Care Quality Commission

Royal Cornwall Hospitals NHS Trust

Royal Cornwall Hospital

Quality Report

Royal Cornwall Hospital
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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	Inadequate
Surgery	Inadequate
Critical care	Good
Maternity and gynaecology	Inadequate
Services for children and young people	Good
End of life care	Inadequate
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Cornwall Hospitals NHS Trust is the principal provider of acute care services in the county of Cornwall. The Trust is not a Foundation Trust and performance is monitored by NHS Improvement (NHSI). The Trust serves a population of around 532,273 people, a figure that can be doubled by holidaymakers during the busiest times of the year.

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

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A further unannounced focused inspection was conducted on 4 and 5 January 2017. We reviewed end of life and urgent care services to review progress against the inadequate ratings for those core services as identified on the previous inspection in January 2016. We reviewed medicine services as continued intelligence had raised concerns with regards to quality and safety of the service. We also looked at the governance and risk management support for the services we inspected. We rated urgent care services as requires improvement, end of life care services and medicine services as inadequate. We did not rate the trust overall as a result of that inspection.

This inspection took place between 4 - 7 July 2017, and was a focused announced inspection. We undertook a further unannounced inspection on 17 and 18 July 2017. We revisited those core services that we had not inspected in January 2017, with the exception of sexual health. We did not revisit medicine or urgent care services, but we did revisit the safe and well led domains in end of life care. We also inspected governance and risk management support for those services we inspected.

This inspection also covered the following sites:

- St Michaels Hospital (for surgery and outpatients and diagnostic imaging)
- West Cornwall hospital (for surgery and outpatients and diagnostic imaging)
- Penrice birthing unit (for maternity)

We had serious concerns that systems to assess, monitor, and mitigate risks to patients receiving care and treatment were not operating effectively. We also had concerns that governance systems and processes were not operating effectively. We served the trust with a Section 29A warning notice on 29 August 2017. The notice required the trust to make significant improvements by 30 November 2017. There were, however, a number of areas where the trust were required to give evidence of immediate action to ensure risks were being identified and managed in the interim. These included processes being in place for identifying and managing deteriorating women in maternity and systems and processes being in place to monitor and manage non-admitted cardiology and ophthalmology patients. Additionally the trust were required to provide evidence that there were two paediatric trained staff on duty at all times in the paediatric emergency department and that a risk assessment had been completed for paediatric staffing in the emergency department and obstetric theatres.

Summary of findings

We rated Royal Cornwall Hospitals NHS Trust as inadequate overall. Surgery, maternity and gynaecology, end of life and outpatient services were rated as inadequate and critical care and children and young people's services were rated as good. These ratings have been aggregated with the findings from the core services we inspected in January 2017.

Key findings:

Safe:

- We rated safety as inadequate overall. Surgery, maternity and gynaecology and outpatients and diagnostic imaging were rated as inadequate, services for children and young people and end of life care were rated as requires improvement, and critical care was rated as good.
- When concerns were raised in surgery or things went wrong, the approach to reviewing and investigating causes was unsatisfactory or too slow. There was little evidence of learning from events or action taken to improve safety. When something went wrong, patients or those close to them were not always told and did not always receive an apology.
- The systems and processes for identifying, grading and managing incidents were not effective and were not conducted in a timely manner.
- The threshold for incident reporting was high so not all incidents were reported. This was true in both maternity and gynaecology.
- There was no evidence of oversight or scrutiny of incidents that related to end of life care at the trust. Therefore, there was no evidence of learning or changes in practice that had resulted from such incidents.
- There was not a clear incident reporting process for staff to follow in the event of a delayed fast track discharge in end of life care. There was also no evidence of executive oversight of the problem caused by inconsistent reporting, and a lack of anyone with clear responsibility for the issue.
- Incidents were not always reported promptly for outpatients. This impacted investigation timeliness and delayed potential learning opportunities.
- Safety was not a sufficient priority. There was limited measurement and monitoring of safety performance. There were significant numbers of serious incidents or never events in surgery.
- Staff did not always assess, monitor or manage risks to patients. Some opportunities to prevent or minimise harm were missed in surgery.
- Changes were made to surgical services without due regard for the impact on patient safety. There were inadequate plans to assess and manage risks associated with anticipated future events or emergencies in both surgery and maternity.
- Not all patients with severe sepsis had timely access to intravenous antibiotics.
- Guidance for midwives in critical areas such as escalation of deteriorating women was sometimes conflicting. For example, the escalation instructions on MEOWS charts did not align with the guidance on the policy on managing the severely ill obstetric woman.
- There was no dedicated high dependency area for deteriorating women and no process to ensure that that there was always a nurse or midwife on duty with the necessary competencies to manage high dependency women. The service did not monitor the number of women needing this level of care.
- One theatre on the delivery suite had dedicated staffing. The contingency plans for using the second theatre in an adjoining room were not clearly understood and an additional theatre team was not readily available, which could result in delays and potentially a risk to women and babies. The process for opening and staffing the second theatre were not well communicated and practiced.
- Risk assessment was poor at all levels. We saw inconsistent use of maternal early warning score (MEOWS) charts and partograms (a composite graphical record of key maternal and foetal data during labour) meant there was a risk that staff might miss signs of deterioration in a woman; on the postnatal ward emergency medicines had been taken off the ward because of the heat, without assessing the risk of doing this, should there be an emergency. Some risks such as staffing were not on the corporate risk register.

Summary of findings

- Other risks had not been identified or monitored, for example skills required of community midwives lone working in remote locations, suitability of the second obstetric theatre and staffing levels in the emergency paediatric department.
- The delivery suite capacity was insufficient for the number of women giving birth with the result that women laboured on the antenatal ward several times a month, often without one-to -one care from a midwife for the whole of their established labour.
- More women than the agreed number were being induced on some days, and these inductions were not planned to take into account activity or capacity on the delivery suite to ensure that induction was safe.
- Ophthalmology and cardiology follow up appointment waiting lists were too long and patients were coming to harm through delays in treatment. The process for risk assessment was not sufficient to adequately protect patients from harm and there were no clear action plans to manage and reduce the backlogs.
- There was a significant backlog in reviewing some cardiology 24 hour tapes which put patients at risk.
- Patient identifiable information, including the results of pregnancy tests, was found in two unlocked sluice rooms on a surgical ward. Other patient identifiable information was found unattended and accessible to the public.
- The different records about women in the maternity service were not linked. Women's hand held records and hospital records, and safeguarding information were held on a separate database which made it difficult for midwives to have an overview of women's health and social history.
- There was not sufficient information or audit for the trust to be assured of the effective use of end of life care documentation. Audits did not address the quality or completeness with which the documentation was completed or understood, and did not contain any follow up action plans to address the issues raised.
- Paper based patient records, including test results in outpatients were not stored securely.
- Due to a different system in operation, the critical care unit did not use the electronic prescription charts used throughout the rest of the hospital. There had been some safety issues for patients discharged from the unit due to staff not always following the correct handover processes for medicines for the patient prior to their discharge.
- Not all staff in the surgery division had received effective mandatory training in the safety systems, processes and practices.
- Multiple mandatory training modules had not been completed by medical staff and therefore did not meet trust targets.
- We could not be assured that community midwives had up to date skills. They did not have training to cannulate women, and not all were up to date with neonatal life support training. We could not be assured that community midwives had the necessary equipment to manage obstetric or neonatal emergencies in the community in the event that the ambulance was delayed.
- Midwives required training and competency assessments in providing epidural top ups, in and in care of high dependency women. The overall 85% target set for training completion in maternity was lower than trust target for training completion of 95%.
- Completion of some mandatory training was also below trust target for staff in children and young people's services and required improvement.
- Although safeguarding training compliance had improved in services for children and young people it remained a challenge and required continued improvement.
- The emergency resuscitation team did not always have immediate access to a member of staff who was able to deal with difficult airway intubation in surgery.
- The service did not always ensure there was adherence to the World Health Organisation (WHO) surgical safety checklist and audits of the checklist did not provide assurance of compliance.
- Some equipment in surgery was not serviced, maintained, tested or calibrated.
- During our inspection, we noticed the critical care unit was not completely free of dust.
- Checks were carried out on the difficult airway trolley in critical care but were not permanently recorded.
- There were insufficient waste bins on the critical care unit which increased the risk of contamination.

Summary of findings

- The antenatal ward was not secure. Open access to the Day Assessment Unit (DAU) which was combined with the antenatal ward was a safeguarding risk to women on the ward. There was also a risk to women's privacy and dignity. These risks were not on the risk register.
- There were environmental risks on the hospital site: the delivery suite had cracked flooring and worn baths which presented an infection risk and the postnatal ward was uncomfortably hot in summer, with trip risks from fans in corridors, and reported problems with drainage and insects. The ambient temperature of rooms where medicines were stored was not always measured.
- There was no clear nursing observation area on the high dependency unit of the children's ward and this represented a risk to children who were not visible to nursing staff at all times.
- The fracture clinic was a risk to patients due its design, unregulated clinic temperature and poorly maintained furnishings. Arrangements to ensure children were safeguarded whilst in the department were not adequate.
- Staffing levels in surgery were consistently under plan on most wards during the day.
- Safety briefings did not always take place prior to the start of an operation or theatre list.
- There were not enough midwives to provide a safe service in all areas at all times. Staff had to activate the escalation policy frequently to achieve safe staffing in the delivery unit. Staffing concerns were not on the risk register.
- Safe skill mix in maternity was not always achieved. There was no system to ensure that there was always a midwife or nurse on the delivery suite with skills in caring for a woman needing high dependency care.
- The handovers on the delivery suite were not multidisciplinary; there were multiple handovers several times a day, midwives to midwives and doctors to doctors at different times which were inefficient. Handovers did not clearly highlight risks. There were no safety briefs occurring in the maternity service.
- There had been gaps in gynaecology on call cover which was a risk to women.
- There were insufficient numbers of suitably qualified nursing staff in the paediatric emergency department to provide safe care at all times. There were also no formal processes in place to ensure appropriate cover was in place in the department at all times, particularly during periods when the qualified nurse was temporarily absent from the department.
- The specialist palliative care team was too small to meet the demands of the trust as per national guidance. It was only able to provide a five day a week service, and even this stretched capacity of the team with limited cover arrangements to accommodate annual leave and sickness. This issue was reported upon following both the January 2017 and January 2016 inspections.
- Treatment escalation plans were audited and consistently shown not to be completed fully, often missing essential information about whether patients had mental capacity to consent to the plan. Incomplete treatment escalation plans were reported on following both the January 2017, and January 2016 inspections.

However:

- Staff were aware of their responsibility to report incidents in critical care and services for children and young people. The electronic reporting system had been improved since our previous inspection. Individual reporting of incidents specific to end of life care had improved since our last inspection and the ability of staff to identify such events was good in many of the areas we visited.
- There was good engagement in morbidity and mortality meetings in surgery, which led to service improvement.
- Surgery ward safety briefings held every morning were well attended, with good communication where safety concerns were aired openly.
- There was an improvement month on month in the number of patients with an end of life care plan based on the five priorities of care.
- Safeguarding was well-managed in maternity as part of an integrated hospital safeguarding team. New safeguarding paperwork had been introduced to improve the quality of safeguarding records and a database enabled midwives to check safeguarding referrals.
- Staff we spoke with in services for children and young people were knowledgeable about the trust safeguarding process and were clear about their responsibilities.

Summary of findings

- Safeguarding policies and procedures were available to staff in outpatients who knew how to access and follow these.
- A new electronic maternity information system due in October was planned which would enable more comprehensive records to be kept and improve the accessibility of information.
- Nursing and medical records had been completed appropriately and in line with each individual child's needs.
- Medicines, including controlled drugs were stored safely in critical care, and accurate records of use were maintained.
- Systems were in place in children and young person's services for the safe storage and administration of medicines and appropriate audit trails were in place for controlled drugs.
- There were effective arrangements in place around the prescription of anticipatory medications to ensure that end of life patients' symptoms could be managed in a timely way.
- Audit compliance scores for the cleanliness of the critical care unit environment were high, which reduced the risk of patients developing unit acquired infections.
- Accommodation in maternity was visibly clean and equipment was well-maintained. There had been no incidents with a contributing factor relating to maintenance in the twelve months to June 2017.
- The children and young people's units were clean and well organised. Staff adhered to infection prevention and control policies and protocols.
- Cleanliness and infection control were found to be well audited and compliant in outpatients. Staff adhered to infection control procedures.
- World Health Organisation (WHO) surgical safety checklists were used in the obstetric theatre and gynaecology theatres and we saw evidence of good compliance.
- Equipment, such as syringe drivers and specialist mattresses were readily available for end of life patients who needed it.

- Staff in maternity reported the quality of training was high. Funds had been secured and dedicated for enhanced training over the coming year

- Nurse staffing levels on the critical care unit had improved and agency use had reduced since our last inspection. Further recruitment of nurses had taken place and was ongoing to ensure the critical care unit was compliant with the Faculty of Intensive Care Medicine Core Standards for nurse staffing levels.
- Medical staffing levels had also improved and further recruitment was taking place at the time of our inspection.
- There was 60 hours consultant cover on the delivery suite which met the recommendations of the Royal College of Obstetricians and Gynaecologists for a maternity unit of this size.
- We found the time taken for diagnostic images to be reported was maintained by increasing staffing levels to meet demand.
- Areas we visited were proactively managing risks, both in and out of hours to meet the needs of patients who were at the end of life.

Effective

- We rated effective as requires improvement overall. Surgery and maternity and gynaecology were rated as requires improvement, and critical care and services for children and young people were rated as good. We did not rate the effectiveness of the outpatients and diagnostics service.
- Systems and processes for identifying, sharing and implementing new or updated guidance were not operating effectively.
- Clinical audits across the trust were not always planned or carried out in a systematic or timely way to ensure compliance and identify risks or learning. Results of clinical audits were not always shared with relevant staff.
- There was a maternity audit schedule for 2017 but no effective process to ensure that cyclical improvement was established and ongoing. Audit plans did not include audit of risks rated as high on the risk register. Changes were made in response to external factors and the service did not always plan these systematically.

Summary of findings

- Outcome data for outpatients was confused and prevented staff from measuring clinic performance.
- We were not assured that all staff were up to date with recent guideline changes, particularly community midwives who did not have remote access to the guidelines. Some guidelines, such as the use of a partogram to show the progress of labour were not followed in many women's deliveries.
- Not all staff had up to date training to use specialist equipment and the system for monitoring competence was not effective.
- Children and young people's staff working in the community did not have access to the electronic records system used by another provider of community health care in the county. Staff said it was difficult to coordinate between the two systems and this could hamper delivery of effective care and treatment.
- Post inpatient follow up reviews did not always take place, which may result in a patient being readmitted for further care and treatment.
- There was limited support from some services at weekends, including pharmacy and physiotherapy.
- There were gaps in management and support arrangements for staff in some areas, such as appraisal, supervision and professional development.

However:

- We could see evidence from audits in some areas where the results triggered change, and evidence that some treatment provided was in line with best practice and national guidance, for example in critical care, gynaecology and children and young people services.
- We saw strong relationships between most multi-disciplinary teams.
- There was good compliance with NHS England's standards for seven-day working in hospitals.
- In critical care and children and young people's services, patients had good outcomes as they received effective care and treatment which met their needs. High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes

Caring:

- Caring was rated as good overall and good for each core service.
- In surgery feedback from patients and relatives was positive overall. For example, the NHS Friends and Family Test scores were mostly above 90% for surgical wards between March 2016 and February 2017. However, the response rate was only 11%, compared to around 25% nationally.
- Patients and their families spoke almost entirely positively about the care they received while in the surgical division. Staff worked hard to uphold patients' dignity, individuality and human rights. We observed staff acting in a respectful, kind and compassionate way to patients and those close to them.
- Staff on the critical care unit were compassionate, kind and sensitive. Patients, relatives and visitors were complimentary about the compassion and kindness they had been shown.
- Communication with patients was effective as they were kept informed of their condition, progress and treatment. Patients' privacy and dignity was maintained throughout their treatment and staff took all steps to protect confidentiality.
- Those close to patients in critical care were involved in their care and were kept updated on any progress or deterioration in condition.
- Care delivered in maternity was kind and compassionate. Women we spoke with and their families spoke well of the care they received. Specialist midwives, helped women understand the specific needs of managing conditions such as diabetes alongside pregnancy.
- The Friends and Family test results were generally good both in maternity and gynaecology.
- Women had reasonable continuity of care before and after birth from a local team of community midwives which enabled them to establish trusting relationships.
- Staff were kind and non-judgemental in the unplanned pregnancy unit.

Summary of findings

- Children and young people were treated as individuals and as part of a family. Feedback from children, young people and parents had been consistently positive. They praised the way the staff really understood the needs of their children, and involved the whole family in their care.
- Parents said staff were caring and compassionate, treated them with dignity and respect, and made their children feel safe. Staff ensured children and young people experienced high quality care. Staff were skilled to be able to communicate well with children and young people to reduce their anxieties and keep them informed of what was happening and involved in their care.
- Parents, siblings and grandparents were encouraged to be involved in the care of their children as much as they wanted to be, whilst young people were encouraged to be as independent as possible. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand.
- We observed staff treating patients with kindness and warmth. The neonatal unit and the paediatric wards and the outpatient department were busy and professionally run, but staff always had time to provide individualised care.
- Staff talked about children and young people compassionately with knowledge of their circumstances and those of their families.
- Staff in outpatients adopted the “hello my name is” by way of introduction to all patients.
- We found people were supported, treated with dignity and respect and were involved as partners in their care.
- We observed outpatient receptionists talking to patients in a respectful way.
- Patients told us nursing staff and doctors explained clearly what options were available to them.
- Patients were empowered and supported to manage their own health, care and wellbeing.

However:

- Some patients we spoke with in surgery did not feel well informed about their care, particularly in terms of when their operation was to take place.
- The critical care unit was not using patient diaries but there were plans to introduce them later in the year.
- There were no formal arrangements for counselling services in the critical care but the unit had developed close ties to the trust’s chaplaincy service which provided patients with spiritual support.
- Although there was supportive care for women in maternity immediately around the time of bereavement, there was no follow up or counselling provided by hospital staff.
- Women were less satisfied with their experience of care on the postnatal ward, particularly during the high temperatures that prevailed during our inspection.
- Privacy and dignity was not always fully maintained as two delivery rooms on the delivery suite did not have blinds for privacy when the lights were on at night.
- The fracture clinic cubicles were small and close together. Private and confidential conversations in adjoining cubicles could be overheard.

Responsive:

- We rated responsiveness as inadequate overall. Surgery was rated as inadequate, critical care, maternity and gynaecology and outpatients and diagnostic imaging were rated as requires improvement and services for children and young people were rated as good.
- Surgical services were planned to meet local needs but lack of capacity and resources meant that plans were not always delivered in a way which met patients’ needs.
- The facilities and premises used did not always meet patients’ needs or were inappropriate, with admission lounges used for surgical and medical patients overnight.
- Surgical patients were unable to access the care they needed at the right time, and referral to treatment times for incomplete pathways had been worse than average from March 2017.

Summary of findings

- Pressures from non-elective admissions and delayed transfers of care led to significant levels of cancellations of elective operations. Twelve patients with cancer had their operation cancelled from January to May 2017, seven on the day of their booked operation.
- Patients were not always operated on in the correct operating theatres, and assessments to identify patient risks were not always carried out.
- Patients did not always have access to services in a timely way for an initial assessment, diagnosis or treatment. Patients experienced significant waits for some services. A high number of patients were not treated within 28 days of their operation being cancelled at short notice.
- There had been too many occasions when patients had to stay in recovery overnight because there were no available beds.
- Due to the lack of capacity within the hospital for beds, critical care patients did not always receive optimal care at the right time. There were frequent delayed admissions, delayed discharges and discharges which took place out of hours.
- At times, level two patients were kept in the recovery area following surgery instead of being admitted to the critical care unit, due to the lack of bed capacity on the critical care unit.
- Patients were not always cared for in separate single sex areas due to patient flow issues.
- The critical care unit did not routinely screen for patients living with dementia when admitted onto the unit.
- In maternity there were regular delays in transferring women to the labour ward because of capacity on the delivery suite, both from limitations of accommodation and staffing.
- The service did not run a dedicated elective caesarean list. This could mean woman scheduled for elective surgery had to wait if there was an emergency underway on the day they were admitted.
- The day assessment unit only had two scanning slots a day. As a result, some women who attended for reduced foetal movements had to return for scanning on another day.
- Not all women were able to give birth in the community as planned as there was a low threshold for transferring women into the main consultant led unit.
- There was a risk to women's privacy and dignity on the antenatal ward as some women gave birth on the ward. The ward did not have closed doors and was merged with the day assessment unit.
- Few partners were able to stay overnight on the postnatal ward as space was limited.
- Some maternity services had to be closed at times because of staffing, such as the homebirth service, birth centres, early pregnancy unit and emergency gynaecology unit.
- There were long waiting times for referral to treatment for some (non-cancer) gynaecology procedures.
- There were delays in completing discharge summaries on the children's wards and performance required improvement.
- The temperature in the neonatal unit was not always at a suitable level.
- There were capacity and demand issues in ophthalmology and cardiology. These demands had led to increased waiting times and unacceptably long waits for follow up treatment.
- Action plans put in place had failed to reduce the number of people waiting for follow up appointments in cardiology and ophthalmology.
- The fracture clinic did not meet patients' needs and issues identified following our January 2016 inspection continued.
- Patient's told us that directional and information signage for moving through the hospital were challenging.
- The outpatients' transformation programme had not managed to improve patent flow through the outpatient clinics.
- There were a high number of cancelled appointments for avoidable reasons.
- Not all outpatient clinics had been designed to be dementia-friendly.
- The surgery service consistently missed targets to respond to complaints within 25 working days. There was little evidence to show lessons had been leaned and practice changed to demonstrate people who complained were listened to.

Summary of findings

However:

- There were good arrangements for supporting patients with a learning difficulty going into theatre.
- The critical care unit had introduced measures to ensure patient flow in and out of the unit did not deteriorate. New systems for assessing bed capacity had been introduced which increased efficiency in the admission and discharge processes.
- Since our last inspection a critical care matron had been appointed which had increased the profile of the unit at daily bed meetings. The coordinators were now more aware of the capacity issues on the unit, which assisted in securing beds for critical care patients to be admitted to.
- The chief operating officer visited the critical care unit or had daily conversations with the critical care matron to assess the unit's bed capacity.
- Antenatal and postnatal services were provided in community locations as far as possible, reducing women's need to travel to the hospital.
- Women deemed low risk could choose to birth at home, at freestanding birth centres or at the hospital delivery suite.
- Midwives assessed women's mood during antenatal visits and were able to signpost women to sources of help for anxiety and depression.
- The unplanned pregnancy service was discreet. Staff were non-judgemental and women gave very good feedback about their care and treatment. Women could access the service in both Truro and Penzance.
- There was a good range of information leaflets for women with early pregnancy problems detailing ways of managing these.
- Good use was made of Facebook to communicate with women and young people.
- Services were tailored to meet the needs of individual children and young people and were delivered in a flexible way.
- There were good facilities for babies, children, young people and their families.
- The environment for the neonatal service had improved considerably with the opening of the new unit in May 2017. Staff had been involved in the design and planning phase of the development of the unit
- There were no barriers for those making a complaint. Staff actively invited feedback from children and their parents or carers, and were very open to learning and improvement. There were, however, few complaints made to the service and those that had been made were fully investigated and responded to with compassion.
- Children and young people of all ages had timely access to care and treatment
- A new wide bore scanner was soon to be available to meet the needs of larger patients.
- We found the time taken for diagnostic images to be reported was adaptable and managed demand.
- Imaging was performing well and managing many of its key waiting times.

