveness of this machine could not be guaranteed, and there was no quality assurance in place for this isolator. We were told that the trust had not completed leak tests for the blood

Requirement notices

labelling isolators. There was a risk that the blood isolator may not have been working to manufacturers specifications because the room where it was situated did not conform to guidelines that recommend a positive pressure environment. This resulted in a risk of contamination of the blood sample and radiation exposure to staff.

Regulation 12 (2) (d)

All facilities where staff are using unsealed radioactive sources should have sealed walls and floors to enable effective decontamination if a spillage or spray of radioactive material occurs. The bubbling plaster wall in the nuclear medicine department posed a risk of radionuclide being absorbed and decontamination being ineffective

This section is primarily information for the provider

Enforcement actions

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.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...