Well led:

- Well led was rated as inadequate overall. Maternity and gynaecology, end of life care and outpatients and diagnostic imaging were rated as inadequate, surgery was rated as requires improvement and critical care and services for children and young people were rated as good.
- The arrangements for governance and performance management in surgery did not always operate effectively. Risks, issues and poor performance were not always dealt with appropriately or in a timely way.
- Not all leaders in surgery had the necessary time to lead effectively. The need to develop leaders was not always identified or action was not always taken. Leaders were not always clear about their roles and their accountability for quality.
- The sustainable delivery of quality care was put at risk by financial challenges facing the trust.
- There was no clear vision or strategy for service development in either the maternity or gynaecology service.
- Management of the maternity service was reactive in response to external reports or adverse events. At times the service focused on solving immediate issues without risk assessing the consequences of these actions on the wider service.

Summary of findings

- The governance processes in maternity did not ensure quality, performance and risk were managed. The maternity dashboard held predominantly clinical information with no staffing information included.
- There was an absence of comprehensive performance and quality audit plan. Several significant risks were identified which were not on the register and risk assessments had not been undertaken.
- There was very little evidence of improvements by self-examination or benchmarking with other similar maternity services. The limited range of audits restricted the scope of quality monitoring and meant there could be little assurance that practices followed guidelines.
- There was some uncertainty concerning the flow of data about the maternity unit's performance to the hospital's executive team. The unit was not holding regular nursing meetings.
- There was poor communication at executive level about the future plans for the end of life service at the trust and a lack of consultation on the business plan that lay behind these plans.
- We saw a business plan for the development of end of life care at the trust going forward. However we saw little evidence that there had been any tangible improvements in end of life care with the exception of the increase in use of the end of life care documentation.
- There was a lack of any systematic audit programme relating to end of life care, and few measures that addressed risk and quality. This issue had been reported following the inspection in January 2017.
- There was no evidence that the End of Life Care strategy was being monitored or taken forward since the departure in May 2017 of the end of life facilitator. Key tasks such as training needs analysis within the strategy had not been completed.
- There was no scrutiny or interrogation of, delayed fast track discharges, or the achievement of preferred place of care, for end of life patients and so no learning could be taken from these.
- In outpatients governance procedures to monitor waiting lists, waiting times, frequency of cancelled clinics, and referral to treatment timelines for patients were not robust enough which meant the impact on patients was not fully known.
- A programme of rolling improvements in the outpatient service was not delivering sufficient results in a timely manner and significant challenges remained.
- Accountability for decision making was unclear in several speciality clinics. Leaders, including the board and divisional management, were not visible within the outpatients department.
- In the surgical division the culture was dictated by senior and executive management. It was not one of fairness, openness, transparency, honesty, challenge and candour. We found there was a disconnect between the executive team and frontline staff.
- Decisions in the maternity service were traditionally made at the top and then communicated to staff. Staff had become accustomed to a top down leadership style, however, efforts were being made to effect a change in this.
- Some staff continued to feel the culture of the maternity services was punitive despite actions to involve more staff in open discussions about the service culture.
- Bullying and undermining behaviour towards other staff, peers or juniors appeared to have been insufficiently challenged in the maternity service. This meant that there was not a clear reporting line of key clinical issues affecting the maternity service. The operational decision-making group for midwifery did not feed into either the obstetrics and gynaecology meeting or the maternity forum.
- A significantly high number of outpatients staff at all levels felt the culture within the trust was one of intimidation, bullying and discrimination and several staff had left or been signed off with stress.
- The critical care unit risk register did not highlight all risks identified by the service and some ongoing risks had been closed. There were also issues with the way in which risks were added and removed from the register.
- We were not assured of sufficient oversight and management of the risk register relating to end of life care.

Summary of findings

- Staff and public engagement was not given sufficient priority in most of the core services. There was a limited approach to obtaining the views of patients who used services and other stakeholders. Feedback was not always reported or acted upon in a timely way. We saw few mechanisms for capturing feedback from patients, their families and carers, or from staff. There had therefore been no input from these groups into the end of life service. This issue had been reported following both the January 2017 and January 2016 inspections.
- There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported and appreciated. Staff did not always raise concerns or they were not always taken seriously or treated with respect when they did.

However:

- We found nursing, theatre and medical staff to be committed to the hospital and dedicated and caring to deliver care and treatment to patients.
- Most managers we spoke to in surgery said they were overwhelmingly proud of the teams they led. There was alignment between the recorded risks and what staff said was on their 'worry list'.
- Innovation and improvement was encouraged within the surgical directorate.
- There was clear vision for the critical care unit and a realistic strategy for achieving it.
- There was an effective governance framework to support the delivery of the strategy and good quality care within the critical care unit.
- All staff working on the critical care unit shared values which promoted the delivery of treatment that was safe and of the highest quality.
- There was good nursing and medical leadership on the critical care unit. Managers were visible and approachable. Staff felt they could bring any concerns to their supervisors and they would be acted upon.
- The service was taking steps to ensure the sustainability of the critical care unit so that it continued to provide safe care and treatment to patients
- New management appointments in maternity had the potential to change the culture and involve staff more in decision making over time. A senior leadership programme for all senior managers had taken place which was in the process of being rolled out to other staff to strengthen staff understanding of leadership and develop skills.
- The leadership, governance and culture of the services for children and young people were used to drive and improve the delivery of high-quality care. The clinical managers were committed to the children and young people in their care, their staff and the unit. Frontline staff and managers were passionate about providing a high quality service for children and young people with a continual drive to improve the delivery of care.
- In end of life care we saw excellent examples of leadership within the specialist palliative care team and the mortuary which meant that staff working within these services benefitted from the support and commitment of their leaders.
- Substantial funding had been agreed which aimed to improve education and provision of end of life care at the trust. There had been some improvement in the profile of end of life services since our last inspection.
- The specialist palliative care team were held in extremely high regard across the trust in all areas we visited.
- In diagnostic imaging we found the leadership to be visible and supportive. The culture in imaging was open and staff felt able to raise concerns.
- Children and young people were able to give their feedback on the services they received; this was recorded and acted upon where necessary.
- A variety of staff engagement activities following from the cultural review in maternity had tapped into staff views about the service and opportunities for improvement, and staff were taking forward some of these.
- There was a high level of staff satisfaction with staff saying they were proud of the children and young people's units as a place to work. They showed commitment to the children and young people, their responsibilities and to one another. All staff were treated with respect and their views and opinions heard and valued.

We saw areas of good practice including:

Summary of findings

- The critical care service had a good track record on safety. There had been no never events or serious incidents. Staff were aware of their responsibility to report incidents and the electronic reporting system had been improved since our previous inspection.
- In children and young people's services risk was managed and incidents were reported and acted upon with feedback and learning provided to staff.
- Individual reporting of incidents specific to end of life care had improved since our last inspection and the ability of staff to identify such events was good in many of the areas we visited.
- The imaging service had good examples of learning from incidents and measures in place to prevent a reoccurrence.
- The mortality rates for critical care were better than the national average, meaning more people would have survived their illness than in other units across the country.
- Safeguarding was well managed in maternity services.
- Staff outpatient teams were up to date and competent with the trust safeguarding training and procedures.
- Equipment, such as syringe drivers and specialist mattresses was readily available for end of life patients who needed it.
- The trust had commenced a major project to implement a radio frequency identification (RFID) tagging system for medical devices.
- There were effective arrangements in place around the prescription of anticipatory medications to ensure that end of life patients' symptoms could be managed in a timely way.
- In critical care nurse staffing levels had been increased since our last inspection and there was less reliance on agency staff. Medical staffing levels had also improved but it had also been recognised that further recruitment was needed to improve consultant presence.
- Areas we visited were proactively managing risks, both in and out of hours to meet the needs of patients who were at the end of life.
- There was an improvement month on month in the number of patients with an end of life care plan based on the five priorities of care.
- Diagnostic imaging worked closely with medical physics to ensure minimal dosage of radiation was given to patients.
- There were good multidisciplinary working relationships in gynaecology. MDT meetings were held to decide on treatment for women with gynaecological cancers.
- Midwives used a recognised communication tool when discussing a case with other professionals to make sure information they reported was structured and consistent.
- Treatment in critical care was provided mostly in line with best practice and national guidance. According to data submitted to the Intensive Care National Audit and Research Centre, outcomes for patients were, in many cases, better than the national average.
- There was a good range of audits taking place in gynaecology and the service took action in response to the results.
- The maternity service generally achieved a better (lower) rate of emergency caesarean section than the national average, and a high proportion of women had unassisted births.
- Treatment and care for children and young people were effective and delivered in accordance with best practice and recognised national guidelines. There was excellent multidisciplinary team working within the service and with other agencies.
- Most staff in obstetrics and gynaecology had an appraisal in the past year.
- We found all staff to be committed to the hospital and dedicated and caring to deliver care and treatment to patients.
- Staff in the unplanned pregnancy service were kind, non-directive and non-judgemental. They maintained women's privacy and confidentiality.
- Staff were compassionate, kind and sensitive to patients, relatives and visitors. Feedback from those who used the services had been consistently positive. All were complimentary about the compassion and kindness they had been shown.

Summary of findings

- Staff understood the individual needs of patients and their families and designed and delivered services to meet them.
- There was an effective vaccination programme for pregnant women. Community midwives gave whooping cough vaccines to pregnant women and also administered flu vaccines.
- Women had a choice of where to give birth. The community birth-rate was much higher than the national average.
- The leadership and culture of some services drove improvement and the delivery of high-quality individual care. In critical care staff promoted the delivery of the highest quality of care. The nursing and medical leadership on the unit was effective and senior staff members were visible and approachable.
- In the children and young people's service there were clear lines of local management in place and structures for managing governance and measuring quality. All staff were committed to children, young people and their families and to their colleagues. There were high levels of staff satisfaction with staff saying they were proud of the units as a place to work. They spoke highly of the culture and levels of engagement from managers.
- We saw excellent examples of leadership within the specialist palliative care team and the mortuary which meant that staff working within these services benefitted from the support and commitment of their leaders. In imaging we found the leadership to be visible and supportive.
- There had been some improvement in the profile of end of life services since our last inspection. The specialist palliative care team were held in extremely high regard across the trust in all areas we visited.
- Substantial funding had been agreed which aimed to improve education and provision of end of life care at the trust.
- There had been significant investment into the trust's diagnostic imaging services.
- There were strong innovative practices across the outpatients department.

We saw several areas of outstanding practice including:

- The critical care unit had arranged for an external provider to provide shiatzu massage to patients on the ward to help with muscular pain. The service was also available to staff.
- The unit was using a local private ambulance to enable patients to go on day trips to local destinations. Nurses and doctors from the critical care unit would accompany them on these visits following a thorough risk assessment process.The patients suggested the destination and the unit endeavoured to grant their wish. Payment for the use of their services comes from the Charitable Fund.
- Emotional support and information was provided to those close to patients. Following the participation in the Provision of Psychological Support to People in Intensive Care (POPPI), three nurses from the unit had undertaken training to enable them to deliver psychological support to improve outcomes for patients being discharged from the unit. The nurses in question were delivering this support to patients during our inspection. The nurses were also able to provide support to colleagues when required.
- A member of the nursing team had recently returned from a secondment with the end of life team. Following their return, the nurse shared what they had learnt with the rest of the nursing staff. An initiative was also put forward to deliver additional support to bereaved children. We saw many tools to help children to cope with their loss. For example, the unit had invested in story books surrounding death. There were also puppets, colouring books and toys which could be used to distract and comfort children.
- If appropriate, deceased patients were moved to one of the isolation rooms so relatives could spend time with them in private. Staff also accompanied bereaved relatives to their cars or waited with them if using public transport so they were not alone.
- There was excellent local leadership of the children's service. Senior clinical managers were strong and committed to the children, young people and families who used the service, and also to their staff and each other.
- The trust had direct access to electronic information held by community maternity services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

Summary of findings

- There was an outstanding commitment from frontline staff including clinicians, administrative and cleaning staff to provide a high quality service for children and young people with a continual drive to improve the delivery of care. Staff were passionate about doing the best they could for the children in their care.
- The outpatient department had introduced an improved treatment option for the rapid removal of blood clots from veins and arteries following the purchase of new equipment. In some instances this prevented patients having emergency surgery and reduced length of stay.
- The imaging department's ability to maintain waiting lists at eight weeks and below.
- The development and implementation of "RADAR" by Royal Cornwall Hospitals NHS Trust improved monitoring of referral to treatment, delays and clinic cancelations. It had won several national awards for innovation.

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

Importantly, the trust **must:**

- Improve the approach to identifying, reviewing and investigating incidents and never events.
- Adopt a positive incident reporting culture where learning from surgical incidents is shared with staff and embedded to improve safe care and treatment of patients.
- Ensure there is an effective system in place to monitor and scrutinise incidents relating specifically to end of life care ensuring subsequent learning can be implemented.
- Take immediate steps to improve incident reporting timeliness, consistency, investigation, learning and sharing of learning processes in outpatients.
- Improve systems and processes to ensure staff follow and apply principles for duty of candour.
- Take immediate steps to address the fracture clinic environmental issues that had been present since the January 2016 inspection.
- Ensure safety checks on surgical equipment are carried out by the planned dates.
- Provide surgical patients with sepsis with timely access to intravenous antibiotics.
- Securely and confidentially manage all patient information.
- Ensure that patient records are stored securely in outpatient departments. Patient confidentiality must be maintained in accordance with the Data Protection Act.
- Ensure that the causes of incomplete treatment escalation plans are addressed and compliance is improved in critical care.
- Ensure patients are risk assessed and operated on in the correct theatre with the correct equipment and staff available.
- Ensure emergency resuscitation teams have immediate access at all times to a member of staff who is able to deal with difficult airway intubation.
- Ensure full compliance with the Five Step to Safer Surgery World Health Organisation (WHO) checklist to prevent or avoid serious patient harm.
- Meet expected levels of medical and nurse staffing levels on surgical wards to keep patients safe.
- Ensure there are sufficient numbers of suitably qualified nursing staff in the paediatric emergency department and formal processes in place to ensure appropriate cover is provided at all times.
- Improve compliance with the use of surgical patient care bundles.
- Ensure all surgical staff receive annual appraisals, mandatory training, appropriate supervision and professional development.
- Take immediate steps to ensure the privacy and dignity of patients using the fracture clinic cubicles.
- Improve the incomplete referral to treatment pathway compliance for surgical patients.
- Ensure all patients have their operations at the right time, whether in an emergency or for a planned procedure.
- Ensure surgical facilities are appropriate to meet patients' needs.
- Improve bed management, and discharge arrangements to ensure a more effective flow of patients across the hospital to improve cancellations of patient's operations.

Summary of findings

- Ensure access and flow into the critical care unit is improved to ensure delayed admissions, delayed discharges and discharges out of hours are reduced so patients receive the right care at the right time and in the right place.
- Take immediate steps to ensure that the backlog of patients awaiting cardiology procedures is eradicated.
- Take immediate steps to ensure that the backlog of 24 hour cardiac recordings and echocardiograms are reviewed.
- Take immediate steps to ensure that the backlog of patients awaiting WARM ophthalmology procedures and glaucoma service is eradicated.
- Improve the response times for patients' complaints in surgery.
- Ensure governance processes are embedded in practice to provide assurance that surgical services are safe and effective and provide quality care to patients. .
- Ensure governance systems and processes are established and operated effectively to ensure the trust can assess, monitor and improve the quality and safety of the services provided to patients receiving end of life care.
- Ensure action is taken to address behaviours and performance which are inconsistent with the vision and values of the hospital, regardless of seniority.

In addition the trust **should:**

- Develop Local Safety Standards for Invasive Procedures.
- Ensure all of the learning points and actions identified during monthly mortality and morbidity meetings in critical care are recorded and followed-up.
- Continue to ensure safeguarding training compliance is brought up-to-date in the children and young people's service and sustained at trust target levels.
- Ensure medical staff mandatory training completion rates in critical care improve to comply with trust targets.
- Continue to ensure staff in the children and young people's service have their mandatory training brought up-to-date and sustained at trust target levels.
- Improve compliance of patient screening for MRSA.
- Promote the use of hand gel for visitors and patients in the ophthalmology department.
- Ensure cleaning checklists in the cardiology outpatients department are used.
- Ensure there is access to patient toilet facilities within the surgical assessment unit and theatre recovery area.
- Repair the toilet facilities on Pendennis ward, to ensure they do not overfill and lead to closure of a bay.
- Ensure all areas of non-compliance with the Department of Health guidelines for critical care facilities (Health Building Note 04-02) are included on the local risk register.
- Reposition the high dependency unit on Polkerris ward to ensure observation of children at all times.
- Improve the environment around the MRI scanners to allow better access for beds and patients.
- Consider improving directional signage around the tower block area of the hospital.
- Improve access facilities within outpatient waiting areas for wheelchair users when clinics are busy.
- Ensure all checks carried out on the difficult airway trolley are permanently recorded to ensure all equipment and medicines are available in the event of an emergency.
- Ensure all resuscitation trolleys in use on the critical care unit are in tamper-evident containers.
- Consider the use of air/oxygen blenders and pulse oximetry on the neonatal unit as recommended in quality standards for cardiopulmonary resuscitation.
- Improve the secure storage of breast milk stored in the fridges and freezers in the milk kitchen on the neonatal unit.
- Improve the processes to identify and safely dispose of out of date medicines in surgery.
- Ensure all controlled drug register checks are carried out and recorded every day, in both the north and south sides of the critical care unit.
- Ensure the issues around the electronic drug charts in use, on the critical care unit and throughout the hospital, are rectified.
- Review the method for checking controlled drugs on the neonatal unit to ensure that stock checks and signatures are recorded for each individual drug.

Summary of findings

- Continue to consider an electronic record system for the community paediatric teams and in the meantime to ensure there are systems in place for the secure carrying of multiple paper records.
- Ensure there are regular nurse meetings on the critical care unit.
- Examine whether the provision of specialist palliative care can be expanded to provide a seven day a week service as per national guidelines, to meet the needs of the trust.
- Review the provision of physiotherapy resource on the critical care unit to improve compliance with NICE Guidance 83 (Rehabilitation after critical illness in adults).
- Ensure staff in the outpatient departments are aware of their roles and responsibilities during a major incident.
- In line with national guidance, routinely audit and evidence if patients are achieving their preferred place to receive their end of life care.
- Expand the scope of audit of end of life care documentation to assess the competency and understanding with which it is used.
- Improve the clarity of outpatient clinics outcome data to allow staff to have ownership and value to the work they do.
- Ensure the use of diaries is offered to patients on the critical care unit to help them, or their loved ones, document the events during their admission.
- Ensure patients, parents/carers are aware of the Friends and Family test and promote good use of this tool.
- Ensure all nursing staff are competent in using specialist equipment on the critical care unit.
- Ensure that there are mechanisms in place which effectively capture feedback from staff, patients and those close to them that can contribute to the design of end of life services.
- Ensure that governance processes and systems can provide assurance that delays with fast track discharges for end of life patients are being monitored and managed in accordance with national guidance relating to end of life care.
- Ensure there is a clear incident reporting process to follow in the event of delayed fast track discharges for end of life patients.
- Continue to improve the discharge paperwork provided to ward staff in critical care to improve compliance with NICE Guidance 50 (Acutely ill adults in hospital: recognising and responding to deterioration).
- Continue to improve the completion rate of discharge summaries in children and young people's services.
- Improve start times in operating theatres.
- Fix the problem with post inpatient follow up appointments.
- Take further action to reduce the number of outpatient clinics that are cancelled for avoidable reasons.
- Improve the procedures used to monitor waiting lists, waiting times and the frequency of cancelled clinics for avoidable reasons.
- Give ownership management of the cardiology waiting referral to treatment lists to the bookings team.
- Improve systems and processes to show how complaints have been scrutinised for themes and level of impact in end of life care and what subsequent actions have been taken.
- Ensure surgical leaders have the time to lead effectively.
- Improve communication between executive level staff and local end of life care teams about the development of the end of life service at the trust.
- Ensure there is a process in place which monitors the delivery of the end of life strategy and the actions held within it.
- Review the effectiveness of the outpatient transformation team.
- Clarify individual accountability for decision making within specialty outpatient clinics.
- Ensure the risk register in use within the critical care unit includes all risks identified by the unit. This includes ensuring that continuing risks are not closed and remain open until the risk is mitigated.
- Ensure there is an effective system at governance level to review, mitigate and improve services in relation to quality, safety and risk for end of life care at the trust.
- Take steps to improve the culture within the outpatient departments where bullying and harassment are present.
- Improve the engagement of both staff and the public across the trust.

Professor Edward Baker

Summary of findings

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Inadequate 	• Safety performance was not a sufficient priority. There were significant numbers of serious incidents and never events. There was little evidence of learning from events or taking action to improve safety. When things went wrong, people were not always told and did not always receive an apology. • There were unacceptable delays for some patients who required emergency surgery due to high demand for theatres and lack of available beds. There was poor compliance with care pathways. • Services were not planned in a way that met people's needs. Facilities did not always meet people's needs or were inappropriate. Pressures from urgent patients' admissions and delayed transfers of care led to significant levels of cancellations of elective operations. Patients were not always operated on in the most appropriate operating theatres, and assessments to identify patient risks were not always carried out. People did not always receive timely initial assessment, diagnosis or treatment. People experienced significant waits for some services. The service consistently missed targets to respond to complaints within 25 working days. • The arrangements for governance and performance management did not always operate effectively. Risks, issues and poor performance were not always dealt with appropriately or in a timely way. Not all leaders had the necessary time and support to lead effectively. There were low levels of staff satisfaction, high levels of stress and work overload. The culture was not one of fairness, openness, transparency, honesty, challenge and candour. • However, we found surgical, nursing and theatre staff to be committed to the hospital and dedicated and caring to deliver care and treatment to patients.

Summary of findings

Critical care

Good 

- **The service had a good track record on safety. There had been no never events or serious incidents. Staff were aware of their responsibility to report incidents and the electronic reporting system had been improved since our previous inspection.**
- Nurse staffing levels had been increased since our last inspection and there was less reliance on agency staff.
- Medical staffing levels had improved since our last inspection but it had also been recognised that further recruitment was needed to improve consultant presence.
- Treatment was provided mostly in line with best practice and national guidance.
- According to data submitted to the Intensive Care National Audit and Research Centre, outcomes for patients were, in many cases, better than the national average.
- The mortality rates for the unit were better than the national average, meaning more people would have survived their illness than in other units across the country.
- Staff were compassionate, kind and sensitive to patients, relatives and visitors. All were complimentary about the compassion and kindness they had been shown while on the unit.
- The culture on the critical care unit promoted the delivery of safe care and treatment to patients. Staff strived to ensure it was of the highest quality.
- The nursing and medical leadership on the unit was effective. Senior staff members were visible and approachable.

However:

- The number of delayed admissions to the unit, discharges out of the unit and the number discharges which took place out of hours was still a concern.
- The unit did not provide patients with diaries to document significant events during their stay.
- The unit did not provide patients with rehabilitation prescriptions, which could be used following discharge from the unit.
- Checks carried out on the difficult airway trolley were not permanently recorded.

Summary of findings

- Safety issues, related to electronic prescription charts, had occurred due to the failure of some staff to correctly follow processes when patients were discharged from the unit.
- Not all staff had up to date training to use specialist equipment and the system used for monitoring competence was not robust as the data was not clear.
- The risk register in use on the unit did not highlight all risks identified by the service and some ongoing risks had been inappropriately closed.
- The unit was not holding regular nursing meetings, as we highlighted during our previous inspection.

Maternity and gynaecology **Inadequate**

- There were not enough midwives deployed to provide a safe service in all areas at all times.
- There was no dedicated high dependency area for deteriorating women and no process to ensure that that there was always a nurse or midwife staff on duty with the necessary competencies to manage women in need of high dependency care. The service did not monitor the number of women needing this level of care.
- There was one theatre on the delivery suite with dedicated staffing. Contingency plans for using the adjoining room as a second theatre were not well set out or clearly understood.
- The environment of the postnatal ward was not fit for purpose in summer when the temperature was high.
- Not all midwives had the necessary skills, for example in neo-natal life support. Only 55% of midwives were up to date with training in neo-natal life support and training compliance for managing obstetric emergencies was 82%. The 85% target set for training completion in maternity was lower than trust target for training completion of 95%.
- Management of the maternity service was reactive in response to external reports or adverse events, but did not have internal systems for assessing, monitoring and responding to risks.
- Risks of harm to women in maternity services were not well identified, analysed and managed, and not all apparent risks were assessed and included on the risk register. The absence of comprehensive

performance audit meant that service did not know its own performance in many areas. There was very little evidence of improvements by self-examination or benchmarking with other similar services.

- Bullying and undermining behaviour towards other staff, peers or juniors appeared to have been insufficiently challenged in the maternity service.
- The trust did not have mechanisms to audit patient notes to see if guidelines were followed. The delivery suite capacity was insufficient for the number of women giving birth. This resulted in a number of women labouring and giving birth on the antenatal ward several times a month, during which time they did not receive one-to-one care. This also impacted upon their privacy and dignity.
- There was no dedicated high dependency area for deteriorating women on the delivery suite and no process to ensure sufficient staff on every shift trained to care for such women.
- Induction of labour had increased at the trust and often more women were being induced each day than the agreed number. Planning for induction did not take into account activity or capacity on the delivery suite to ensure induction was safe.
- We could not be assured that community midwives had the necessary equipment and competences to manage obstetric or neonatal emergencies in the community in the event that an ambulance was delayed.
- The antenatal ward was not secure. The Day Assessment Unit adjoined the antenatal ward and the entrance doors were not closed except at night. This was a safeguarding risk to women and babies. Information sharing within the maternity service was inefficient. The different women's records in the maternity service were not linked and women's hand held notes and the hospital record held different information which meant it was not easy to see an overview of each woman's status.
- There is no credible statement of vision and staff were not aware of what limited vision there was. What existed was not underpinned by detailed objectives and plans.
- The governance arrangements and their purpose were unclear. The processes in place did not support a clear governance framework. There was

insufficient collection and monitoring of performance and quality measures to ensure clear and accurate oversight or service development and improvement.

However:

- Safeguarding was well managed in an integrated hospital service. They maintained women's privacy and confidentiality.
- There was an effective vaccination programme for pregnant women.Community midwives gave whooping cough vaccines to pregnant women and also administered flu vaccines.
- Midwives used a recognised communication tool when discussing a case with other professionals to make sure information they reported was structured and consistent.
- There was a good range of audits taking place in gynaecology and the service took action in response to the results.
- The maternity service generally achieved a better (lower) rate of emergency caesarean section than the national average, and a high proportion of women had unassisted births.
- Women had a choice of where to give birth. The community birth-rate was much higher than the national average.
- Most staff in obstetrics and gynaecology had an appraisal in the past year.
- There were good multidisciplinary working relationships in gynaecology. MDT meetings were held to decide on treatment for women with gynaecological cancers.

Services for children and young people

Good

- Risk was managed and incidents were reported and acted upon with feedback and learning provided to staff. Staff adhered to infection prevention and control policies and protocols.
- The units were clean, organised and suitable for children and young people.
- Treatment and care were effective and delivered in accordance with best practice and recognised national guidelines. There was excellent multidisciplinary team working within the service and with other agencies.

Summary of findings

- Children and young people were at the centre of the service and the priority for staff. Innovation, high performance and the high quality of care were encouraged and acknowledged. Children, young people and their families were respected and valued as individuals. Feedback from those who used the service had been consistently positive.
- Care was delivered in a compassionate manner. Parents spoke highly of the approach and commitment of the staff that provided a service to their children.
- Children received excellent care from dedicated, caring and well trained staff that were skilled in working and communicating with children, young people and their families.
- Staff understood the individual needs of children, young people and their families and designed and delivered services to meet them.
- There were clear lines of local management in place and structures for managing governance and measuring quality. The leadership and culture of the service drove improvement and the delivery of high-quality individual care.
- All staff were committed to children, young people and their families and to their colleagues. There were high levels of staff satisfaction with staff saying they were proud of the units as a place to work. They spoke highly of the culture and levels of engagement from managers.
- There was a good track record of lessons learnt and improvements when things went wrong. This was supported by staff working in an open and honest culture with a desire to get things right.

However:

- There was no clear nursing observation area on the high dependency unit and this represented a risk to children who were not visible to nursing staff at all times.
- There were insufficient numbers of suitably qualified nursing staff in the paediatric emergency department to provide safe care at all times. There were also no formal processes in place to ensure

appropriate cover was in place in the department at all times, particularly during periods when the qualified nurse was temporarily absent from the department.
- Although safeguarding training compliance had improved it remained a challenge and required continued improvement.
- Completion of some mandatory training was below trust target and required improvement.
- There were delays in completing discharge summaries and performance required improvement.

End of life care — **Inadequate**

- There was no evidence of oversight or scrutiny of incidents that related to end of life care at the trust. Therefore, there was no evidence of learning or changes in practice that had resulted from such incidents.
- Treatment escalation plans were audited and consistently shown not to be completed fully, often missing essential information about whether patients had mental capacity to consent to the plan.
- The specialist palliative care team was too small to meet the demands of the trust as per national guidance. It was only able to provide a five day a week service, and even this stretched the capacity of the team.
- There was not sufficient information or audit for the trust to be assured of the effective use of end of life care documentation. Audits did not address the quality or completeness with which the documentation was completed or understood, and did not contain any follow up action plans to address the issues raised.
- There was no clear incident reporting process for staff to follow in the event of a delayed fast track discharge. There was no evidence of executive oversight of the problem caused by inconsistent reporting.
- There was poor communication at executive level about the future plans for the end of life service at the trust and a lack of consultation on the business plan that lay behind these plans.

Summary of findings

- We saw a business plan for the development of end of life care at the trust going forward. However we saw little evidence that there had been any tangible improvements in end of life care with the exception of the increase in use of the end of life care documentation.
- There was a lack of any systematic audit programme relating to end of life care, and few measures that addressed risk and quality.
- There was no evidence that the End of Life Care strategy was being monitored or taken forward since the departure in May 2017 of the end of life facilitator. Key tasks such as training needs analysis within the strategy had not been completed.
- There was no scrutiny or interrogation of, delayed fast track discharges, or the achievement of preferred place of care, for end of life patients and so no learning could be taken from these.
- We saw few mechanisms for capturing feedback from patients, their families and carers, or from staff. There had therefore been no input from these groups into the end of life service.
- We were not assured of sufficient oversight and management of the risk register relating to end of life care.

However:

- Individual reporting of incidents specific to end of life care had improved since our last inspection and the ability of staff to identify such events was good in many of the areas we visited.
- There was an improvement month on month in the number of patients with an end of life care plan based on the five priorities of care.
- Equipment, such as syringe drivers and specialist mattresses was readily available for patients who needed it.
- Areas we visited were proactively managing risks, both in and out of hours to meet the needs of patients who were at the end of life.
- There were effective arrangements in place around the prescription of anticipatory medications to ensure that patients' symptoms could be managed in a timely way.

Summary of findings

- Locally, we saw excellent examples of leadership within the specialist palliative care team and the mortuary which meant that staff working within these services benefitted from the support and commitment of their leaders.
- Substantial funding had been agreed which aimed to improve education and provision of end of life care at the trust.
- There had been some improvement in the profile of end of life services since our last inspection.
- The specialist palliative care team were held in extremely high regard across the trust in all areas we visited.

Outpatients and diagnostic imaging

Inadequate

- Incidents were not always reported promptly. This impacted investigation timeliness and delayed potential learning opportunities.
- The approach to declaring and serious incident was slow and investigations took too long.
- Ophthalmology and Cardiology follow up appointment waiting lists are too long and patients are coming to harm through delays in treatment.
- The fracture clinic remains a risk to patients due its design, unregulated clinic temperature and poorly maintained furnishings.
- Records in cardiology of 24 hr cardiac record tapes and echocardiograms were not stored securely and were found stored in a letter tray.
- The 24 hr cardiac record tapes and echocardiograms were not being managed in a timely way and were dated back as far as March 2017. These and were yet to be interpreted by specialists.
- There was a lack of Wet Age Related Macular degeneration or glaucoma clinics causing significant delays in treatment for patients.
- Managers and staff told us there were capacity and demand issues in some clinics that meant there were an insufficient number of clinics running to deal with demand.
- Patients had unacceptably long waits for follow up treatment in ophthalmology & cardiology.
- The fracture clinic remained not fit for purpose and issues identified from the January 2016 inspection remain.

Summary of findings

- A programme of rolling improvements in the outpatient service which was led by the outpatient improvement board had made some progress but significant challenges remained.
- An unusually high number of staff at all levels in outpatients felt the culture within the trust was one of intimidation, bullying and discrimination and several staff had left or been signed off with stress.
- Accountability for decision making was unclear in several speciality clinics.
- Visibility of CEO and board staff was minimal.
- Governance procedures to monitor waiting lists, waiting times, frequency of cancelled clinics, and RTT timelines for patients were not robust enough which meant the impact on patients was not fully known.
- In ophthalmology demand continued to outgrow capacity at a predicted rate of 4,000 clinic slots by the end of 2017.
- There remained significant challenges around access to appointments and the high volume of clinic cancellations.
- We spoke with 12 patients and they were not made aware of the friends and family test.

However:

- Staff teams were up to date and competent with the trust safeguarding training and procedures.
- The imaging service had good examples of learning from incidents and measure in place to prevent a reoccurrence.
- Imaging worked closely with medical physics to ensure minimal dosage of radiation was given to patients.
- The trust has commenced a major project to implement a radio frequency identification (RFID) tagging system for medical devices.
- There were strong innovative practices across the outpatients department.
- In imaging we found the leadership to be visible and supportive.
- There had been significant investment into the trust's imaging services.

Royal Cornwall Hospital

Detailed findings

Services we looked at
Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to Royal Cornwall Hospital

Royal Cornwall Hospitals NHS Trust provides care to around 532,273 people across Cornwall, which can increase twofold during holiday periods. This includes general and acute services at Royal Cornwall Hospital, elective surgery and outpatient services at St Michaels Hospital, day surgery, medicine, outpatient and renal services at West Cornwall Hospital and maternity services at Penrice unit at St Austell Hospital. CQC inspected the main Royal Cornwall Hospital site during this focused inspection, as well as surgery and outpatients core services at St Michael's and West Cornwall Hospitals and maternity services at Penrice Birthing Unit.

The hospital has over the last few years, seen significant and ongoing periods of instability at board level. Since the first inspection in January 2014 there had been three chief executives in post, two of those on an interim basis. A permanent chief executive was appointed in April 2016. A new chair was appointed in January 2017, but prior to this there had been three chairs in post since 2015. The director of nursing was newly appointed in May 2017 and in post at the time of the inspection; prior to this there had been an interim director of nursing in post since November 2015. The interim medical director was in post since October 2016, and we were told this post had recently been made substantive on an honorary contract for a period of 12 months. The chief operating officer post was interim from October 2016, and we were told that this post had been filled by an external candidate who was due to commence in post in August 2017. The director of human resources commenced in post in December 2016, and the director of corporate affairs commenced in post in January 2017. The director of finance was the longest standing executive member of the team having been in post for six years. There had been changes to this post in recent months with the current finance director taking the lead on the Sustainability and Transformation Plan (STP), and a co-appointed (with another local hospital) finance director had been in post since May 2017. This meant that by August 2017, there would be a full complement of board directors in permanent posts for the first time in a number of years.

This inspection was carried out in order to inspect those services and locations we did not inspect in January 2017 (with the exception of sexual health), and to follow up on additional concerns we had following the January 2017 inspection, in relation to the safe and well led domains within end of life care services. The ratings from this inspection have been aggregated with those ratings from the inspection we carried out in January 2017.

Our inspection team

Our inspection team was led by:

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

Detailed findings

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

Inspection Manager: Julie Foster, Care Quality Commission

The team included three inspection managers, 12 CQC inspectors, an assistant inspector, a planner, and a variety of specialists: two medical directors, a chief nurse and governance specialist, two surgical consultants, three senior surgical nurses, a CCU nurse specialist, an anaesthetist, a paediatrician and a senior paediatric nurse, a senior midwife and an end of life nurse specialist. We also had a CQC IRMER inspector present for part of the inspection.

How we carried out this inspection

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

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

The inspection team inspected six core services:

- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatient and diagnostic imaging

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

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

We carried out an announced inspection of the main hospital site, West Cornwall and St Michael's hospitals and Penrice birthing unit, and we held 28 staff drop in sessions for a range of staff with various roles and levels of seniority across the hospital. These included clinical and non-clinical staff including nurses at all levels, consultants and junior doctors, health care assistants, allied health professionals, chaplains, administrative staff, volunteers, managers and senior leaders. We held two additional drop in sessions for staff working at West Cornwall and St Michael's sites. These sessions were generally very well attended and staff were able to share their experiences with us. People also contacted us via our website and contact centre to share their experience.

We talked with 74 patients and over 225 members of staff from across the hospital, including nurses at all levels, consultants and junior doctors, health care assistants, allied health professionals, chaplains, administrative staff, volunteers, managers and senior leaders. We observed how people were being cared for, talked with carers and family members, and reviewed over 93 patient records, including individual patient care records, patient treatment escalation plans, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms, medical notes, observation charts and pharmacy records.

Overall the trust was rated as inadequate, with Royal Cornwall Hospital rated as inadequate, West Cornwall Hospital rated as good and St Michaels Hospital rated as good. Penrice Birthing Unit was rated as requires improvement. We rated caring as good overall across all locations and services apart from St Michael's Hospital which was rated as outstanding for caring.

Facts and data about Royal Cornwall Hospital

Local Population:

Detailed findings

- Around 532,273 people (according to 2011 census report release published in February 2013**)** are served by the trust, although this figure can double during busy holiday seasons
- According to the 2011 Census, Cornwall's population was 98.2% white, 52% are women, 56.7% are between the ages of 20 and 64 and 18.7% are over the age of 65
- In the 2015 Indices of Multiple Deprivation, Cornwall was in the second-to-worse quintile for deprivation. The proportion of children aged 16 and under in low-income families was slightly lower than the England average.
- Cornwall performed better than the England averages for 25 of the 32 indicators in the Area Health Profile 2015. Areas where the county performed worse than average included excess weight in adults and incidence of malignant melanoma

Bed occupancy:

The trust's bed occupancy was consistently lower than the England average between quarter 3 of 2015/16 and quarter 4 of 2016/17. Occupancy varied between a low of 81.2% in quarter 1 2016/17 and a high of 84.7% in quarter 3 2016/17. In quarter 4 of 2016/17 occupancy was 83.0% compared to the England aggregate figure of 89.0%.

The trust has a total of 777 beds spread across various core services:

- 706 General and acute beds
- 45 Maternity beds
- 26 Critical care beds

Between February 2016 and January 2017 the trust had:

- 90,885 A&E attendances
- 110,270 Inpatient admissions
- 754.277 Outpatient appointments

Between January 2016 and December 2016 the trust had:

- 3,955 deliveries

Between Feb 2016 and January 2017 the trust had:

- 1,641 deaths
- 275,815 bed days

Staffing:

- As of April 2017, the trust employed 4984.3 whole time equivalent (WTE) staff out of an establishment of 5311.1 WTEs, meaning the overall vacancy rate at the trust was 14.7% for registered nursing and midwifery staff and 6.8% for medical staff.
- These comprised 793 medical staff (6.8% vacancy rate), 1,467 nursing and midwifery staff (14.7% vacancy rate), 260 allied health care professionals (6.1% vacancy rate), 1,489 categorised as other clinical staff (4.2% vacancy rate) and 1,293 categorised as other non-clinical staff (7% vacancy rate).

Revenue (between April 2016 and March 2017) :

In the latest financial year, 2016/17, the trust had an income of £379.5 million, and costs of £380.4 million, meaning that it had a deficit of £929,000 for the year. The trust predicts that it will have a deficit of £386,300 in 2017/18.

Commissioning:

- Services are commissioned by NHS Kernow Clinical Commissioning Group.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Requires improvement	Good	Inadequate	Requires improvement	Inadequate
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	N/A	N/A	N/A	Inadequate	Inadequate
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate

Notes

The above ratings have been aggregated with the January 2017 ratings for urgent and emergency services, medical care and end of life care.

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

Surgery

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

Information about the service

Royal Cornwall Hospital, Treliske, Truro, provides a range of surgery and associated services. Within the hospital, the surgery teams are part of the surgical services division, which includes surgery and surgical wards; theatres and anaesthetics; trauma and orthopaedics; pain services; and critical care.

The division includes surgery performed in West Cornwall Hospital, Penzance, and St. Michael's Hospital, Hayle. Some of the data referred to in this surgery report, unless we have been able to exclude it, will therefore include the other hospitals.

The Royal Cornwall Hospital in Truro has three main operating theatre units. One unit is located on the third floor of the Tower Block where there are six theatres for both day case surgery and inpatients, and on the second floor of the Trelawny wing where there are a further six operating theatres. Both sites are used for day case surgery and for inpatients, and include a theatre and recovery area for children. There are two further day case theatres in Newlyn unit on the main site.

Patients in Trelawny wing were admitted for elective (planned) procedures through Theatre Direct, St. Mawes surgical receiving unit, or the Newlyn unit. Patients in the Tower Block were admitted for elective procedures through the surgical admissions lounge. All emergency patients were admitted through the Trelawny wing, the St. Mawes surgical receiving unit, the trauma unit, or the emergency department.

The surgical services provided include trauma and orthopaedics, general surgery, urology, vascular surgery, ophthalmology, oral, and ears, nose and throat (ENT).

The trust had 5,947 elective (planned) admissions, 8,890 emergency admissions and 19,577 day-case admissions in surgery between February 2016 and January 2017.

There are four surgical wards at the Treliske site: 23 beds on St. Mawes ward, 56 beds on the trauma unit, 24 beds on Pendennis ward, and 22 beds on Wheal Coates ward.

There are also two day-theatre units, Theatre Direct, and the surgical admissions lounge. At the time of the inspection both units were being used as inpatient wards due to bed pressures across the hospital site.

At the last inspection where we inspected surgery, published in May 2016, we rated surgery as good overall. The individual domains were each rated as good with the exception of responsiveness, which was requires improvement.

We inspected the service on 4 to 7 July 2017 and undertook an unannounced visit on 17 and 18 July 2017.

Surgery

Summary of findings

We rated this service as inadequate because:

- When concerns were raised or things went wrong, the approach to reviewing and investigating the cause was unsatisfactory or too slow. There was little evidence of learning from events or actions taken to improve safety.
- Safety was not a sufficient priority. There was limited measurement and monitoring of safety performance. There were significant numbers of serious incidents and never events.
- Not all patients with severe sepsis had timely access to intravenous antibiotics.
- The emergency resuscitation team did not have immediate access at all times to a member of staff who was able to deal with difficult airway intubation.
- The service did not always ensure there was adherence to the World Health Organisation surgery safety checklist and audits of the checklist did not provide assurance of compliance.
- There was low compliance in patient screening for methicillin-resistant Staphylococcus aureus(MRSA).
- Staffing levels were consistently under plan on most wards during the day.
- There were significant delays for some patients having emergency surgery due to a lack of theatre availability. Operating theatres were not used efficiently.
- Too many patients were unable to access the care they needed, and referral to treatment times for patients to complete their treatment were not meeting national targets for most procedures.
- Pressures from urgent patient admissions and delayed transfers of care led to significant levels of elective operation being cancelled. Twelve patients with cancer had their operation cancelled from January to May 2017, seven on the day of their booked operation.
- Patients were not always operated on in the most appropriate operating theatres, and assessments to identify patient risks were not always carried out.
- Patients were frequently and consistently not able to receive services in a timely way for an initial assessment, diagnosis or treatment. Patients experienced significant waits for some services.
- The arrangements for governance and performance management did not provide assurance that the service was safe, effective and met people's needs.
- Risks, issues and poor performance were not always dealt with appropriately or in a timely way.

However:

- We found staff to be committed, dedicated, caring and motivated to deliver care and treatment to patients. Most patients we spoke with told us their experiences of care were positive, and staff were caring and professional.
- There were good arrangements for supporting patients with a learning difficulty going into theatre.

Surgery

Are surgery services safe?

Inadequate

We rated safe as inadequate because:

- When concerns were raised or things went wrong, the approach to reviewing and investigating causes was unsatisfactory or too slow. There was little evidence of learning from events or action taken to improve safety.
- When something went wrong, patients or those close to them were not always told and did not always receive an apology.
- Safety was not a sufficient priority. There was limited measurement and monitoring of safety performance. There were significant numbers of serious incidents and never events.
- Staff did not always assess, monitor or manage risks to patients. Some opportunities to prevent or minimise harm were missed.
- Changes were made to services without due regard for the impact on patient safety. There were inadequate plans to assess and manage risks associated with anticipated future events or emergencies.
- Not all patients with severe sepsis had timely access to intravenous antibiotics.
- The hospital was poorly compliant with care bundles.
- Patient identifiable information, including the results of pregnancy tests, were found in two unlocked sluice rooms.
- Not all staff had received effective mandatory training in the safety systems, processes and practices.
- The emergency resuscitation team did not always have immediate access to a member of staff who was able to deal with difficult airway intubation.
- The service did not always ensure there was adherence to the World Health Organisation (WHO) surgical safety checklist and audits of the checklist did not provide assurance of compliance.
- Staffing levels were consistently under plan on most wards during the day.
- Safety briefings did not always take place prior to the start of an operation or theatre list.
- Some equipment was not serviced, maintained, tested or calibrated.

However:

- There was good engagement in morbidity and mortality meetings, which led to service improvement.
- Ward safety briefings held every morning were well attended, with good communication where safety concerns were aired openly.

Incidents

- Incident reporting was not a sufficient priority and the approach to reviewing and investigating incidents was unsatisfactory or too slow. Between October 2016 and June 2017, the hospital reported nine never events, five of which related to surgery. The other four, whilst coming under the medical division (for example in cardiology or endoscopy), all involved the use of pre-operative checking systems which had failed. Two of the surgical never events were 'wrong site surgery' and three were 'retained foreign objects post-procedure'. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Senior managers could not provide assurance that all staff had read and understood the briefings regarding incidents. They told us about, and we saw, briefings for staff regarding the never events in theatres in 2017. We were told this was emailed out to staff and a briefing placed in the 'hot topic' folder in theatres, but they could not provide assurance that the briefings had been read, understood, and actions implemented.
- In accordance with the Serious Incident Framework 2015, the trust reported 16 serious incidents in surgery between June 2016 and May 2017. These met the reporting criteria set by NHS England as serious incidents. Of these, the most common type of incident reported was 'slips/trips/falls' (four). The second was 'surgical/invasive procedure incident' (three) and the third was 'treatment delay' (three). We saw actions plans for recent serious incidents were produced and there were plans to review these to gain assurance actions had been completed.
- At the time of the inspection the trust recognised its systems relating to the identification, grading and investigation of incidents required improvement. We saw an action plan from the 'executive serious incident panel' where grading of serious incidents across the

hospital was discussed. Within surgery, at the time of the inspection, a surgeon had been tasked with reviewing all reported incidents to check whether incidents had been graded correctly.

- Most staff we spoke with understood their responsibilities to raise concerns, record safety incidents, and near misses and were encouraged to report them. Most staff told us they would have no hesitation in reporting incidents and were clear on how they would report them. However, they felt limited action would be taken as a result. Staff rarely received feedback on incidents they had reported, and some ward managers told us they had little time to share feedback with staff. For example, we found 30 of the 44 incidents on Trauma Direct were overdue for review. This was due to a lack of management time, and responding to incidents was not given sufficient priority. This meant incident reporting, categorisation, investigation and learning was not consistent or undertaken in a timely manner, which could affect patient safety.
- Senior managers told us action plans following incidents were followed through to ensure learning was embedded, or when new equipment was an action this was provided. A review of action plans formed part of the new governance meeting structure. We saw reviews of actions plans were booked for meetings six months after the action plan was published to seek assurance the actions had been completed. However, we had concerns about the quality of some action plans and the processes for ensuring all actions were monitored through to completion in a timely way.
- Lessons from serious incidents were not sufficiently shared in the wider trust to ensure action was taken to improve safety beyond the affected team or service. Managers were unable to provide examples of learning from one part of the organisation being shared with other divisions, specialties or areas. Staff could not tell us about lessons they had learned from other divisions.
- Opportunities for investigating, identifying and sharing learning were sometimes missed. We found evidence showing incidents resulting in harm to the patient were not always being reported appropriately. There were examples of incident reports for pressure ulcers graded three and four (the most serious categories), which were reported as 'No apparent injury or minor injury not requiring first aid'.
- Some staff felt investigations into incidents were about blame and not learning. Relevant staff were involved in the review or investigation of a serious incident. However, some staff involved in never events told us they felt the process was focused on allocating blame and not about learning lessons.
- Monthly surgical mortality and morbidity reviews fed into service improvement. There was a mortality review oversight group, and key messages were shared at governance meetings. Meetings were well attended, and we saw evidence of lessons learned to improve patient care. We saw examples of morbidity and mortality with good quality information presented and actions identified with a clinician identified who was accountable for each action.

Duty of candour

- The service was not meeting the requirements relating for duty of candour in line with this regulation (including training, support for staff, audits, monitoring). The duty of candour is a regulatory duty which relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw that some duty of candour conversations were written in the patients' records, but this had not been followed up in writing. Mandatory training for duty of candour showed 93% compliance for nursing and midwifery staff and 60% compliance for medical staff. However, it was not clear whether the data provided related to all those in the surgical directorate or to all medical staff at the Treliske hospital. Senior managers or executive leaders could not provide assurance of oversight of duty of candour, as there was no monitoring in place. There were no audits of duty of candour to give assurance of compliance against this regulatory duty.
- Patients, or those who spoke for them, were not always told when they were affected by something which went wrong, given an apology or informed of any actions as a result. The trust's 'Being Open and Duty of Candour' policy (which included duty of candour) was not being followed in line with the regulation. When things went wrong, reviews were not always carried out. We saw that conversations had taken place with patients and their families and had been recorded in the patient's notes. However, the record of these conversations did not

always cover all areas outlined in the policy and had not been followed up with a letter. We saw there were differences across the division concerning how duty of candour was implemented and reported.

Safety thermometer

- Not all patients were receiving care and treatment that avoided them coming to harm. The service monitored the incidents of avoidable harm to patients from pressure ulcers, falls, catheter-associated urinary tract infections, and venous thromboembolisms. The NHS safety thermometer is an improvement tool used to record the prevalence of avoidable harm to patients. It will provide information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient avoidable harm and its elimination. The surgery division had missed its local target of 93% of no avoidable harm in six of twelve months between June 2016 and May 2017.
- Safety thermometer information was displayed clearly on all surgical wards, which informed patients and relatives of how the ward was performing in these areas of patient safety.
- We reviewed data relating to surgical areas from the Patient Safety Thermometer between April 2016 and April 2017. Surgery reported 40 new pressure ulcers, 15 falls with harm and 12 new urinary tract infections in patients with a catheter. There were no new urinary tract infections in patients with a catheter in March or April 2017. We saw in meeting minutes the wards were working toward reducing hospital acquired pressure ulcers.
- The trauma unit reduced the number of falls by the introduction of a national initiative 'Bay Watch': an intervention to reduce falls in patients living with dementia. The initiative was to ensure a member of staff was always present in a bay with patients at high risk from falls. Following a reduction in falls, this initiative was being rolled out to other areas of the trust.
- Not all patients, on admission, received an assessment of venous thromboembolism (VTE) or blood clots, and their bleeding risk. The service had met its local target of 90% from June to December 2016. However, from January to May 2017 it consistently missed this target.
- As required, patients were reassessed within 24 hours of admission for risk of VTE and bleeding, and we saw this was documented in all 19 patient records we looked at.

Cleanliness, infection control and hygiene

- There were mostly reliable systems to prevent and protect patients from healthcare associated infections throughout the surgical areas.
- The National Institute for Health and Care Excellence (NICE) guidance set out explicit guidance based on best evidence in respect of the preoperative phase. This included showering, hair removal, patient theatre wear, and staff theatre wear. NICE also set guidance on the intraoperative phase; including hand decontamination, incise drapes, sterile gowns, gloves antiseptic skin preparation. During the inspection, we observed surgery and saw staff adhered to the guidance.
- NICE guidance QS61 Statement 3 (2014) states patients receive care from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. The service undertook monthly audits of the 'five moments of hand hygiene'. Audits showed between 96% and 100% compliance for hand hygiene each month between November 2016 and June 2017 in surgical wards and theatres.
- The audit practice was not consistent with our observed care. We saw a number of nursing staff, occupational therapists, a bed manager, and a cleaner who did not cleanse their hands when entering or leaving the ward areas on St Mawes ward and the trauma unit. There were also no hand washing facilities or hand gels available on the entrance to bays on the trauma unit. The hand gel on admission to St Mawes ward was blocked by three wheelchairs. We also noted hand gel was not available outside the three bays in the surgical admissions lounge.
- There was close to full compliance with infection risk avoidance in urinary catheter care. An audit of compliance with NICE guidance QS61 Statement 4: Urinary Catheters showed there was compliance in 10 out of 12 months in 2016/17. Patients who needed a urinary catheter had their risk of infection minimised by procedures necessary for the safe insertion and maintenance of the catheter, and its removal as soon as it was no longer needed.
- Staff told us standards of cleanliness were not always maintained at night. Although wards had regular cleaning staff, ward staff told us domestic staff finished either at 1.30pm or at 5pm. We reviewed the high-risk service level agreement, which outlined wards areas

would be cleaned between 5pm and 9am, but staff told us domestic cleaning staff did not always turn up. This meant by the evening some bins could be overflowing and toilets could need cleaning. If cubicles required deep cleaning, nursing staff would request a cleaning team but would sometimes have to escalate this to a site manager to get the work undertaken. Staff on the surgical admissions lounge told us due to a shortage of cleaners they sometimes cleaned the toilets, emptied bins or deep cleaned cubicles themselves.

- There were unresolved maintenance issues, which were a risk to the spread of infection. On Pendennis ward, staff told us sewage regularly backed up through a toilet in one of the patient bays. This had been ongoing for three years, and nurses reported this had been getting worse over the last three months. The impact was a bay of four beds was regularly closed, and also meant there was only one available shower for female patients, leading to queues for washing.
- Staff in the operating theatres said they were satisfied with the standard of cleaning. The cleaning was undertaken by a private company, and the hospital undertook monthly audits of the standards of cleanliness on wards and in theatres. We saw cleaning logs in theatres and anaesthetic rooms were signed daily. Staff in theatres told us they were satisfied by the cleaning service provided.
- 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. Staff told us this system worked well with fast-track stickers used when reusable equipment was required again urgently.
- Staff told us they had identified some sterile packaging with holes in, and they were auditing this at the time of the inspection. We saw these had been reported. However, these were categorised under many different headings so it was difficult for the service to get a clear picture of how often this had occurred. Staff told us that these packs could be replaced quickly where required.
- There was a variable performance with control of hospital-acquired infections. For the period April 2016 to March 2017, the service reported one hospital acquired methicillin-resistant Staphylococcus aureus(MRSA) bacteraemia against a target of zero. The case went through the post infection review process and was deemed to have been avoidable. Specific actions relating to wound care, including correct assessment and documentation) had been identified.
- Across the hospital there were 25 hospital acquired methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemias reported during 2016/17. This was above the target of 14 agreed with commissioners. A thematic review carried out with support from Public Health England did not identify a specific strain of Staphylococcus aureus or any recurring themes. Root cause analysis investigations had been carried out on all cases with actions identified and implemented. Of the 25 cases of MSSA identified across the hospital, 22 were related to the use of vascular access devices. An action plan was agreed to make improvements to infection rates relating to these devices. This included a month-long focus on line care and documentation, and to strengthen the audit programme.
- There were variable results in the audit of patient screening for MRSA. The concerns were with screening of elective patients on Newlyn ward with 16% of patients not screened for MRSA between April 2016 and March 2017. In the surgical admissions lounge, 20% of patients were not screened (with data collected from January to March 2017). For emergency patients, data was collected from October 2016 to March 2017. This showed 37% were not screened on Wheal Coates ward, 16% on the trauma ward, and 33% on both the surgical admissions lounge and Theatre Direct. On Pendennis ward, 79% of patients were not screened, although this was for a low number of patients (eight out of 11). We saw no evidence of this issue being reported as part of patient safety in the governance meeting minutes.

Environment and equipment

- The design, maintenance and use of facilities and premises meant there were risks to patients. We found some wards were not equipped for their designed use

because of the number of medical and surgical patients being admitted to a ward not suited to their needs. For example, the Newlyn day unit was often used as an admissions ward for patents directly from the emergency department, and medical patients being admitted to the unit. Consequently, operating theatre lists were frequently under-booked, less productive and efficient, while waiting lists were increasing. Staff had raised this as an issue with management. They had been advised to continue to under-book theatre lists due to the expectation of continuing to use wards for medical patients.

- The systems and processes for ensuring equipment was serviced, maintained, tested or calibrated were not effectively managed. Equipment on some wards had not been safety tested within the required length of time. For example, on the trauma unit we found a bladder scanner, which was due a safety test in January 2017. In Theatres Direct, we found a manual blood pressure cuff, which was due a safety check in January 2014. On the surgical admissions lounge we found an oxygen saturation monitor and an electrocardiogram monitor, which were due to be safety checked in June and July 2016 respectively. We saw daily checks of anaesthetic equipment were undertaken before the start of the theatre lists and the logbook of equipment was signed on a daily basis in line with The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines for checking for anaesthetic equipment. Staff told us they would contact the medical physics department if a machine was found to be faulty, but would use a spare machine in order to proceed with the days operating list. However, a maintenance record of medical devices report dated June 2017 showed planned preventative maintenance had not been carried out by the expected date on three out of 18 anaesthetic machines (17%); and 11 out of 110 (10%) anaesthetic syringe pumps. The report did not include an action plan to resolve this.
- Surgical equipment including resuscitation equipment was available and checked in line with professional guidance. Resuscitation trolleys were placed within wards and units so they were accessible and visible. 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 or checked. Daily checks were required for resuscitation trolleys, and equipment including defibrillators on each ward, theatres and other surgical areas. Records we looked at confirmed these checks were taking place. However, on Theatre Direct ward we found the anaphylaxis kit had expired on 30 June 2017 despite daily checks being undertaken. This was immediately rectified by ward staff on the unit.
- The arrangement for managing waste and clinical specimens kept people safe. This included classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste. Clinical waste was stored and disposed of safely. We saw sharps bins were being used following the manufacturers guidance were not overfilled, shut when not being used, signed, and dated when sealed ready for disposal. Monthly audits of sharps bins on wards showed they were mostly used in line with trust standards, such as being stored correctly, the temporary closure in place and items below the fill line. Compliance in January to March 2017 across the surgical wards ranged from 70% to 100%.

Medicines

- Arrangements for managing medicines, medical gases and contrast media did not always keep patients safe. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of medicines.
- Some medicines had passed their expiry date. On the trauma unit we found a batch of lorazepam, which had expired in April 2017. We also noted an incident had occurred on the trauma unit during the inspection period when a patient was administered an out of date controlled drug. However, the report stated there was 'no apparent injury or minor injury not requiring first aid'. On the surgical admissions unit we found two bags of intravenous energy feed which had expired in November 2016. On St Mawes ward, all the medication we checked was in date.
- There was a lack of security around the disposal of some medicines. On our unannounced inspection, we found four bins filled with large number of nearly empty medicine bottles and broken glass vials in the unlocked sluice room on the Theatre Direct unit. Some bottles contained droplets of oromorph, paracetamol, and flucloxacillin. Staff and senior managers told us these bins, which did not have lids, had been introduced

across the hospital. They recognised this was a risk to patients and visitors to the hospital. This incident was not subsequently reported on the hospital's incident reporting system or on the surgery risk register.

- There was a lack of oversight to keep medicines at the correct temperature. We noted some medication storage rooms were warm. An incident had been reported in June 2017 regarding fentanyl being stored in a treatment room, which had reached 31 degrees Celsius. The pharmacy department was aware of this issue, and was developing advice for staff on medicine expiry date reduction in hot weather, although this was not in place at the time of the inspection.
- Some patients did not have timely access to medication. We noted in June and July 2017 there were two incidents reported where patients with Parkinson's disease did not receive their medication on time. In one incident, medication was not prescribed by the admitting doctor. The second incident related to a patient who was not consistently receiving their medication, with doses being given up to two hours late or one hour early. Medicine for Parkinson's disease is time-critical. The patient was not given the option to administer their own medication in line with the hospital's policy.
- Patients' own medicines were either stored in a locked cupboard or, if available, in the unit by the patient's bed. Any controlled drugs brought in by a patient would be locked in the controlled drugs cabinet, and listed in the controlled drugs book. However, pharmacists told us patients who had their own drugs in a locker by their bed were reliant on nurses to unlock the cupboard as keys given to patients had gone missing. It was acknowledged this meant patients' own medications could still be given late to patients in times when nurses were busy.
- There was not always good discharge planning in relation to medicines. Pharmacists told us they liked to be part of the ward rounds and therefore plan in advance the medicines for patients to take home upon discharge. However, staffing shortages within the pharmacy team meant they could not always be part of the daily ward rounds.
- An inpatient pharmacy service supplied medicines to all wards and departments and dispensed 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.
- As required for safety, intravenous fluids were stored in locked cupboards on all wards we visited during our inspection.
- Fridges on wards were electronically connected to the pharmacy and therefore temperatures were monitored remotely. This enabled pharmacy staff to be promptly alerted to any issues with fridge temperatures which could be dealt with promptly.
- Nursing staff were aware of the guidance on administration of controlled drugs as per the Nursing and Midwifery Council – Standards for Medicines Management. Nurses who were administering controlled drugs were correctly signing the book in duplicate and checking each other's actions to ensure everything was carried out correctly. Controlled drugs were securely stored in lockable cupboards, checked daily, and signed for. We checked a sample of controlled drugs, which agreed with the drug register. However, there had been 19 controlled drug discrepancies reported in anaesthetics and theatres between June 2016 and May 2017.
- The pharmacy department developed its own electronic dashboards using the data within hospital-wide systems. These were available for pharmacists, nurses, medicines' management technicians, and doctors. They were used to help prioritise workload and flag high-risk patients and issues.

Records

- There was good completion of patients' records, although areas of patient confidentiality needed to improve. Patients' individual care records were written and managed in a way that kept patients safe. This included ensuring patients' records were up-to-date, complete, and legible in line with the hospital's policy.
- Staff at the hospital used an electronic system to record patients' observations such as temperature, blood pressure and heart rate. This meant current information was always available to clinical staff caring for each patent.
- The hospital did not have effective systems and processes in place to ensure that confidentiality was maintained at all times. We found bags containing patients' notes on the floors at ward entrances across several surgical areas. On one occasion, we found a porters' trolley unattended in the main hospital corridor full of zip lock bags containing patient notes. We also found lists of patients on wards which contained patient

identifiable information, including names, addresses and dates patients were due to come to the hospital for their operation. These were placed on a shelf in a corridor at the main entrance Theatre Direct, which could not be viewed from the staff workstation and was not staffed out of hours. This meant that members of the public had open access to view or remove these folders. There were several unlocked consulting rooms in this area, which contained filing cabinets that were unlocked, containing patient notes. In one consulting area, we found a patient's test results left on a desk. Outside the consulting rooms was a wall mounted box, which contained letters to patients and further test results. There was, however, a system on most surgical wards for keeping patients' medical and nursing records secure. Lockable trolleys were provided outside each bay, and we saw records were accessed and locked away as soon as staff had finished with them.

- Wards used whiteboards at the staff workstations to provide an overview of patient information. This provided staff with the most up-to-date information at all times about their patients. This did not contain confidential personal information, and nurses were vigilant in maintaining patient confidentiality.
- The systems, processes and practices essential to maintain some patient confidentiality were not always identified, operating effectively, and communicated to staff. On the unannounced inspection, we found the results of 12 pregnancy tests on Theatre Direct and 17 on St Mawes ward in unlocked sluice rooms. In both places, the information included patient identifiable details including the patient's name, date of birth, NHS number and pregnancy status. We escalated these incidents to the nurses in charge of the wards and actions were taken to resolve our immediate concerns. However, staff and senior managers confirmed this was a hospital-wide issue, but recognised this information should be stored securely. These incidents were not subsequently reported on the hospital's incident reporting system.

Safeguarding

- There was poor compliance with updating mandatory training for safeguarding. As at 31 May 2017, the trust's 95% target was met for nursing staff in surgery for safeguarding adults' level one (98.8%). However, the target was not met for any of the other safeguarding training. Completion was particularly low for safeguarding children level two (54.5%) and safeguarding children level three (62.5%). The trust's target was not met for medical staff for any of the four safeguarding modules for which these staff were eligible. Completion was particularly low for safeguarding children level two (53.7%).
- Staff had access to a safeguarding link nurse who provided good support. We also saw good examples where nurses and theatre staff had identified patients at risk, escalated these and taken appropriate action to keep patients safe.
- There were arrangements to safeguard adults and children from abuse, which reflected relevant legislation and local requirements. Staff understood their responsibilities and followed safeguarding policies and procedures. For example, staff working in the recovery area told us they had undertaken adult and child safeguarding training. They explained how they would make safeguarding referrals and had received feedback on past referrals.
- Staff received training in emerging areas of concern around abuse. This included identification and escalation of suspected female genital mutilation.
- We saw posters regarding safeguarding were on notice boards in all staff areas in theatres and on wards to remind staff of their responsibilities and action to take if they had any concerns.

Mandatory training

- Data supplied to us demonstrated not all staff had received effective mandatory training in safety systems, processes and practices. However, managers and the human resources business partner confirmed the electronic staff record reports did not accurately reflect completion of training.
- There were 22 mandatory training modules for nursing and midwifery staff and 21 for medical and dental staff. The hospital target was for 95% of staff to complete the mandatory training modules Furthermore, mandatory training modules did not include data protection, control of substances hazardous to health (COSHH) or lone working, as suggested by Skills for Health.
- The trust's training target of 95% completion was met for nursing and midwifery staff for Equality Diversity and Human Rights (99.4%) and Mental Capacity Act training (100%). However, the target was not met for infection control training (80.6%), duty of candour training (90.3%) or resuscitation and basic life support (81%).

- The trust's target was also not met for medical and dental staff. In particular, only 57.8% of the required staff were up to date with duty of candour training. Only 70.1% were up to date with infection control training.
- In March 2017, high-risk medical devices were included in mandatory training for clinical staff. The medical device team undertook a training needs analysis for every staff group, and introduced an online training module. This was to be followed up by an assessment to ensure staff were competent to use medical devices.
- Staff told us, although they could book time for training, there were occasions when this was cancelled because of staff shortages, or in periods of operational pressures.

Assessing and responding to patient risk

- Comprehensive risk assessments were not carried out for some patients and not all risk management plans were developed in line with national guidance. Risks were not managed positively.
- The service did not always ensure compliance with the World Health Organisation (WHO) surgical safety checklist. This had included failure to mark the surgical site (marking on the patient where the operation will occur). The information provided by the hospital showed a number of occasions where marking of a surgical site had been completed incorrectly or with limbs not being marked. There were also changes of personnel in theatre after completion of the WHO checklist. Furthermore, there were two never events of wrong site surgery which may have been prevented by proper completion of the checklist.
- There was reason to question the validity of the audit of the WHO checklist. Audits of compliance with the WHO checklist showed completion of between 95 and 99% from May 2016 through to May 2017. Some managers cast doubt on the validity of the audits, telling us staff that carried out the audit were too close to the working environment, and there had been selection of lists and theatres where compliance was expected to be high.
- In response to the concerns of staff, from June 2017 a revision had been made in the auditing of WHO checklists where staff would audit theatres external to their usual work place. The service was in the process of revising the WHO checklists to make these specific to some particular specialties, including breast surgery, and trauma and orthopaedics, which should more effectively mitigate any identified risks associated with that specialty. For example, the revised trauma and orthopaedic WHO checklist would include an increased focus on the management of venous thromboembolism prophylaxis (preventative treatment) and checking of components for removal of metalwork. The revised perioperative document would include the six-point prosthesis checklist to be completed for all cases of implant.
- Systems and processes for ensuring patients were risk assessed prior to surgery were not adequate. The service had no current guidance available for staff to set standards as to which patient should be allocated to which list, in which theatre. This meant that at times, patients were operated on in an inappropriate operating theatre, without the required level of skilled staff or equipment. Coupled with that, we found that safety briefings were not always undertaken prior to the start of an operation or theatre list.
- The emergency resuscitation team did not always have immediate access to a member of staff who had experience to deal with difficult airway intubation. Anaesthetists told us the emergency resuscitation team should call for a member of the intensive care team if a patient required airway management. A consultant anaesthetist said that although all anaesthetists had training in difficult airway intubation, they had not all had experience of dealing with these situations.
- Patients were assessed and monitored using the National Early Warning System (NEWS). This was a system to alert staff to a patient deteriorating when certain clinical 'triggers' were reached. The trust's monthly clinical dashboard showed in surgery and theatres there were good levels of compliance in noting NEWS scores in patient records. This included a clear patient identifier, observations recorded as per the required frequency, and clinical response taken appropriately. Compliance scores were between 93% to 100% per month from December 2016 to May 2017. The recording of NEWS scores on surgical wards was good overall. However, on Pendennis ward staff had not reached the required standard of 90% in four out the seven months of the audit.
- The hospital was poorly compliant with care bundles. The care bundle approach is now a recognised and familiar approach to improvement across the NHS. Care bundles typically bring together a small number of focused interventions designed to effect improvement in a particular disease area, treatment or aspect of care. Data from 2016/17 showed only:

- 66% of patients with acute kidney disease, and
- 53% of patients with chronic obstructive pulmonary disease patients, and
- 33% of patients with community-acquired pneumonia, and
- 40% of patents with sepsis were on an appropriate care bundle.

- Theatres teams used NEWS scores to assess any potential deterioration in patients. We saw NEWS scores used during surgery. Patient observations were entered on to a mobile device, which monitored the vital signs of the patient. In one case, sedation was given to a patient, and their oxygen levels were observed to have dropped. This increased the patient's NEWS score, and the procedure was halted until the patient became stable. The mobile device automatically alerted the critical care outreach team. However, the nurse in theatre was able to override the alert as an experienced consultant was present and the situation was under control. We were told the mobile device, which altered the critical care outreach team, was invaluable. This was particularly on evenings and weekends, where if a patient's condition deteriorated, the outreach team would be alerted and responded quickly.
- Surgical site infections were mostly an infrequent occurrence. The service monitored surgical site infection rates for all surgery including hip replacement, knee replacement, the repair of fractured neck of femur, and reduction of long bone fractures. From July to September 2016, data was collected and reviewed for total hip replacements, total knee replacements and neck of femur repairs. Two infections were identified out of 104 neck of femur repairs (1.9% against a national average of 1.4%). No infections were identified in total knee replacement, total hip replacement and long bone surgery. Breast surgical site infection rates were monitored from October to December 2016. Breast surgery was carried out on 247 patients. Three patients developed superficial infections (1.2% against a national rate of 3.7%)
- There had been progress with response to patients with a fractured next of femur. The service had a fractured neck of femur work stream which had identified the average time for a patient to be operated on had improved steadily from June 2015 to April 2017. The average time to theatre was 26 hours compared to 32 hours nationally. A steady improvement in mortality was evident over the same period, which was in line with national averages.
- The hospital had a nurse-led clinic, which assessed patients for elective and day surgery. The nurses linked with GPs to ensure patients were prepared for surgery, for example, by adjusting medication, as well as getting ready for coming into hospital. We followed a patient through their pre-assessment clinic and found it very thorough, with plenty of opportunities and encouragement for the patient to ask questions, or ask for clarification.
- There was some improvement on sepsis recognition and monitoring, but not on patients being prescribed timely antibiotics. For those admitted patients identified as having sepsis, there was evidence of continuation of monitoring and treatment. Data regarding sepsis covered both the emergency department and surgical admitting areas, and therefore it was not possible to identify the performance of sepsis management specifically within the surgery division. We saw evidence there was an improving trend on patients being screened for sepsis, and the trust had exceeded its 90% target from February to May 2017. However, performance across the hospital for inpatients with severe sepsis receiving intravenous antibiotics within one hour was declining from June 2016 to May 2017. Performance ranged from 37% to 65%.
- We saw evidence of the sepsis toolkit being used on the wards. There was a 'Sepsis 6' box available on all wards. This contained all the information for nurses to use with patients who were suspected of having sepsis.
- Ward safety briefings were held every morning prior to surgery. We saw these were well attended, and well led. There was good communication of issues with any safety concerns aired openly. The discussion we observed included staff dealing with four cancellations in the theatre suite in Trelawny theatres.
- For emergency surgery, patients' fitness for surgery was assessed by anaesthetists using the American Society of Anesthesiologists (ASA) classification system. The hospital was unable to provide data to assure us if preoperative mortality was assessed at more than 10%, patients were reviewed by a consultant within four hours. They were not able to provide evidence that the procedure was also overseen by a consultant anaesthetist irrespective of the day or night.

- The service recognised but had not addressed the risk that emergency surgical patients would not be seen within four hours of arriving on the surgical admissions lounge. This was because the lounge did not have the facilities to record arrival time of patients, and because doctors based in the unit were working on the emergency department. This issue was raised by the Coroner in a Rule 43 letter in 2014 and was on the corporate risk register. The potential impact noted on the register was insufficient rapid recognition of deteriorating patients leading to avoidable harm and possible adverse outcomes. Gaps in controls included adequate staffing levels, and systems not able to record patients' admission time and determine whether the standard had been breached. There was also a risk that the patient's surgery would be delayed, as doctors were not monitoring the patients.

Nursing staffing

- There were high levels of vacancies among nursing staff and healthcare assistants in surgery.
- We saw during April to June 2017, the surgical wards were consistently under plan for nurses on shift during the day, with the exception of Wheal Coates, which had the planned number of registered nurses in May 2017. The surgical assessment unit and Theatre Direct had 82% of planned nurses during the day in April, 85% in May and 88% in June. This was of particular concern as the numbers of healthcare assistants also fell short of planned levels during the day in these two areas where there were 81% of planned numbers in April, 75% in May and 75% in June. However, we noted the surgical wards were mostly meeting or exceeding the number of planned nurses and healthcare assistants at night.
- Due to a high number of nurse vacancies, most of the senior nurses were not able to maintain their supernumerary status at all times. Supernumerary status meant the senior nurse had oversight and management of the ward, rather than being directly involved in patient care. To help with staff shortages or not quite the right skill mix, most of the senior nurses we met on wards or the operating theatres were required to work clinically at least once or usually more each week. This had become embedded practice and was seen as business as usual.
- The hospital used the Safer Nursing Care Tool to identify the number of nurses required. Staffing was based on the needs of the patients and the ward. The only increase in staff against the recommendations was in Theatre Direct, where night staffing on Friday, Saturday, and Sunday nights had been funded to enable the theatre to stay open for 24 hours, seven days a week. The surgical admissions lounge did not use the Safer Nursing Care Tool but work on staffing requirement had been completed in summer 2016 with the change to a 23-hour unit.
- There was a high number of nursing-staff vacancies:
  - The surgical admissions lounge and Theatre Direct had a vacancy rate of 22.5% against a funded establishment of 54.8 whole time equivalent (WTE) nursing staff.
  - Pendennis had a vacancy rate of 11% against a funded establishment of 30.2 WTE nursing staff.
  - Wheal Coates had a vacancy rate of 23.4% against a funded establishment of 33.3 WTE nursing staff.
  - On the trauma unit, there was a vacancy rate of 17.1% against a funded establishment of 80 WTE nursing staff.
  - St Mawes ward met its funded establishment figures for nursing.

At the time of the inspection, the service was working with its human resources business partner to identify how to fill vacancies, and actions included to increase the use of using the trusts internal bank staff to reduce agency use.

- The trust used its own in-house bank staff to cover most vacant nursing shifts. Between April 2016 and March 2017, the trust reported an average bank and agency use of 9.7% across the surgical wards. All five wards reported use of over 10% of bank and agency staff in at least three months in this period. Pendennis ward reported use of bank and agency staff of over 10% in nine of the 12 months. Wheal Coates was the only ward to report over 20% (in December 2016 and March 2017). For anaesthetic services between 9 and 15% of theatre time was covered by agency staff.
- Staff in both the surgical admission lounge and Theatre Direct told us they could work flexibly across both areas. During the inspection, we saw one nurse on the surgical admissions lounge had become responsible for admitting patients to the lounge as well as those recovering from surgery. This was recognised as potentially unsafe and so another nurse was then moved from Theatre Direct to help provide support. Staff told us this was a regular occurrence and was not safe for patients as it often left other wards short staffed.

- It was not possible for the trust to be assured there were safe levels of staffing in theatres. We requested theatre staffing data so we could assess what nurse staffing levels and skill mix had been planned to compare with actual staffing levels. We were supplied data by the trust with the caveat the "data is not a suitable measure for demand-based rostering as used in theatres and recovery therefore the data submitted for these areas should be used with caution".
- There were variable vacancy levels in the operating theatres:
  - Across Trelawny theatres, Tower theatres and Newlyn ward, there was a vacancy rate of 5.9% against a funded establishment of 108.7 WTE nursing staff.
  - In anaesthetic services, there was a vacancy rate of 14.2% against a funded establishment of 39.6 WTE nursing staff.
  - In recovery, there was a vacancy rate of 8.9% against a funded establishment of 53.0 WTE nursing staff.
- Sickness rates across medical and nursing posts in the division was at 4.5% in March 2017. This was 0.7% above the acceptable level set by the trust, and 0.4% above the trust's average. 'Anxiety, stress, depression, or other psychiatric illnesses' accounted for 25% of absence in the division.
- Arrangements for handovers and shift changes ensured patients were safe. We saw thorough handovers between theatre staff and recovery staff, which included any issues, such as NEWS scores. Staff gave instructions about patient observations. We also saw good handovers among ward staff with clear and timely information given in an unhurried manner.

Surgical staffing

- There were high vacancy rates in medical staffing. In March 2017, there was a vacancy rate of 14.2% (relating to 44 WTE vacancies). Senior managers confirmed recruitment was a significant challenge. The highest vacancy rates were in the trauma and orthopaedics specialty, where there were 39.1% middle grade vacancies and 25.6% junior doctor vacancies. However, the vacancy rate for consultants in this specialty was low at 4.2%. For the head and neck specialty, there was a vacancy rate of 20.5% for middle grade doctors and 34.6% for junior doctors. Senior managers told us there was to be a hospital-wide approach to recruitment with an overseas and summer campaigns, but not specific to surgical vacancies.
- There was a high rate of medical staff leaving the trust, although reasons for staff leaving were not analysed. Between June 2016 and May 2017, the trust reported a turnover rate of 18.6% for medical staff in surgery. This breached the trust target range of between 10 and 14%. Turnover rates were over 20% in four out of 10 surgical specialties: oral and maxillofacial (26.3%), surgery (20.8%), urology (25%), and vascular surgery (25%).
- There were low levels of sickness in the majority of the surgical specialties. Between May 2016 and April 2017, the trust reported a sickness rate of 2.4% for medical staff in surgery. This was within the trust target of 3.75%. Only one specialty, vascular surgery, reported a sickness rate of over 10% (11.5%).
- Theatre staffing followed the Association for Perioperative Practice (AfPP) guidelines. The emergency operating theatre was staffed 24-hours a day, seven days a week. An anaesthetic support assistant was on call between 9pm and 8am to support the two staff on duty.
- In January 2017, the trust's medical staffing skill mix was slightly different to the England average with more consultants in post in percentage terms. Management and staff confirmed they were under resourced for junior doctors and the deanery were unable to provide enough trainees. They also confirmed they were finding it increasingly difficult to recruit to non-trainee grades. Managers had asked consultants to 'act down' to fill for junior doctors absences. The division had identified there was a risk the medical rota would not be covered due to the high level of vacancies. This was because of the loss of deanery posts and the inability to recruit to vacant posts, which could affect appropriate care and cause delays to treatment. Rota coordinators escalated the problems to managers when rotas could not be covered. In orthopaedic surgery, criteria for a daily safety brief were being drawn up to ascertain whether it was safe to perform elective operations.
- The orthopaedic directorate employed 25 junior doctors, but this was to be reduced to 22 in August 2018 because of a reduction in the number of posts funded by the deanery responsible for postgraduate medical training.

Major incident awareness and training

- The hospital had an emergency preparedness policy. The covered any occurrence which may present a serious threat to the health of the community. This

included disruption to the service or caused such numbers or types of casualties as to require special arrangements to be implemented by the hospital. Staff knew how to access the plan in an emergency.

Are surgery services effective?

Requires improvement

We rated effective as requires improvement because:

- There was not an effective system for identifying and sharing new or updated guidance.
- Results of clinical audits were not always shared with relevant staff.
- The hospital demonstrated poor compliance with care pathways to bring about improvement in a particular disease area, treatment or aspect of care.
- There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development.
- Post inpatient follow up reviews did not always take place, which may result in a patient being readmitted for further care and treatment.

However:

- There was good multidisciplinary working. When patients lacked the mental capacity to make a decision staff made best interest decisions for them in accordance with legislation.
- There was good compliance with NHS England's standards for seven-day working in hospitals.

Evidence-based care and treatment

- The hospital's system for identifying and disseminating new or updated national guidance, standards and practice was not effective. We found during the inspection that the wrong framework for identifying never events was used within the surgical division. A change to the framework was made in 2015 and, although this was known at the trust level, this was not known within the division. Staff told us that NICE guidance and safety alerts would be implemented, disseminated and monitored through the trust's guidelines and alerts steering process group. However, we did not see evidence of oversight and checks to ensure that relevant staff were aware of all new guidance.
- There was easy access to trust policies through its intranet site. Some wards kept hard copies of protocols available for staff in offices or on staff workstations. However, there were no processes to ensure that the policies kept in files were up-to-date and represented the latest version.
- Surgical teams were involved in a wide range of clinical audits but it was not always clear how results of audits were shared with colleagues. These include national audits, specialty audits, and audits of NICE guidelines. However, it was not always clear where results of audits were shared. Clinical audits were not on the agenda for the dermatology specialty meetings or the ophthalmology audit or governance meetings. However, there were some specialty team meetings where results of audits were discussed. For example, in the ear, nose and throat department, and trauma and orthopaedics governance meetings there were standing agenda items for results and actions of clinical audits.
- Surgeons had worked with the British Association of Day Surgery to meet recommended day case rates, and highlighted good practice and areas for development. Orthopaedics in particular reviewed their pathways in detail and changed a number of elements increasing the number of patients seen as a day case rather than as an inpatient.
- Preoperative assessments for patients we reviewed were comprehensive and covered all health needs, including clinical needs, physical health, nutrition and hydration. We saw there were specific guidelines for certain patient groups, such as those attending for bariatric surgery. Patients' social care needs were also addressed preoperatively.
- Surgical staff were engaged in NCEPOD data collection and reporting. However, there was no evidence they used this to monitor their services against best practice and benchmark their outcomes. The purpose of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is to assist in maintaining and improving standards of care for adults and children by reviewing the management of patients, undertaking confidential surveys and research, maintaining and improving the quality of patient care and publishing results of such activities.

Pain relief

- Patients' pain was managed effectively for patients who had the capacity to communicate effectively. The

hospital had a 24-hour consultant-led dedicated pain team who assisted with chronic and acute pain. The team did daily ward rounds, and staff told us they were contactable at any time for advice or to review a patient.

- In 2014, the acute pain team identified a problem with the postoperative pain management for patients undergoing amputation at RCHT. The quality improvement framework for major amputation surgery recommends there should be a formal pain management protocol for post amputation pain management with access to the acute pain team. In February 2016, a range of changes to protocols and guidelines were rolled out. At the time of the inspection, an audit was being repeated following the implementation of the changes to evaluate their effectiveness.
- Nurses were compliant with training in post-epidural management. Nurses classed as competent in caring for epidural analgesia had undergone a trust standardised theory assessment, with practical assessment and medical device training. Nursing staff were up to date and compliant with medical device training which occurred on a three-yearly basis. This information was recorded and audited and kept up to date on a compliance matrix.
- Patients we spoke with said their pain was managed well and they received timely pain relief. We saw nurses ask patients whether they were in pain and this was documented in patients' notes.
- There was no specific tool used by staff for routinely assessing and managing patients' pain for those who were not able to express themselves. Staff told us they would refer patients who could not verbalise their pain to the pain team. This was confirmed in the trust's clinical guideline for the assessment and documentation of pain in adults.

Nutrition and hydration

- Nutrition and hydration needs of patients were assessed and actions were taken to address concerns as soon as they were identified. The malnutrition universal screening tool (MUST) was used to assess and record patient's nutrition and hydration risks on admission to hospital and weekly thereafter. We saw this had been completed in all 19 sets of records we looked at. Nursing staff told us that a nutritional care plan would be created for patients with a high MUST score. Nurses also told us that they could refer patient to the dietitians, including patients requiring artificial feeding via a tube, renal patients on dialysis, and newly diagnosed coeliac patients.
- Patients were fasted preoperatively when admitted as inpatients or day cases prior to their surgery. There was a hospital policy in relation to safe sedation covering preoperative fasting. The policy covered patients either requiring general or regional anaesthetic. Easy to follow flow diagrams were at the start of the policy for staff to use. The policy covered both adults and children undergoing planned or emergency procedures. It had been updated in August 2016 to include instructions for patients having an ophthalmic procedure.

Patient outcomes

- Outcomes for patients were variable. Information about the outcomes of patients care and treatment was routinely collected and monitored. We reviewed outcomes for bowel cancer, oesophagus-gastric cancer, emergency laparotomy, and hip fractures.
- There were a number of areas in which the trust performed slightly better than or within the expected range. In the 2016 Bowel Cancer Audit:
  - 43% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national average.
  - The risk-adjusted 90-day post-operative mortality rate was 2.4%, which was within the expected range.
  - The risk-adjusted two-year post-operative mortality rate was 24.8%, which fell within the expected range.
  - The risk-adjusted 30-day unplanned readmission rate was 12.2%, which fell within the expected range.
  - The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 55.5%, which fell within the expected range.
- In the 2015 National Vascular Registry (NVR) audit (the latest data available), the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.2% for Abdominal Aortic Aneurysms, indicating the trust performed within expectations. Within Carotid Endarterectomy, the median time from symptom to surgery was 13 days, better than the national aspirational standard of 14 days. The 30-day risk-adjusted mortality and stroke rate was within the expected range at 1.8%.
- In the 2016 Oesophagus-Gastric Cancer National Audit), the age and sex adjusted proportion of patients

diagnosed after an emergency admission was 2.1%. This placed the trust within the lowest 25% of all trusts for this measure, which was good. The proportion of patients treated with intent to cure their disease in the Strategic Clinical Network was 36.7%, in line with the national aggregate. This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres. The result can therefore be used as a marker for the effectiveness of care at network level. Better cooperation between hospitals within a network would be expected to produce better results.

- There were some areas which indicated the trust were at the higher end of the expected range. In the 2016 National Emergency Laparotomy Audit (NELA). The hospital achieved:
  - an amber (50-79%) rating for the crude proportion of cases with preoperative documentation of risk of death. This was based on 54 cases.
  - amber (50-79%) rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 78 cases.
  - a green (>80%) rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre, based on 85 cases.
  - an amber (50-79%) rating for the crude proportion of highest-risk cases admitted to critical care post-operatively, based on 64 cases.
  - The risk-adjusted 30-day mortality for the hospital was better than expected, based on 242 cases.

However, staff reported patients undergoing an emergency laparotomy were not always going to the critical care unit as there were occasions when there were no available beds. This affected achieving NELA outcomes.

- Not all hip fracture patients were operated on at the optimal time. In the 2016 Hip Fracture Audit:
  - The proportion of patients having surgery on the day of or day after admission was 65.9%, which did not meet the national standard of 85%.
  - The perioperative medical assessment rate was 92.8%, which did not meet the national aspirational standard of 100%.
  - The risk-adjusted 30-day mortality rate was 8%, which fell within the expected range.
  - The proportion of patients not developing pressure ulcers was 98.2%, which falls in the middle 50% of trusts.
  - The length of stay was 16.7 days, which falls in the middle 50% of trusts.
- Patients were reporting variable outcomes. In the Patient Reported Outcomes Measures (PROMS) from April 2015 to March 2016, varicose vein outcomes showed more patients' health improving, and fewer patients' health worsening, compared to the England averages. Groin hernia and varicose vein outcomes both showed fewer patients' health improving compared to the England averages. The latter also showed fewer patients reporting a worsening in their health compared to the England average. Otherwise, the indicators were in line with the England averages in terms of the proportions of patients reporting an improvement and a worsening in their condition.
- At the time of the inspection, the hospital participated in a number of national audits. We saw results of these audits were discussed at some specialty team meetings. This included the results of a gallstone pancreatitis audit. Also discussed at governance meetings were deep vein thrombolysis audit results, treatment escalation plans, femoral nerve blocks in fractured neck of femur, and adequacy of fractured neck of femur forms.
- There were mostly low rates of unplanned readmissions for patients in the same course of treatment. Between January and December 2016, patients at the trust had a lower than expected risk of unplanned readmission for both elective and non-elective admissions when compared to the England average. Of the top three elective and non-elective specialties, elective ear, nose and throat (ENT) surgery was the only specialty where the risk of unplanned readmission was higher than expected at trust level (so including data from the two community hospitals). At site level, elective ENT and colorectal surgery at Royal Cornwall Hospital had higher than expected risk of unplanned readmission.

Competent staff

- Staff did have the right qualifications, skills, knowledge and experience to do their job when they started employment, took on new responsibilities, and on a continual basis.

- Junior doctors told us they had good support from senior trainees and good access to consultants. They told us they attended weekly team meetings and these provided a good learning experience
- Simulation training (staff being involved with true-to-life mock situations to learn how to manage the situation) occurred every two weeks at different locations. During our inspection, we observed a simulation with recovery staff following hospital protocols. The recovery staff had to manage a patient who would not wake up due to low blood sugar. Staff followed the hospitals protocol and successfully woke the patient up. This was followed by a debrief and feedback from the trainer and senior staff.
- The hospital was not meeting its target for 100% of staff to have had their annual performance review. It is a requirements of doctors' registration to have an annual performance review as part of their revalidation programme, as required by the General Medical Council in 2014. By 31 May 2017, within surgery only 74% of medical staff and 78% of nursing staff had an appraisal in the preceding 12 months. Within trauma and orthopaedics, 86% of medical staff and 78% of nursing staff had an appraisal. In oral and maxillofacial trauma and orthopaedics, appraisals had been undertaken with only 55% of medical staff and 43% of nursing staff. Parameters exclude staff on long-term leave such as maternity, career break or long-term sickness. Only two of the five senior managers in the surgery division team had an appraisal in the last 12 months.
- The arrangements for supporting and managing staff included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation. However, managers told us the capacity to have annual appraisals for their teams were limited due to lack of management time.
- Staff were encouraged but had limited opportunities to develop. Most staff told us they had access to training and managers told us they had budgets to enable staff to access training. However, we were told it was difficult for staff to find time for training and development, or they could not be released from the ward because of a lack of staff.
- Nurses had opportunities to have link roles on wards, which included medical devices; blood transfusion; infection prevention and control; safeguarding; tissue viability; pain; and end of life care. However, due to capacity pressures and staff shortages these link roles were not all filled.
- Staff received training on sepsis covering screening, management and the trust policy. Staff told us they had face to face training with the lead sepsis nurse. Where there had been failure by the trust to meet the treatment for sepsis targets, actions were focused on improving systems, not increasing staff training and awareness. We saw in trust board papers from April 2017, the trust had achieved 100% for patients in inpatients areas receiving antibiotics within an hour (of those patients audited). However, it was acknowledged the data collection was 'limited'.
- Newly qualified nursing staff worked as supernumerary for two weeks when they started on a ward. This meant that they were not included in the numbers of staff delivering direct patient care to give them time to settle in and learn their new role.

Multidisciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing patients' care and treatment. The patient records demonstrated input from dieticians, physiotherapists, and occupational therapists. Records also showed input from pharmacists, medical teams, and diagnostic and screening services
- In surgical services, there was a shortfall against the planned number of physiotherapists. The service had planned for 9.1whole time equivalent (WTE) physiotherapists, but only had 8.05 WTE and 7.95 WTE in April and May 2017 respectively. Staff on Pendennis ward raised concerns therapists were overstretched so they could delay patients' discharge home by not completing their assessment or treatment in good time.
- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients were due to move between teams or services. This included referral, discharge and transition. Staff were aware good multidisciplinary communication was central to safe patient transfers and could describe how they would do this. This included preparation and risk assessment. The hospital had a policy which staff could refer to for the safe transfer of patients between care areas within the hospital and to other hospitals. Staff could also describe how they would receive a patient from other areas or hospitals to ensure the patient was kept safe.

- Senior nurses reported they were not always able to attend weekly clinical meetings which involved consultants, specialist nurses and junior doctors because of work pressures.

Seven-day services

- The hospital performed well against national benchmarks for weekend services. In 2016/17, data showed 80% of patients had a consultant review within 14 hours of admission over the weekend. This performance was actually better than during the week, where 74% of patients were seen within 14 hours (with Mondays (63%) and Fridays (65%) performing the worst). A working group had plans to increase reviews within 14 hours over the weekend to 100% by 2020/21. Analysis undertaken by the hospital of weekend patient NEWS scores were higher than weekday scores suggesting sicker patients were admitted over the weekend.
- Ward staff told us junior doctors would be responsible for the ward rounds over the weekend. This had led to times when it was difficult for staff to locate a doctor, as the doctor had a wide-range of responsibilities. However, junior doctors told us they had good support from consultants and they could access them quickly by telephone or in person both out of hours and at weekends.
- A full review of the seven-day services across all specialties in the trust in line with NHS England's 10 clinical standards for weekend working. This had been undertaken by the chief pharmacist. The review showed that against the four priority standards (time to consultant review; access to diagnostics; access to interventions; and ongoing review) the hospital had met targets set by March 2017. An action plan was signed off by the trust Management Committee. There was an executive lead and a working group to implement the action plan.
- There was an emergency surgery team on site 24-hours a day, and additional access to consultants on call and able to attend the hospital within 30 minutes.
- On the first day of the inspection, there were nine medical patients in the surgical admissions lounge. Due to the lack of beds in medical wards, a number of patients were placed in other departments' wards (usually in surgical wards). Staff told us it could be difficult to get medical and vascular doctor cover at weekends. They told us some patients wished to leave the hospital but there had been times when there were no doctors to review or discharge them.
- There was access to all key diagnostic services including endoscopy 24 hours a day, seven days a week to support clinical decision-making. This included critical patients' services (imaging and reporting within one hour), urgent patients (imaging and reporting within two hours); and all non-urgent patients within 24 hours.
- There was a 24 hour, seven-day interventional radiology service. Interventional radiology refers to a range of techniques which use radiological image guidance to target therapy as an alternative to open or keyhole surgery.

Access to information

- Staff at the preoperative assessment unit told us they had good access to information and patient records.
- When patients moved between teams and services, including referral, discharge, transfer and transition, we saw information needed for their ongoing care was shared in a timely way and in line with relevant protocols.
- Patient records were well managed. The notes were held in an electronic booking system which tracked them as they moved around the hospital.
- Access to patients' diagnostic and imaging results was good. Surgical and nursing staff told us results were provided quickly, and urgent results were prioritised.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Mandatory training data showed 100% of nurses and 90.2% of medical staff in surgery had completed the Mental Capacity Act 2005 training. The trust's 95% target was therefore met for registered nursing staff but slightly below target for medical staff.
- There was a standard policy for consent based upon guidance from the Department of Health. There was a consent flowchart for staff to follow to identify whether consent could be given verbally. This was to be recorded in the patient's notes and 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.

- Staff ensured informed consent was given by speaking to preoperative patients about their understanding of their surgery. There was documented evidence of risk assessments and shared care plans. We heard patients being asked to confirm their consent by anaesthetists prior to their operations.
- When patients lacked the mental capacity to make a decision staff made best interest decisions for the patient in accordance with legislation. We saw best interest discussions were documented in a patient's notes for a patient with a learning difficulty. We also saw a patient who did not have the mental capacity to make their own decisions who became too anxious to proceed with their surgery. The surgery was postponed, and a discussion about having a best interest meeting was arranged.
- The hospital had a safe sedation policy which outlined actions staff needed to take where patients lacked mental capacity to understand the implications of an intervention. This included options of holding a best interest meeting, and using an independent mental capacity advocacy (IMCA) service.
- The hospital had a Deprivation of Liberty Safeguards policy to aid staff to identify a patient whose treatment or admission to hospital may constitute deprivation of liberty. The Deprivation of Liberty Safeguards provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. Forms were available for staff to refer patients, and the hospital's safeguarding team could support staff.

Are surgery services caring?

Good

We rated caring as good because:

- Feedback from patients and relatives was positive overall. For example, the NHS Friends and Family Test scores were mostly above 90% for surgical wards between March 2016 and February 2017. However, the response rate was only 11%, compared to around 25% nationally.
- Patients and their families spoke almost entirely positively about the care they received while in hospital.
- Staff worked hard to uphold patients' dignity, individuality and human rights. We observed staff acting in a respectful, kind and compassionate way to patients and those close to them.

However:

- Some patients we spoke with did not feel well informed about their care, particularly in terms of when their operation was to take place.

Compassionate care

- The patients we spoke with were largely positive about the compassion and kindness of staff and their dedication to providing good care. Patients described their care as "brilliant" and "first-class". Patients described the staff on the ward as "lovely", "great", "fantastic", "good as gold", and a patient's relative described staff members as "angels in disguise."
- We observed staff having everyday kinds of conversations, appropriately joking and laughing with patients on the wards. For example, we observed a nurse wishing a patient happy birthday (which was also written on a whiteboard above the patient's bed) before proceeding to help with medication.
- We observed good attention from all staff to patient privacy and dignity. We saw during physical or intimate care, staff drew curtains around the bay, and closed doors in side rooms when necessary. We also observed examples of staff helping patients to rearrange clothing if this had slipped while sitting in bed or walking around on the ward in order to preserve dignity.
- The majority of patients felt they were given appropriate and timely support and information regarding their care. We observed staff explaining to patients what they were about to do, about treatments and general information about their care. For example, one patient said the doctor explained everything well and involved the patient's spouse. Relatives told us staff kept them up to date about the patient's care and treatment. Another patient said her surgeon spoke to her in person and explained the reason for the cancellation of an operation. However, a few patients expressed a different view. One patient found there was no clear initial communication about a cancellation of an operation. Another patient did not feel they understood what was

going on in terms of diagnostic tests and when these were to take place. Another patient waiting for surgery explained, "different people tell me different things" in terms of when the operation was to take place.

- One patient told us they could not fault the treatment or staff. The anaesthetists and surgeon had "really calmed me down as I was a very nervous patient". The patient had been in recovery for six hours while waiting for a bed, but told us they had been treated very well in recovery.
- Staff took the time to interact with patients and those close to them in a respectful and considerate manner. For example, we observed healthcare staff checking on patients in a gentle, kind and dignified manner. Interactions like these were also consistent in a Short Observational Framework for Inspection (SOFI) study of a group of four patients on a ward. During this observation, we found healthcare staff interacted with patients regularly and did so in a respectful and considerate manner. During the observed period of 30 minutes, the four patients all together had 13 interactions by healthcare staff. The majority of these related to care and treatment and a small number were interactions about other things, such a chat about a family member who had called the ward. In another group of three patients, two of them were asleep for the total of the 30 minutes and were not interrupted at the time.
- We saw staff in theatres treating patients with respect, and were kind are caring throughout. We saw staff patiently explaining what was going to happen to a patient in the anaesthetic room, and the patient given opportunities to make sure they were understood and could ask questions. One patient told us it "was nice to be spoken with about non-medical issues."
- There was a low level of responses from patients to the national questionnaire asking them whether they would recommend services. Between March 2016 and February 2017, the NHS Friends and Family Test response rate for surgery at the trust was 11%. This was significantly worse than the England average of 29%. However, in the year from March 2016 to February 2017, the scores were mostly above 90% of patients saying they would recommend surgical wards to their friends and family. The exceptions were the Oral Day Case Unit in May 2016 (86%), Pendennis Ward in December 2016 (78%), and Trauma in May, July and October 2016 (89%, 88% and 88%).
- Results from the NHS Inpatient Survey 2016 showed the patient views were mostly in line with other NHS trusts. This included standards of care and treatment, admission and discharge processes, and their surgery. Patients rated the hospital better than other hospitals in relation to the specialist they saw in hospital giving them all the necessary information about their condition or illness.

Understanding and involvement of patients and those close to them

- The family members we spoke with felt well informed and updated by staff and the information was well explained. One family member in particular was extremely pleased with the way staff had accommodated their visits to the hospital as they lived quite far away from the area. They also said the bereavement team at RCHT was "fantastic".
- We observed a doctor taking a medical history from a patient and explaining the tests they were going to carry out. The consultation was undertaken in an unhurried and sensitive manner and everything was explained to the patient in a way they could understand. However, one patient told us that they had not fully understood what they had been told by their doctor and was not given an opportunity to ask questions.

Emotional support

- Patients received the support they needed to cope emotionally with their care, treatment or condition. We observed caring interactions from staff when patients showed signs of being in distress. For example, while we were shown around a theatre, we noticed a patient who was visibly upset and the theatre staff immediately went to the patient to listen to their concern and reason for being upset. They spent time with the patient until they were reassured.
- Staff understood the impact a patient's care, treatment or condition would have on their wellbeing and on those close to them both emotionally and socially. We saw staff on all surgical wards taking time to support patients in their care, including reducing anxiety. We saw several examples of nurses taking time to discuss patients' care and treatment, and making sure each patient had time to ask questions and be reassured. One patient told us how nervous they had been, and

how reassuring the nursing staff were. We also saw theatre staff were responsive to patients. When one patient had their operation cancelled, we saw staff were supportive during this distressing time for the patient.

Are surgery services responsive?

Inadequate

We rated responsive as inadequate because:

- Services were not planned or delivered in a way which met patients' needs
- Services were planned to meet local needs but lack of capacity and resources meant that plans were not always delivered in a way which met patients' needs.
- The facilities and premises used did not always meet patients' needs or were inappropriate, with admission lounges used for surgical and medical patients overnight.
- Patients were unable to access the care they needed at the right time, and referral to treatment times for incomplete pathways had been worse than average from March 2017.
- Pressures from non-elective admissions and delayed transfers of care led to significant levels of cancellations of elective operations. Twelve patients with cancer had their operation cancelled from January to May 2017, seven on the day of their booked operation.
- Patients were not always operated on in the correct operating theatres, and assessments to identify patient risks were not always carried out.
- Patients did not always have access to services in a timely way for an initial assessment, diagnosis or treatment. Patients experienced significant waits for some services. A high number of patients were not treated within 28 days of their operation being cancelled at short notice.
- There had been too many occasions when patients had to stay in recovery overnight because there were no available beds.
- The service consistently missed targets to respond to complaints within 25 working days. There was little evidence to show lessons had been leaned and practice changed to demonstrate people who complained were listened to.

However:

- There were good arrangements for supporting patients with a learning difficulty going into theatre.

Service planning and delivery to meet the needs of local people

- Service planning and delivery did not meet the needs of local people. Executives and senior managers of the service told us with winter pressures followed by the large influx of tourists over the summer months, services were under pressure all year around. Services were planned to meet local needs but due to a lack of capacity and resources they were unable to ensure services offered flexibility, choice and continuity of care.
- The facilities and premises were not always appropriate for the services which were planned and delivered. We saw evidence operations were occasionally undertaken in theatres which were not correctly equipped. In addition, patients were moved from one side of the hospital to the other after their operation to recover. We saw the two day-theatre units, Theatre Direct and the surgical admissions lounge were used too often as wards due to bed pressures across the hospital site.
- There was not enough access to showering and toilet facilities on Theatre Direct, where patients were being accommodated to stay overnight. There were two showering facilities on the unit – one for male and one for female patients. However, these were situated inside the toilets in two of the three available toilets.
- Staff in the preoperative assessment unit told us there were not enough consulting rooms and the waiting area was often overcrowded. Staff also reported the unit was a long way from the main hospital for patients. Some patients were frail and exhausted by the time they reached the unit because of the lack of nearby parking facilities.

Access and flow

- Patients did not always have access to timely initial assessment, diagnostic or urgent treatment.
- Between April 2016 and June 2017, the trust's referral to treatment times (RTT) for incomplete pathways for surgical services were variable when compared with the England overall performance. The latest figures for June 2017 showed there was a decline in performance from September 2016. The trust had failed to meet the target since March 2017 and was at 90.7% in May 2017 (92% is the national target). The overall size of the referral to treatment waiting list was continuing to grow. As at May

2017, the backlog of patients was at 2,238. Trauma and orthopaedics (80.8%), paediatric surgery (69.5%) and colorectal surgery (76.1%) accounted for the three longest waiting lists across the trust.

- There were significant delayed discharges out of the hospital. During the inspection, there were 52 medical and surgical patients unable to leave the hospital due to packages of care not being available for them to be safely discharged at the time. Consequently, patients were at risk of deteriorating both physically and mentally while remaining in hospital. Pressures from emergency patient admissions and delayed transfers of care led to significant number of cancellations of planned operations. This, in turn, led to reduced bookings for future planned operations, affecting both patient experience and staff morale. The result was the under-delivery of the number of planned operations, and a rise in the number of patients not being treated in line with the target. At the time of the inspection, delayed transfers of care were at 9.8%, equating to 61 per day. The referral to treatment incomplete standard had been missed from April to June 2017.
- Data provided by the hospital showed 5% of operations were cancelled across the hospital sites in 2016/17, and this figure was increasing. NHS Improvement set all hospitals a target of a maximum of 5.1% of operations cancelled due to non-bed related issues. Across all three hospitals in the trust, 90 (7.9%) of operations were cancelled for this reason in April 2017, and 138 operations (9.1%) were cancelled in May 2017.
- The hospital's policy was that an operation which was rescheduled to a time within 24 hours of the original scheduled operation should be recorded as a postponement and not as a cancellation. This was in line with national guidance from NHS England. We requested data regarding operations that were recorded as postponed on the day of surgery, but were told that "we do not recognise the term postponed… patients who do not receive their operations as expected are classified as cancelled". We were not therefore assured that the hospitals data of 5% of operations cancelled was correct.
- The service had a high proportion of last minute cancellations of surgery. A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard. The patient should be offered treatment at the time and hospital of their choice. For the period between April 2016 and March 2017, the trust cancelled 2,095 operations for non-clinical reasons. Of these, 543 (more than a quarter) were not treated within 28 days. The trust's performance was consistently worse than the England average over this period.
- In operating theatres, the safety briefing included staff involved in booking patients on theatre lists, and who would deal with 'on the day' cancellations. Electronic systems were used to try to match capacity with demand. This included the 'theatre system', a recently introduced monitoring system which listed waiting emergencies. However, during our inspection we noted some of the patients on the emergency list were not true surgical emergencies, such as a cardioversion and an overdue cholecystectomy.
- Surgery service managers confirmed three patients admitted for breast cancer surgery were cancelled because of lack of high dependency beds post-operatively in the last 12 months. A further 11 patients with cancer had their operations cancelled between January and May 2017, seven cancelled on the day of their surgery. Reasons included lack of an available critical care bed, allocation to an inappropriate surgeon, or because other urgent patients took priority. For each of these cases, the hospital had exceeded the referral to treatment targets of 31 or 62 days.
- We were also told about cancellations for bariatric patients on the day of surgery. This was particularly of issue for these patients, as most would have been on a special diet for six weeks prior to their operation.
- We also observed an operation cancelled when the patient was in the anaesthetic room. This was due to the recovery area being full, as, at the time, there were no beds to return patients to wards after their surgery.
- The service had identified a risk of patients experiencing significant delays in emergency surgery. This was caused by a lack of theatre capacity, and could result in patient deterioration and potential harm. A consultant prioritised patients for the emergency theatre. If additional theatre capacity was required, this was allocated from cancelling sessions for planned surgery. All elective lists were reviewed daily to utilise staff and

theatres if capacity was required to support the emergency theatres. Where there were delays resulting in patient harm, staff were requested to complete an incident form to monitor the risk.

- The efficiency of the operating theatres was poor. From December 2016 to April 2017, we saw average monthly theatre utilisation ranged between 77.1% and 83.4%. The service had rated the risk as 'red' in April and May 2017 (significant risk) with the number of operations per month falling short of what was planned, as well as the high number of operations cancelled on the day.
- Theatre lists rarely started on time. Operations were due to start in theatres at 9am from Monday to Saturday. However, we saw between January and June 2016 the average (mean) start time for operations was 9:28am. Senior managers expressed their frustration as the total time lost across the 14 theatres every day was having a big impact on theatre productivity. In April 2017, the theatres' productivity task and finish group was required to increase throughput by improving start times, increasing booking, improve list scheduling and reduce cancellations on the day. Theatre staff told us they wanted to start promptly most days this was 'hampered by bed problems'.
- Average length of stay for patients in the hospital was below or in line with national performance. Between February 2016 and January 2017, the average length of stay for surgical elective patients at the trust was 2.5 days, compared to the England average of 3.3 days. The trust's performance had increased to 3.3 days in June 2017. For surgical non-elective patients, the average length of stay was 4.2 days, compared to the England average of 5.2 days.
- Staff told us there were insufficient rooms available for consultants or doctors to review their patients before their operation and check their consent. We were told the delays meant theatre safety briefings often started between 15 minutes and 30 minutes late.
- In June 2017, the surgery division instigated a root cause analysis investigation for cancellations due to insufficient time on operating lists. This had not been completed at the time of the inspection.
- The hospital did not capture readmission data for patients who had their surgery cancelled. Patients who were cancelled because they were unfit for surgery were managed through preoperative assessment and their own GP. Once declared fit for surgery they would be returned to an active waiting list and rescheduled for their surgery. Patients cancelled for reasons not related to their fitness for surgery would be prioritised for rebooking. They would then be added to the next available list with the appropriate consultant.
- There were bed shortages for surgical patients. Some patients would be discharged home directly from the recovery area due to lack of beds available on wards. Staff told us beds which had been allocated to patients post-operatively would 'disappear' when the patient went to theatre. We were told when this happened, patients were screened in one side of the recovery area to maintain privacy. Their discharge was supported by ward staff with experience in the discharge management of the patient's procedure or specialty. Some patients were supported in recovery overnight because there were no available beds. This included one patient who required a high dependency bed who was in recovery over a three-day period. When this happened staff completed an incident form.
- Not all patients were admitted to the best place for their care. Ward staff and managers confirmed medical patients being admitted onto surgical wards were the biggest problem. One member of staff told us "the hospital simply isn't big enough for the community it serves". Senior managers told us there were usually between 25 and 40 medical patient outlying in surgical beds. On the first day of the inspection, there were 42 medical outliers in surgical beds (21% of all patients across all three hospital sites). Staff told us medical patients were reviewed by a medical team every day with specialist input. However, at the time of the inspection there was not a named consultant for each medical patient responsible to ensure their care across their entire stay was coordinated.
- On the first day of the inspection, the surgical assessment lounge had 20 patients overnight. However, there was an agreement to limit this to 12 patients. Staff told us this would delay the start of theatre lists, as they were caring for patients who had been in overnight rather than supporting patients as they came in for surgery. The following day there were six medical patients. Four were medically fit for discharge and waiting for community beds and packages of care to enable them to go home. On the second day, the ward was able to admit the planned number of elective

surgery patients due for admission as there were available beds that day. Senior managers expressed frustration with the lounge being used in this way as at times this meant it was not able to function as designed.

- The Newlyn ward was designated to care for day surgery patients having surgery in the Trelawny wing theatre suite. However, managers told us day surgery was also undertaken in theatres in the Tower theatre suite. This made managing patients admitted to the Newlyn ward but operated upon across both sites difficult. Coupled with this were patients admitted to the Newlyn ward when no other beds were available. Doctors then undertook ward rounds to try to move the new patient to a more suitable place for their care.
- Certain patient admissions resulted in operations cancelled on safety grounds. For example, we were told about a patient with an infected hip being allocated to Newlyn ward. This resulted in patients coming in for eye surgery being cancelled that day due to the risk of infection.
- Due to the historical good performance in the average length of stay for surgical patients, the service was able to reduce their bed base by a full ward. In April 2016 South Crofty ward was converted from a surgery ward to a medical ward. However, this had affected access and flow within surgery, with less flexibility in the system for the division care for their own patients.
- Staff told us patients could wait a long time for their medications to take home. On Pendennis ward, we were told there was one pharmacist to cover three to four wards and they did not get to Pendennis ward until 3pm on the day of the inspection. At our unannounced inspection, we met a pharmacist who was covering three wards due to colleagues being on annual leave.
- Not all patients were able to use the discharge lounge. There were issues with agency staff not being able to produce some of the necessary discharge paperwork, and a printer not being available. However, when patients were able to use the lounge, they could wait there for their medicines, and this released a bed back to the ward.
- Bed management meetings took place every weekday to identity where there were staff shortages, outlying patients, and how these could be managed. We attended a bed management meeting. Managers confirmed the surgery division was more often affected by bed pressures. For trauma and orthopaedic and maxillofacial patients attending the hospital on a Sunday, there were no formal arrangements for them to be reviewed. Therefore, these teams were playing 'catch up' on Monday and Tuesday, when most elective operations were booked. This meant more operations were cancelled on these days. This was a known issue and senior managers were looking at options to address this concern. We saw there were good levels of cooperation at bed management meetings to maintain or reach safe staffing levels. Managers across the hospital adjusted their staffing rotas to help keep patients safe.
- The service had identified a risk that patient follow up reviews were not happening due to a lack of standardised administrative processes, not enough ward clerk cover, and the high workload. The Information Services team had developed a post inpatient follow up report and monitoring process. This used completed discharge summaries, to ensure the hospital knew which patients had not been seen at follow-up. However, the report could only identify patients where a 'requires follow-up' had been entered onto the hospital electronic patient system. It had been recognised this was not entered for all patients, even when it was required. This remained a high risk for the service, especially for patients who required a follow up appointment but this had not been identified on the electronic system. This had been identified on the corporate risk register which stated there were not adequate organisational processes to ensure patients were followed up.

Meeting people's individual needs

- There were arrangements for supporting patients with a learning difficulty. This included a regular operating theatre list specifically for these patients. Recovery nurses told us they had good access to support, including access to a team of specialist nurses. People with learning disabilities are known to often be anxious about medical procedures. Actions taken to help people with learning disabilities improve their experience included dimmed lighting in the recovery area and calming music playing. Furthermore, patients' family members and carers were allowed into the recovery area as soon as the patient was out of theatre. Their cannula in their hand would be removed immediately to reduce anxiety. Often and where possible, patients would be able to wear their own clothes and shoes in theatre and would be covered by a sterile gown. The

patient would then be permitted to go home as soon as it was safe for them to do so. We spoke to relatives of one patient with a learning difficulty who told us they were really pleased with the service had been provided, describing it as "excellent". The patient was very calm and happy prior to their operation. Staff were described as "very caring", and the relative told us they had been actively involved in the patient's treatment plan.

- There was a variable performance from wards support patients living with dementia. Services were mostly planned, delivered and coordinated to take account of patients with complex needs such as those living with cognitive impairment. There was a designated link nurse for dementia within the surgery service. This nurse met with the surgical teams every six months to provide updates and training on supporting patients living with dementia. Dementia-related key performance indicators (KPIs) were measured quarterly. These included patients having a named carer in their nursing documentation and an individualised care plan. Patients should have a completed and visible 'This is Me' or 'Life Story Book' by their bedside. These are tools for staff to use to better understand the patients. Other indicators to alert staff to a patient living with dementia were used discretely in the patient's records. Audits against this KPI showed in January 2017 St Mawes ward met 100% of the targets and Pendennis ward met 83%, but Wheals Coates ward only met 31%.
- Almost all patients we spoke with enjoyed the food and the options available to them. Staff said there was a long-stay menu with more options. This made the choice less repetitive for patients who stayed in hospital for a longer period of time. Staff were able to cater to various dietary needs such as gluten free, lactose free, as well as cultural dietary needs such as Halal and vegetarian. However, one diabetic patient mentioned her meals at times were bland. Another patient said she was well supported to eat independently and staff had provided her with special cutlery for this. A third patient felt she was well cared for when she arrived to the ward just after the main meal had been served. She had been asked within 20 minutes if she would like something to eat, which staff were able to provide.
- Staff on the units and wards we visited were aware and could demonstrate how they would access interpreting services for people who did not speak English as a first language. There were services including British Sign Language and braille provision should the need arise. Nurses told us they were able to pre-book the interpreter service or access it in an emergency. The service was available 24 hours a day, all year around.
- The hospital had appropriate equipment for patients who required bariatric surgery, including an operating table which could hold extra weight and had hydraulic leg rests.
- Staff ensured that patients and those close to them were able to find further information or ask questions about their care and treatment. Patient leaflets were available on all wards we visited so patients could access information about their condition, treatment and support services. Display boards on wards were comprehensive and information displayed was up-to-date.
- The trust did not comply with the NHS England Accessible Information Standard introduced in 2016. This required the trust to be able to identify, record, flag, share and meet the information and communication needs of patients with a disability or sensory loss. The trust did not have a specific Accessible Information Standard policy at the time of the inspection. It was not able to meet the required standard due to the administration system not enabling a flag for a relevant patient to be reliably seen by booking staff. The need for this has been built into the procurement process of the new administration system which was due to be rolled out in October 2017.
- The service has access to a home sedation service for patients who lacked the capacity to make decisions. We saw a multidisciplinary team held best interest meetings with the patient's family or carers, learning difficulty nurses and a psychiatrist. On the day of surgery, a private ambulance would go to the patient's house and an anaesthetist from the hospital would enter and sedate the patient in his or her own home. The anaesthetist would monitor the patient on route to hospital. Following surgery, the patient would be taken home accompanied by the anaesthetist and an operating department practitioner. The anaesthetist would then bring the patient around in their own home and would stay until they judged the patient to be safe.

Learning from complaints and concerns

- Patients who used the service knew how to make a complaint or raise concerns. Patients told us they felt comfortable and confident to speak up. Staff told us

they always tried to resolve complaints locally. If a patient wanted to make a complaint they would speak to the nurse in charge, or direct them to the patient advice and liaison service (PALS).

- Few complaints were responded to within the trust's deadline. From June 2016 to May 2017, the service consistently missed the target of closing complaints within 25 days. The target was for 90% to meet this deadline. The average working days for complaints to be closed were 69 days. Of the 118 complaints received over this period, 22 (19%) were upheld, and 42 (36%) were partially upheld. The top reasons for patient complaints were: clinical treatment, communication, and issues with admissions and discharges. In May 2017, the surgical division had brought together a team of staff to address the backlog of complaints which had arisen due staff vacancies and a resulting lack of communication within the division.
- We saw complaints data was reported at the surgical services business and governance meetings. Reports showed the number of complaints and the number of concerns raised through the patient advice and liaison service. However, there was no evidence to show lessons had been recognised and learned from complaints.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The arrangements for governance and performance management did not always operate effectively.
- Risks, issues and poor performance were not always dealt with appropriately or in a timely way.
- Not all leaders had the necessary time to lead effectively. The need to develop leaders was not always identified or action was not always taken. Leaders were not always clear about their roles and their accountability for quality.
- There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported and appreciated.
- The culture was dictated by senior and executive management. It was not one of fairness, openness, transparency, honesty, challenge and candour. We found there was a disconnect between the executive team and frontline staff.
- Staff did not always raise concerns or they were not always taken seriously or treated with respect when they did.
- There was a limited approach to obtaining the views of patients who use services and other stakeholders. Feedback was not always reported or acted upon in a timely way.
- The sustainable delivery of quality care was put at risk by financial challenges facing the trust.

However:

- We found nursing, theatre and medical staff to be committed to the hospital and dedicated and caring to deliver care and treatment to patients.
- Most managers we spoke to said they were overwhelmingly proud of the teams they led.
- There was alignment between the recorded risks and what staff said was on their 'worry list'.
- Innovation and improvement was encouraged within the directorate.

Leadership of service

- Leaders had the skills, knowledge, experience and integrity they needed both on appointment and on an ongoing basis. The surgical service leadership team included clinical directors, an associate clinical director, and an associate director of nursing, who provided leadership and management to staff.
- Leaders did not have the capacity to lead effectively. Although leaders understood the challenges to good quality care and could identify some of the actions needed to address them, there was a lack of time and support to deal with challenges. We saw leaders in the service were sometimes ambivalent about the future because of the difficulties about patient flow which they felt mostly powerless to address.
- Nursing staff told us about ongoing issues which were not addressed despite raising them with managers. As a consequence some staff were reluctant to report issues to senior managers and felt they would not be supported by the service leaders.
- We were told about incidents of bullying and intimidation in the operating theatre, and staff not being

able to speak up or be listened to. Senior leaders said this had been recognised as a cultural issue which affected a couple of particular surgical teams, and they were attempting to address this. We were told they had support from the executive team to deal with issues, but the systems and processes could be obstructive. For example we found some grievances had not been addressed for several months. We also found examples where serious allegations had been made, and performance management had either not been initiated, or had been halted.

- Leaders were not always visible and approachable. Staff could not always identify the emergency surgery medical and nursing lead and their roles and responsibilities. Some theatre staff told us the unit was well led by managers. However, other theatre staff told us senior managers were not visible and there was poor communication. The 2016 NHS Staff Survey showed the percentage of staff reporting good communication between senior management and staff was in the bottom 20% of all NHS trusts.
- Managers also told us they lacked time to review incidents and complaints within deadlines. The surgical management team met weekly, and the associate director met with the clinical directors every week. However, these meetings were not minuted, so it was not possible to see what actions were being taken forward.
- Managers expressed frustration as they lacked time to support staff in the way they required, such as having regular team meetings and timely appraisals.

Vision and strategy for this service

- The trust had a vision which included providing high quality care for its patients, and was underpinned by five values:
  - care and compassion
  - inspiration and innovation
  - working together
  - pride and achievement
  - trust and respect.
- The strategy for the surgical division was developed by the senior managers within the service, with, we were told, limited input from surgical and nursing staff.
- The annual business plan 2016-2018 for surgery included three key objectives. The first was to ensure surgical services continued to deliver high quality care, which supported the delivery of the NHS Constitution. The second objective was to roll out seven-day services across all specialties to deliver the four priority clinical standards by November 2017 and progress work to deliver the other six standards. The third objective was to review and streamline a number of surgical pathways, for example, fractured neck of femur, acute cholecystitis, glue ear, back pain and one stop diagnostics. However, there were no clear measures to determine how the objectives of the service were being delivered.

Governance, risk management and quality measurement

- There was not an effective governance framework to support the delivery of the strategy and good quality care.
- In April 2017, the governance structure was changed to bring together the divisional board and the divisional governance board to reduce the number of meetings for staff, and in recognition that there was overlap between the two meetings. It was recognised in April 2017, that the previous structure did not 'provide the required assurance from specialty level and has become too broad, cumbersome, and not always relevant to all attendees which has led to some disengagement from the process'.
- The new governance meeting consisted of the senior management team, clinical governance leads, clinical matrons and service leads. The terms of reference of the divisional governance board was to escalate governance matters and share good practice through the division. It was also to provide a forum to review incidents and complaints, and analyse risk trends and themes. However, the terms of reference were not apparent in the performance report presented at the July divisional board meeting as they did not include the required topics.
- In 2016, the trust-wide quality and safety team were dissolved and the responsibilities were given to the divisions. However, no additional staff resources were provided to carry out the work.
- Business plans within the surgical directorate had not been completed. We were provided with business plans for surgery (2016-2018), theatres and anaesthetics (2017-2019), and surgery, trauma and orthopaedics (2016-18). The business plan for surgery was dated 4 December 2016, but there were paragraphs which stated, "need to update figure", and "need to check". The document had not had final approval. The theatres and

anaesthetics business plan dated 17 November 2016 also had highlighted gaps in data and had not been approved. The surgical, trauma and orthopaedics business plan was still to be completed. There were no plans for working with other directorates within the hospital, despite recognising delayed transfers of care were a threat to delivery of the business plan.

- There were no arrangements for covering absence of the member of staff who was responsible for governance, complaints, incidents, risk management, and duty of candour. For incident reporting, there were no formal agreements for allocating incidents for investigation, although we were told by a member of staff "somebody always picks them up".
- Some assurance and safety systems were not being utilised. Managers had not ensured there was a plan to develop Local Safety Standards for Invasive Procedures. They had not assessed the need for these against all invasive procedures carried out. The Local Safety Standards were designed to improve upon and extend the World Health Organisation (WHO) surgical safety checklist and to standardise care.
- Some arrangements to ensure the information used to monitor and manage quality and performance was accurate, reliable, timely and relevant were not always effective. We saw examples, such as WHO audit results and sepsis data, which was acknowledged by the trust to be either incorrectly collected or should be more accurate. We also found when requesting information for the inspection, data was not available at site level, such as data on mandatory training or staffing numbers for theatre staff.
- There was a lack of a reliable system for identifying, recording and managing risks, issues and mitigating actions. We saw departmental risks were discussed at various meetings but these risks were not always reflected on the departments risk register. For example, in trauma and orthopaedics, key risks included breaching 52-week waiting targets due to recurrent operation cancellations. For general surgery a risk had been identified there was an increased wait for patients with benign but serious conditions, particularly colorectal disease. Neither of these risks was on the risk register. However, there was some alignment between the recorded risks and what staff said was on their 'worry list'. Nearly every member of staff we spoke to during the inspection identified patient flow and the impact on patients as one of their highest concerns. This was one of the key items on the risk register.
- Ward sisters told us they provided a weekly report to their matron including operational and staffing issues, which would feed through to the executive team. However, they did not receive feedback on these reports.

Culture within the service

- We found surgery staff to be committed to their patients, focused on providing the best care they could, and supporting each other. They were very concerned about the problems with the flow of patients around the hospital, operations being cancelled on the day of surgery and the impact on patients. We found staff were resigned to these issues and felt powerless to do anything about it. The issue around patient flow was having a detrimental effect on staff, especially with having to cancel patients' operations at the last minute. One member of staff told us they "we do not feel in control of our own destiny" due to the lack of capacity across the hospital, and this affected the level of care they could give to patients.
- Most staff told us they felt respected and valued by their managers. Nursing staff told us ward managers were supportive and understood their concerns. Managers at all levels told us they were most proud of their staff. They told us staff were very caring and committed, and they were proud of the care staff gave, and their teamwork. The service had introduced a 'listening into action' meeting with theatre teams to address the number of operations cancelled on the day. Staff raised concerns about patients flow and bed availability affecting theatre productivity, as well as losing a surgical ward in the last 12 months. However, there was no evidence of what actions had followed these concerns being raised.
- Action was not always taken to address behaviours and performance which was consistent with the trust's vision and values, regardless of seniority. Senior managers told us responses to underperformance were dependant on the situation, and management of underperformance was variable. Actions taken ranged from informal discussions to dismissal. Senior managers told us there had been some poor performance and behaviour from some surgeons and consultants. Clinical directors were

expected to deal with these issues. A clinical director told us there was an embedded culture of poor performance and behaviour in some areas, and it was difficult to turn this around.

- We were given several examples of poor communication between surgeons and ward staff stemming from frustrations of poor patient flow. During our inspection an argument had taken place between a surgeon and ward sister in front of patients. This had been immediately reported to the matron and entered on the hospital's incident system. However, the sister told us although no action would be taken, they would personally have a conversation with the surgeon to discuss the issue.
- The hospital produced quarterly 'Team Talk' briefings and presentations for staff. These provided a summary which gave an overview of issues affecting the hospital and staff such as delivering the operational plan, improving staff engagement, capital investments and changes to senior staff. Staff were aware of the 'Team Talk' briefings and we saw these were on notice boards in staff areas within the directorate. However staff could not provide explicit examples of subject covered in these briefings.

Public engagement

- Patients were able to give feedback on their experiences through the NHS Friends and Family Test. Results were mostly above 90% for surgical wards in May 2017. However, the response rate was only 11%, compared to around 25% nationally. We saw response rates were improving and this was due in part to the help of ward assistants.
- Patients took part in patient-led assessments of the care environment (PLACE). PLACE work provided a snapshot of how an organisation performed against a range of non-clinical activities which impact on the patient experience of care. Results from the 2016 audit across the hospital showed the hospital scored above the national average for disability and dementia support, and cleanliness, but below the national average for food, and condition, appearance and maintenance.
- The trust had links to organisations which could provide additional support to patients and carers. This included local support groups, drug and alcohol support, as well as links to national charities such as the Alzheimer's Society and the Red Cross.

Staff engagement

- Staff views were not routinely collected and acted on to improve the service and culture.
- The 2016 NHS Staff Survey showed there was low engagement across the trust. The trust was in the lowest (worst) 20% when compared to trusts of a similar type. This was based on: staff recommendation of the hospital as a place to work or receive treatment; staff motivation at work; and staff ability to contribute towards improvements at work, all of which were in the lowest 20%.
- The division undertook local analysis to compare results within surgery against the hospital's performance in the NHS staff survey. Of the 32 key findings, surgery performed worst in 25 areas, the same in three areas, and better in four areas. Areas where surgery performed worst included: appraisals and support for development; equality and diversity; working patterns; and issues relating to managers.

Innovation, improvement and sustainability

- At the time of the inspection, the medical director had commissioned a review of services across the hospital and senior managers were waiting for the outcome to consider how to move forward. As such, most staff did not know what the plan was for the service. Staff told us they were focused on getting through each day.
- Innovation and improvement was encouraged within the directorate. There had been a number of innovations and improvements.
- New patient pathways were introduced in management of gallstones to reduce waiting times to surgery.
- The service had a team of 13 colorectal specialist nurses who were instrumental in achieving the target for a patient to been seen within two weeks. The service dealt with GP referrals of patients with any of the typical symptoms of gastrointestinal malignancy, and accepted around 3,000 patients per year. The service was aiming in future to reduce waits to seven days. The service shared their success more widely, and the lead colorectal nurse specialist presented results at national meetings.
- There were examples of where financial pressures compromised care. Senior managers told us financial constraints made it difficult to take on some innovative

ideas. Managers wanted to move some planned surgery to St. Michael's Hospital to create more flexibility and improve patient flow at Treliske, but this required capital investment.

Critical care

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

Information about the service

The critical care unit 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 are admitted following complex and/or serious operations and in the event of medical and surgical emergencies.

The unit provides support for all inpatient specialities within the acute hospital and to the emergency department. A consultant intensivist (a consultant specialising in intensive care medicine) leads the service with support from the consultant team, junior doctors, and a team of nurses and support staff. The unit has 19 bed spaces, used flexibly and funded by commissioners to provide care to 15 patients.

The unit is divided into two discrete areas built to slightly different standards. The 'north' side of the unit has seven bed spaces and is the more modern area. This area accommodates mostly level three patients when possible. The 'south' side of the unit has 10 bed spaces and two side rooms. This area mostly accommodates level two patients and patients who need isolation facilities. Female patients are accommodated, when possible, on one side of the south side and male patients on the other. A nurses' station partitions the two sides.

From 1 April 2016 to 31 December 2016, the department admitted approximately 35% of surgical patients and 65% were non-surgical patients. Of the surgical patients, around half had undergone high-risk elective surgery and the other half had undergone emergency surgery.

The unit had admitted an average of 90 patients per month from January to May 2017. The average number of patients admitted per month throughout 2016 was 91, with admitted patients peaking at 119 in July 2016. In 2016, the critical care team cared for approximately 1,096 patients.

We visited the critical care unit on Tuesday 4, Wednesday 5, Thursday 6 and Friday 7 July 2017. We spoke with a range of staff, including consultants, doctors, trainee doctors, nurses, healthcare assistants, pharmacists, physiotherapists, a speech and language therapist, dietician, a member of the housekeeping team and nurses from the critical care outreach team. We met with the clinical lead for the service, the matron and the two senior nurses who were responsible for the management of the nursing team, clinical governance and education. We met with patients who could talk with us, 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:

- The service had a good track record on safety. There had been no never events or serious incidents. Staff were aware of their responsibility to report incidents and the electronic reporting system had been improved since our previous inspection.
- Nurse staffing levels had been increased since our last inspection and there was less reliance on agency staff.
- Medical staffing levels had improved since our last inspection but it had also been recognised that further recruitment was needed to improve consultant presence.
- Treatment was provided mostly in line with best practice and national guidance.
- According to data submitted to the Intensive Care National Audit and Research Centre, outcomes for patients were, in many cases, better than the national average.
- The mortality rates for the unit were better than the national average, meaning more people would have survived their illness than in other units across the country.
- Staff were compassionate, kind and sensitive to patients, relatives and visitors. All were complimentary about the compassion and kindness they had been shown while on the unit.
- The culture on the critical care unit promoted the delivery of safe care and treatment to patients. Staff strived to ensure it was of the highest quality.
- The nursing and medical leadership on the unit was effective. Senior staff members were visible and approachable.

However:

- The number of delayed admissions to the unit, discharges out of the unit and the number discharges which took place out of hours was still a concern.
- The unit did not provide patients with diaries to document significant events during their stay.
- The unit did not provide patients with rehabilitation prescriptions, which could be used following discharge from the unit.
- Checks carried out on the difficult airway trolley were not permanently recorded.
- Safety issues, related to electronic prescription charts, had occurred due to the failure of some staff to correctly follow processes when patients were discharged from the unit.
- Not all staff had up to date training to use specialist equipment and the system used for monitoring competence was not robust as the data was not clear.
- The risk register in use on the unit did not highlight all risks identified by the service and some ongoing risks had been inappropriately closed.
- The unit was not holding regular nursing meetings, as we highlighted during our previous inspection.

Critical care

Are critical care services safe?

Good

We rated safe as good because:

- The service had a good track record on safety. There had been no never events or serious incidents.
- Staff were aware of their responsibility to report incidents and the unit's electronic reporting system had been improved since our previous inspection.
- Audit compliance scores for the cleanliness of the critical care unit environment were high, which reduced the risk of patients developing unit acquired infections.
- Medicines, including controlled drugs were stored safely, and accurate records of use were maintained.
- Nurse staffing levels on the critical care unit had improved and agency use had reduced since our last inspection. Further recruitment of nurses had taken place and was ongoing to ensure the critical care unit was compliant with the Faculty of Intensive Care Medicine Core Standards for nurse staffing levels.
- Medical staffing levels had improved and further recruitment was taking place at the time of our inspection.

However:

- During our inspection, we noticed the unit was not completely free of dust.
- Checks carried out on the difficult airway trolley but were not permanently recorded.
- There were insufficient waste bins on the unit which increased the risk of contamination.
- Due to a different system in operation, the critical care unit did not use the electronic prescription charts used throughout the rest of the hospital. There had been some safety issues for patients discharged from the unit due to staff not always following the correct handover processes for medicines for the patient prior to their discharge.
- Multiple mandatory training modules had not been completed by medical staff and therefore did not meet trust targets.

Incidents

- The service had a good track record on safety. We were provided with reported incident data, which demonstrated there were low levels of incidents causing avoidable patient harm.
- Between May 2016 and April 2017, the critical care unit reported no incidents which were classified as never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In the same reporting period, the trust reported one serious incident (SI) which met the Serious Incident Framework 2015 reporting criteria set by NHS England. However, during our inspection we were told that following investigation, the incident had been downgraded and was no longer classified as a serious incident. During our inspection, we reviewed the report into the incident and found it had occurred due to human error. Appropriate action had been taken to reduce the risk of the incident occurring again. The patient suffered minimal harm and sufficient learning opportunities had been identified and shared with all staff.
- Since our last inspection the electronic incident reporting system had been improved to address the issues that had previously been identified. The system now allowed incidents to be categorised and the unit was looking at themes of incidents during clinical governance meetings. We saw this in the three set of minutes we reviewed. The system allowed incidents to record the harm caused, severity, description, action taken, investigation outcome and lessons learned from an incident. We were provided with a report of all the incidents which had occurred in the period from June 2016 to May 2017. The information recorded for most incidents was clear and sufficiently detailed.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. All staff told us they were encouraged to report incidents and received feedback on incidents they had reported. Staff were aware of the issues caused by delayed admissions, discharges and out of hours discharges, discussed in the access and flow section below. However, these issues,

they were not always reported as incidents when they occurred. Nevertheless, there were multiple entries in the report which highlighted delayed discharges and admissions as the cause of some of the incidents.

- The critical care unit held monthly mortality and morbidity meetings. At the time of the inspection, attendance at the meetings was by doctors only. Nurses were welcome to attend but did not, due to staffing issues. We were told senior nursing staff attendance at the meetings would improve in future as it was recognised their nursing expertise would be valued in identifying learning points for their staff. We were provided with three sets of minutes from these meetings. The number of admissions to the unit, number of deaths while on the unit/after unit discharge and transfer to other hospitals were recorded for each month. The minutes demonstrated that each death was discussed, what elements of care were good or poor, what learning points were been identified and any actions required. However, there were some deaths, where elements of care were found to be poor, which failed to record any learning points or actions to take forward.
- Patients and their families were told when they were affected by something that went wrong. They were given an apology and informed of any actions as a result. The unit had introduced and applied the duty of candour in all applicable situations we were aware of, with all staff being aware of their duties and when it applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw evidence of the duty of candour being applied when patients and/or their relatives made complaints but also when an incident occurred, such as when the serious incident, as detailed above, occurred. The documentation we reviewed set out what went wrong, why and what was being done to reduce the risk of it occurring again. An apology and the opportunity to discuss the issue with the matron or senior nurses was offered to the patient and relatives. Staff were open and honest with patients and/or relatives/carers.

Safety thermometer

- The trust reported data on avoidable patient harm each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a 'snapshot' of patient harm 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 causing harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis).
- The safety thermometer was used to record the prevalence of avoidable patient harm and to provide information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient avoidable harms and their elimination.
- Data provided to us by the trust showed the critical care unit had reported 100% harm-free care throughout the period from May 2016 to March 2017. There had been no falls resulting in harm, no urinary tract infections in patients with catheters or grade three or four pressure ulcers. However, it was reported that three patients had developed lower grade pressure ulcers in July, September and October 2016.
- The critical care unit displayed their safety thermometer data so that all staff, patients, relatives and carers could see it.

Cleanliness, infection control and hygiene

- Staff washed their hands before and after each patient direct contact or episode of care, in accordance with NICE QS61 (Infection prevention and control). We saw recent hand hygiene audit results which demonstrated staff on the unit had been 100% compliant with hand hygiene standards in nine of the last 11 months (May 2016 to March 2017), with scores of 90 and 95% in the remaining two months. During our inspection, we saw all staff on the unit were bare below the elbow to enable effective hand-washing, and witnessed them washing their hands at all appropriate times. There was adequate personal protective equipment, such as disposable gloves and aprons, available to staff on the unit and we saw it being appropriately used during each patient interaction.
- We were provided with data which demonstrated the unit was compliant with their infection prevention and control practices for intravascular lines. They had achieved 100% compliance in every quarter an audit was carried out throughout 2016 and up to June 2017.

Critical care

- The critical care unit had audited their infection prevention and control practice regarding urinary catheters and had achieved 100% compliance in four of the previous 11 months (May 2016 to March 2017). Throughout the remaining months the unit had achieved 90% or above compliance rates for infection prevention control standards.
- There were reliable systems to prevent and protect people from healthcare-associated infections. If staff on the unit required advice, there was a link nurse within the unit they could refer to with infection prevention and control expertise. As part of their role they linked in with the trust-wide infection prevention and control leads and attended meetings regularly.
- The compliance rate for aseptic non-touch technique (ANTT) from May 2016 to March 2017 was 100%. ANTT is a technique used for the accessing all venous access devices and is the standard aseptic technique in the UK. A venous access device is a small, flexible tube which is placed in large veins.
- Rates for unit-acquired infections had increased since our last inspection. Data reported by the unit to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland) supported this evidence. The data showed that the critical care unit rate for unit-acquired infections in blood had been higher (worse) than the national average through 2016/17 but had been similar to the national average throughout 2015/16. Data submitted showed that there had been two cases of unit-acquired Methicillin-resistant Staphylococcus (MRSA) in 2016, specifically in May and August 2016. However, in the period January to May 2017 there had been no unit-acquired Clostridium difficile or MRSA).
- Patients on the critical care unit were screened for MRSA. Recent data showed almost all patients (96%) were screened as required.
- When unit-acquired infections were identified, appropriate staff members completed a root cause analysis to determine the cause of the infection. They implemented any measures to reduce the risk of patients acquiring the infection in the same way.
- During our inspection, the critical care environment and equipment was visibly clean, organised and tidy. Bed spaces were visibly clean in both the easy and hard to reach areas.
- The standards of cleaning within the critical care unit were generally compliant with the trust's policy. In July 2017 an audit of the environment and equipment was carried out, achieving 89% or above for cleanliness standards. According to the trust's policy, in order to be compliant with standards, an area had to achieve an 85% compliance score. The areas which were compliant were the kitchens, estates, equipment, domestics, dirty utility, clinical room, bathrooms, bed space and clinical practices. The only area which did not achieve this was the store room, achieving a score of 80%. It had been marked down as dust had been found on top of cupboards and on top of bins. Within the audit, actions for each item of non-compliance had been identified. During our inspection, we checked and did not find any dust in the areas mentioned in the audit. However, we did notice dust upon the store cupboards within the oxygen store room.
- The housekeeper, who worked only on the critical care unit, had won an award for the high standard and quality of work she delivered.
- We reviewed the isolation policy as there was a patient being cared for in one of the isolation rooms during our inspection. We saw practice was in line with policy. There was a side room equipped with air change facilities on the unit; although staff told us the room was rarely used. They told us they would seek advice from the infection control lead within the trust if they were unsure on whether a patient should be isolated or not.
- There was adequate signage and guidance reminding staff and visitors to use the hand sanitising gel on the unit. There was appropriate hand sanitising gel available which we saw being used at appropriate times by both staff and visitors.

Environment and equipment

- Premises and facilities were designed, maintained and used to keep people safe.
- Almost all equipment was maintained and used safely. There was regular servicing and maintenance of equipment. We checked a range of equipment and the servicing data on the unit and saw almost every piece of equipment had been serviced within the last 12 months. However, there was a set of paediatric weighing scales that appeared to not have been serviced since 2013. We made the staff on the unit aware of this.
- The unit held the appropriate equipment required in an emergency. There were resuscitation trolleys on the unit

which contained the appropriate emergency equipment. However, the trolleys they were not in tamper-evident containers, a concern we identified at our last inspection and in breach of Resuscitation Council (UK) guidance. We were told this had been risk assessed since our previous inspection and it was felt that staff could respond more promptly in the event of an emergency because removing tamper evident tags would slow down response times. Managers said they had accounted for this by having the trolleys in highly visible locations. We were told the risk of anyone tampering with equipment or medicines in the trolleys was low. However, practice on the unit should be in line with the relevant guidance.

- Resuscitation trolleys were equipped with appropriate medicines and equipment, including defibrillators. To ensure the trolleys were safe for use they had to be checked once a day by a member of staff on the ward. Completion of daily checks of the resuscitation trolleys was consistent and we only saw one gap in June 2017. This issue had been identified during two previous inspections and it was evident the issue had been rectified. During our inspection, we checked both the resuscitation and difficult airway trolleys and saw all appropriate equipment was present and accounted for.
- The process for checking the difficult airway trolley had not changed since the previous inspection. It was still part of a daily safety check which was completed by the senior nurse in charge of the unit during the shift. The check was not permanently recorded as when a task was completed it was ticked on a laminated copy of the list and then wiped off at the end of each day. Therefore, it was not known whether the check had been carried out on every occasion and there was no permanent record as evidence.
- As part of the daily safety checklist, we saw evidence that staff completed: a log of the same sex arrangements on the unit, checks of the commodes, bed spaces, controlled drug count and oxygen cylinders.
- As we identified in our previous inspection, the unit was not ideally designed to provide security. Although access to the unit was restricted, as entrance to the unit could only be granted to those who were buzzed in by staff, once on the unit, visitors were able to enter the clinical areas of the unit without any further restrictions. On arrival in the unit staff directed visitors to the waiting rooms and we saw staff doing this during the inspection.
- As highlighted during our previous inspection, the unit's facilities complied with most of the Department of Health guidelines for critical care facilities (Health Building Note 04-02). There had not been any significant changes to the structure or facilities within the unit since our previous inspection so there remained some areas of non-compliance. For example, on the south side of the unit the equipment around the bed space was not installed on ceiling-mounted pendants, electric sockets still had on-off switches and not all bed spaces were equipped with clinical hand washing basins. These areas of non-compliance were not included on the unit's risk register and there were no plans to address them.
- There were appropriate arrangements for managing clinical waste. Clinical waste was segregated and disposed of in separate clinical waste bins or sharp-instrument containers. We saw staff following waste management practices during our inspection and none of the waste bins or containers on the unit were unacceptably full. An audit was carried out on sharp bin compliance each month to ensure they were being used safely and appropriately. We reviewed data from May 2016 to March 2017 which demonstrated the unit had achieved 90-100% compliance throughout the period. Areas where the unit had not been consistently compliant were the appropriateness of items within the sharps bin and the label on the bin had not been completed correctly. However, we noted there were insufficient bins on the south side of the unit, specifically by bed one and 19, on the second day of our inspection but some had been provided by the third day.

Medicines

- Arrangements for managing medicines kept people safe. There was pharmacist support on the unit which included a critical care band 8a specialist pharmacist and a band seven rotational pharmacist. The service operated Monday to Friday. If pharmacy input was required when the staff were not available, the unit staff on the unit had access to an on-call pharmacist.
- Non-emergency medicines were stored appropriately. All appropriate medicines and fluids were stored securely in locked cupboards. An audit of storage of medicines was carried out in April 2017 which showed

the unit was 100% compliant with trust practices and procedures. In a random check of a range of medicines stored within the critical care unit, we saw that all were in date.

- Medicines which required refrigeration were kept at the correct temperature. The temperatures were monitored by an electronic system which could be checked by pharmacists remotely. Fridge temperatures would flash green, amber or red to show the temperatures at any given time. The system would set off an alert if the temperature increased or decreased to unsafe levels.
- The management of controlled drugs was in line with legislation and NHS regulations. There was a controlled drug register which recorded drugs being booked into stock, administered to a patient and any destruction or return to pharmacy. Staff we spoke with were aware of the policies on the administration of controlled drugs. When we reviewed the register, we saw it had been completed in full for the north side of unit but there were gaps in recording daily checks within the controlled drug storage cupboard on the south side. For example, there were gaps in April, May and June 2016.
- We saw that epidural medicines were stored safely within the controlled drug cupboard and potassium chloride was stored as a controlled drug.
- Prescription charts used on the unit were complete and included all the relevant information. We reviewed five prescription charts during our inspection. Upon review it was clear who prescribed a medication, when the prescription had been made and what allergies a patient had. Information also included, whether venous thromboembolism prophylaxis had been indicated, including what had been put in place, what medications had been administered or omitted, and if antibiotics been given in line with guidelines.
- There was an electronic patient record system in operation on the critical care unit which was different to the system in use on the other wards or departments within the hospital. This meant that when a patient was admitted to the unit from another ward within the hospital, the drug chart in operation before admission needed to be suspended and a new one commenced. This involved suspending the old drug chart in use throughout the rest of the hospital and then transcribing any continuing medication to the system in operation on the critical care unit. Once a patient was transferred to another ward, their original drug chart was reinstated, with any additional medicines added and any old ones, if unnecessary, removed. However, there had been occasional incidents where staff had not reinstated the old drug chart. When this occurred ward staff were not aware of the medicines patients required, as their drug chart would not show on the system. There had not been any incidents where patients had suffered harm from this oversight, but the risk to patients could be serious if patients were not administered with their required medicines.
- The senior staff on the unit were aware of the risk and had changed processes to prevent incidents occurring. Notices had been placed on bed side computer terminals to reinstate the drug chart upon discharge, but there had been another incident following the implementation of the notices. To address this, we saw the unit had implemented a new system whereby patients could not be transferred without a consultant signing to confirm the original medicines chart had been reinstated.
- Attempts had been made, by the trust, to get the critical care and trust wide electronic prescribing systems to communicate with each other but had been told, by the software providers, it was not possible. As an alternative, the unit were working to change their electronic patient record system. The change involved prohibiting a patient's discharge until they had confirmed, on the system, that the electronic drug chart used throughout the rest of the trust had been reinstated. The system would alert the user the drug chart had to be reinstated.
- This risk had not been included on the local risk register but we were shown it had been submitted for inclusion by the end of our inspection.

Records

- Patient's individual care records were written and managed in a way that kept patients safe. All records were secure and kept confidential as the system was password protected, so only authorised staff could access them.
- All information relating to a patient's care was recorded on the system on admission and updated throughout the duration of their stay on the unit. Each patient had their own care plan which was revised and adapted as treatment progressed. The system allowed patient infusions and medicines prescribed and given to be recorded, which gave staff quick and easy access to the information.

- We reviewed five sets of patient records during our inspection and found that all were detailed and fully completed. All records, where applicable, contained information on the events which resulted in the patient's admission to the unit. We saw notes relating to the consultant's review on admission and daily consultant ward round. In addition to the above, further information included venous thromboembolism risk assessments, assessment of fluid state, review of in-dwelling lines, review of sedation and antibiotics and input from the multidisciplinary team.
- The records contained completed and accurate risk assessments for the prevention of pressure ulcers and malnutrition. It was clear who had completed the entry in the records and the time and date it had been entered. Any actions from the assessments were identified and implemented.
- It was clear from the records whether a patient had been assessed by a consultant within 12 hours of admission to the unit. In the records we reviewed, each patient had been assessed within 12 hours, which was in line with The Faculty of Intensive Care Medicine guidelines.
- There no longer appeared to be a problem with saving new information entered by visiting multidisciplinary staff, which we had identified during our previous inspection. We saw that the system allowed information to be recorded and saved in different sections of the patient record.
- During our previous inspection, we identified there was an issue with the discharge summaries created following a patient's transfer to a ward. During our inspection staff told us the summaries had been improved but were still not fully compliant with NICE Guidance CG50 (Acutely ill adults in hospital: recognising and responding to deterioration). We were told this was work in progress; further work was being done to improve them to address the issues. The senior staff were working with the electronic patient record system provider to make the required changes.
- The critical care outreach team had developed a simplified discharge summary, which was to be completed a maximum of two hours prior to a patient's discharge from critical care. It included the hospital and critical care admission date and number of days in critical care unit. Additional information included essential information such as; National Early Warning Score, waterlow (hydration) score, infection status, allergies, diagnosis, airway and breathing information. It also had a section for the critical care and ward nurse to sign to show there had been a handover.
- The critical care outreach team provided skilled nursing care and assessment to the sickest and most venerable patients in the hospital. They reviewed patients who had been discharged from the critical care unit and those who were at risk of deterioration. They also educated ward staff on early recognition and management of deteriorating patients.

Safeguarding

- There were systems, processes and practices to protect patients from abuse. Staff understood their responsibilities and adhered to safeguarding policies and procedures. Staff could describe when a safeguarding referral should be made and the process for doing so. They had detailed knowledge of the safeguarding adult and children policies and could describe recent events which required a referral. They were able to provide examples when a referral had been made and for what reasons, even if they were not involved directly.
- There were arrangements to safeguard adults and children from abuse that reflected relevant legislation and local requirements. We reviewed the unit's safeguarding policies for both children and adults and found them to be compliant with relevant legislation. The staff could tell us where to find the policies for both safeguarding children and adults.
- The unit had a link nurse with experience in safeguarding and staff could approach them for advice and guidance. The link nurse was responsible for sharing learning with staff and linked with the safeguarding lead within the trust.
- Staff were required to complete level two safeguarding updating training for children and adults, which included online and face-to-face training. There was a good proportion of staff that had completed both sets of training; however, not all staff were up to date. We saw evidence which confirmed 84% of staff had completed level two safeguarding children training and 93% had completed level two safeguarding adult training. Although not completed, the remaining staff had been scheduled to attend courses.

- There were shift leaders within the unit, who had completed level three safeguarding children training, although we were not provided with the exact numbers.

Mandatory training

- Staff received effective mandatory training in the safety systems, processes and practices. All nursing staff were expected to update their mandatory training programme each year. The programme included adult and paediatric basic life support, conflict resolution, infection prevention and control, electronic patient record system, fire safety, manual handling, aseptic non-touch technique (ANTT), and information governance.
- Medical staff also completed a mandatory training programme which included the same modules as above. Training compliance rates ranged between 10% and 100%. The areas of low compliance included manual handling of patients (10%), conflict resolution (70%) and infection prevention and control (82%). The trust target was 95% so there were a number of areas where significant improvement was required.
- The entire mandatory training nursing programme was delivered on the same day and took place once a month for staff to attend as required. As part of the mandatory training day, the unit also held simulation training sessions.
- The training programme was run by a senior nurse on the unit who was given protected time to perform the role. The nurse was responsible for ensuring staff had completed training and kept a record of those who had completed sessions and those who had sessions outstanding.
- The mandatory training days were held on the same day as clinical governance meetings so staff undergoing training could also attend those meetings.
- Data provided confirmed that mandatory training compliance rates were over 95% against a trust target of 100%. Any staff that had not completed any modules had been booked on to attend them. Staff told us the training delivered was of high quality.

Assessing and responding to patient risk

- There was a hospital-wide standardised approach to detecting deteriorated patients which was compliant with NICE Guidance CG50 (evidence-based recommendations on recognising and responding to deterioration in acutely ill adults in hospital).
- The trust had recently implemented the use of an electronic National Early Warning Score (NEWS) reporting system in all inpatient services. The system required staff to record patients' vital signs and calculate NEWS scores, which would identify acutely unwell or deteriorating patients. These patients would be referred to the critical care outreach team or a doctor, triggering a visit and assessment of the patient. Depending on the assessment, appropriate treatment was provided and, if required, an admission to the critical care unit was arranged.
- The critical care outreach service had been expanded to provide cover 24 hours a day, seven days a week. Data was captured for each task performed and the number of patients seen had increased since the expansion.
- The expansion of the outreach team had also improved the liaison between critical care and other wards. There were now more staff available to provide support and advice to colleagues who were treating patients requiring transfer to the critical care unit or in need of specialist advice.
- Comprehensive risk assessments were carried out for patients and risk management plans developed in line with national guidance. It was evident from patient records that venous thromboembolism (VTE), falls and pressure ulcer risks were being routinely assessed, which was in line with NICE guidance.
- Fluid balance status and medicines' prescribing were regularly reviewed and unnecessary medications were stopped. Sedation and antibiotic review was carried out frequently, and we saw two examples of sedation being discontinued when it became apparent it was no longer required.
- There were care bundles and comprehensive protocols in use on the unit which kept patients safe. A care bundle is a set of interventions that, when used together, can significantly improve patient outcomes. We saw care bundles for nasogastric feeding, urinary catheters, central venous catheters, ventilator associated pneumonia, sepsis and Richmond Agitation Sedation Scale. Richmond Agitation-Sedation Scaleis a medicalscaleused to measure the agitation or sedation level of apatient.In the records we reviewed, we saw all reviews had been carried out as applicable. Staff could describe the associated protocols for the care bundles outlined above.

Nursing staffing

- Nursing staff levels and the skill mix were planned to ensure that patients received safe care and treatment, which was in line with relevant tools and guidance. The unit used an acuity tool to determine safe levels of staffing and appropriate skill mix. However, data submitted demonstrated there had been gaps in staffing, during the period from February to May 2017. There were occasions when the unit had been four members down. However, this was covered by the band six shift leader providing direct patient care, and the use of bank or agency staff.
- The unit ensured the Guidelines for the Provision of Intensive Care Services 2015 were complied with in respect of nurse to patient ratios. Guidelines stated that level three patients required a registered nurse/patient ratio of a minimum of 1:1 to deliver direct care. Level two patients require a registered nurse/patient ratio of a minimum 1:2 to deliver direct care. We saw data which demonstrated the unit had 74 registered nursing staff to cover six level three beds, and nine level two beds. Staffing levels were planned to have 12 registered nurses on each shift. This allowed nursing staff to provide safe care and treatment to six level three patients and nine level two patients, allowing additional one and half nurses to account for any unplanned changes in acuity. If the acuity changed during a shift and an additional level three patient was admitted, the staffing levels remained safe.
- Nursing staffing levels over the period from March to May 2017 were as follows:

- In February there were adequate fill rates during the day (83%) but significantly better rates at night (92%).
- In March there were good fill rates during the day (90%) and at night (91%).
- In April there were good fill rates during the day (91%) and at night (90%).
- In May there were good fill rates during the day (92%) and at night (92%).

- Data submitted showed that the use of agency nurses was consistent through the period from June 2016 to January 2017 but had been substantially reduced by the time of our inspection. Guidance for the Provision of Intensive Care Services stated that units should not utilise greater than 20% of registered nurses from the bank or an agency on any one shift when they are not their own staff. The data showed at no time had there been an excess of 20% of agency staff being used during any one shift. However, we were told by a senior nurse on the unit there had been occasions when agency staffing had exceeded 20% on a shift but we did not see specific data confirming this. Agency staff completed an induction programme and the clinical nurse educator was responsible for ensuring it was completed on the first shift.
- We were told and saw evidence that the unit had recruited more nurses to the unit. In April and May 2017, new nurses had started and were working through their induction training. We were told there remained five band five nursing vacancies at the time of our inspection and recruitment was ongoing.
- The critical care outreach team had been extended to provide 24-hour care throughout the hospital. The team had been successful in recruiting to all registered nurse vacancies. All members of the nursing team were band seven registered nurses. There were nine nurses filling seven and a half whole time equivalent positions. The team also had two healthcare assistants to support them.
- Band six nurse shift leaders were not always supernumerary during a shift and would regularly take over the care of level two and three patients, if staffing levels on the unit were low. We were told this was not usually a problem if it occurred during the day, as one of the two band seven nurses could take responsibility for the management of the unit. However, if the shift leader was required to take over the care of a patient on a night shift, there was no one to oversee the unit. We were told this was now a rare occurrence as the unit had been successful in recruiting new nurses which had increased the established nursing numbers.
- Arrangements for handovers and shift changes ensured people were safe. There were standardised handover procedures for medical and nursing staff, both for shift handovers and discharge of patients. Each morning and night during shift changes, the consultants held a handover from night to day and day to night shift.
- An electronic system was used to review the acuity of nursing throughout the hospital and to identify areas where additional staffing was required. Meetings to discuss the acuity in the hospital were held at 8:30am and 3:30pm each day, following which, nurses could be moved from the unit to work on other wards. Staff told us this system would often identify the critical care unit as having excess nurse staffing for the number of admitted patients. Staff told us the system did not

account for the possibility of an emergency admission or a change in the number of admitted patients following the second meeting. We were told it was often difficult to move the critical care nurse from the ward back to the unit. This matter had been escalated and the band seven nurses and band six shift leaders were taken out of the calculations when determining the acuity levels. Further discussions were taking place to have an additional nurse taken out of the calculations.

Medical staffing

- Medical staff levels and the skill mix were planned and reviewed so people received safe care and treatment. The critical care unit was compliant with the Guidelines for the Provision of Intensive Care Services 2015 for clinical leadership. The unit was led by a consultant in intensive care medicine who was a fellow of the Faculty of Intensive Care Medicine (FICM). There were a further ten consultants working on the unit, of which nine were consultant anaesthetists and one was a physician intensivist.
- The critical care unit had audited the seven day working arrangements for consultants and identified the current provision was not sustainable in relation to working patterns. It had been identified the unit required three additional consultants to bring the establishment up to 14 and ensure consultant cover was always at safe levels. The unit had submitted a business case for further resource to recruit additional consultants, which had been successful. At the time of our inspection recruitment was underway.
- The level of consultant cover on the unit was compliant with professional standards. Guidance for the Provision of Intensive Care Services stated the consultant ratio should not exceed one consultant to 15 patients. As highlighted during our previous inspection consultant presence on critical care followed the recommendations of the Faculty of Intensive Care Medicine Core Standards. The consultant to patient ratio through the week was good but was at the minimum level during weekends.
- Two consultants provided cover to the unit during the day, Monday to Friday. One consultant worked 8am to 8pm; the other worked 8am to 7pm. At weekends one consultant covered from Friday to Sunday, meaning there was only one consultant on duty. The out of hours arrangements involved one consultant covering the unit on an on-call basis, commencing at 5pm, to allow handover from the day team, and continuing until 8am the following day. Consultants provided support to the critical care outreach service using the same cover arrangements as on the unit. In line with guidance, when on call, consultants were immediately available and able to attend the hospital within 30 minutes of being called. Consultants participating in the duty rota were not responsible for delivering any other services within the hospital.
- The arrangements for junior doctors were in line with the FICM core standards. The unit's arrangements met the recommendation which requires at least one junior doctor for a maximum of eight patients. There were two junior doctor rotas, a foundation rota and a middle grade rota. The foundation rota had six doctors at foundation level one or level two. By day at least two doctors were present on the unit, one working a standard day from 8am to 5pm, and the other working an extended day until 8:30pm. The middle grade rota had six doctors at core trainee or staff trainee grade. Again, during the day there were at least two present on the unit, working the same pattern as the foundation grade junior doctors.
- At night, cover was provided by one doctor from the foundation rota and one from the middle grade rota, starting at 8pm and finishing at 9am. At weekends cover was similar, with a minimum of three doctors by day and two overnight.
- There was a good commitment of consultant time on the unit. The FICM Core Standards require 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.
- The handover arrangements on the critical care unit were in line with professional standards as two took place, one at 8:30am and one at 8:30pm. Handovers were very clear with good interaction between consultants and trainees. There were wide discussions by the entire group with patients' diagnosis, treatment plans and tasks for the day clearly identified.
- The ward round arrangements were compliant with professional standards as they took place twice a day. We observed a morning ward round during our inspection. Participants demonstrated excellent communication, good teamwork, with involvement of the entire staff including nurses, physiotherapists, pharmacists and administration staff. The computer

system allowed clear communication between attending specialists as everything was documented. Trends in patients' conditions were clear and test results were discussed. The ward round was professional, efficient and detailed. All aspects of patient management were considered.

Allied Health Professionals

- As highlighted during our previous inspection, there was good support from the pharmacist team but the service did not meet the recommendations of the Faculty of Intensive Care Medicine (FICM) Core Standards in terms of cover provided. The consensus of critical care pharmacists, the United Kingdom Clinical Pharmacy Association and the Royal Pharmaceutical Society is that there should be at least 0.1 WTE band 8a specialist clinical pharmacist for each single level 3 bed and for every two level 2 beds.
- 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. The cover in place had not changed since our previous inspection as the unit had cover from 0.5 whole-time equivalent (WTE) band eight pharmacist and 0.5 WTE band seven pharmacist. They were present on the unit during weekday mornings and were often present on morning ward rounds.
- As with pharmacy cover, the unit did not meet the requirements of the FICM Core Standards for physiotherapists. Physiotherapy should be available 24 hours a day if required, dependent on patient need. Recommended staffing levels were 1 WTE physiotherapist to 4 beds. The arrangements had not changed significantly since our previous inspection. There was one WTE band seven post which was shared between three physiotherapists, one WTE band six post and a part time band four rehabilitation technician. A full physiotherapy service was provided Monday to Friday but was limited at weekends. Physiotherapists provided care which met the Faculty of Intensive Care Medicine core standards as they were able to provide patients with 45 minutes of each active therapy that was required for a minimum of five days per week. The physiotherapists could provide respiratory rehabilitation at weekends but not physical as there was not enough cover.
- There was a good regular service from dietitians and speech and language therapists on weekdays. The dietitian visited most days and would attend at other times when needed. There was cover from two band 6 dietitians who rotated on a six-monthly basis. Staff felt that the service provided was safe but more provision was required to deliver a better service for patients. The speech and language therapist came to the unit on request.
- There was a good service from occupational therapists. Nurses told us that if patients required input from the team they could make a referral and would receive a service which was both safe and of high quality.

Major incident awareness and training

- Potential risks were considered when planning services. We saw an up to date major incident plan, specifically for the critical care unit, which set out the protocols to be followed in the event of seasonal fluctuations, adverse weather and disruptions to staffing. The actions to be taken in each event were safe and appropriate. The plan included what arrangements would be put in place in the event of emergencies and major incidents. However, it was not clear whether drills took place consistently, although fire alarms were tested every Wednesday and drills were carried out once a year.
- The plan identified how the hospital would increase its capacity temporarily to care for additional critically ill patients during major incidents such as a pandemic flu crisis or a serious public incident.
- As highlighted during our previous inspection, the trust had a current major incident plan. Staff could explain how to access and distribute the policy and when it would become relevant.

Are critical care services effective?

Good

We rated this domain as good because:

- Treatment provided to patients was in line with best practice and national guidance.

- The unit, in partnership with other departments within the hospital, had developed and implemented a new chest injury care pathway which had improved patient outcomes.
- Patients had good outcomes as they received effective care and treatment which met their needs.
- There was good multidisciplinary team working which led to better outcomes for patients.
- The unit submitted data to the Intensive Care National Audit and Research Centre which showed outcomes for patients were, in many cases, better than the national average.
- Data showed the mortality rates for the unit were better than the national average, meaning more people would have survived their illness than in other units across the country.
- Staff on the critical care unit were competent, with over 50% of nursing staff having a post-registration qualification in critical care nursing.
- The organ donation arrangements within the unit were effective and data showed it was performing better than the national average in many aspects.

However:

- There was limited support from some services at weekends, including pharmacy and physiotherapy.
- As identified at our previous inspection, there were aspects of NICE Guidance QS90 (Rehabilitation after critical illness) that were still not being delivered. Patients were not being provided with structured and supported self-directed rehabilitation booklets for use for at least six weeks after discharge from critical care.
- It was not always evident that patient delirium screening was always being carried out, as recommended by the Faculty of Intensive Care Medicine Core Standards.
- Not all staff had up to date training to use specialist equipment and the system for monitoring competence was not effective.

Evidence-based care and treatment

- Relevant and current evidence-based guidance, standards and best practice was used to develop how services, care and treatment were delivered. As highlighted in our previous report, there was a trust-wide system for identifying and disseminating national guidance, standards and practice. Guidance issued by NHS England, the National Institute for Health and Care Excellence (NICE) and Public Health England was included in this process. New guidance and best practice was discussed and shared at clinical governance meetings.
- The critical care unit reviewed their practices, facilities and systems against the Faculty of Intensive Care Medicine Core Standards. We saw evidence of the unit's recent audit, in which areas of non-compliance were identified and actions taken to improve compliance. For example:

- The unit had highlighted the insufficient pharmacy technical staff to provide support as an aspect of non-compliance. Therefore, the unit had submitted a business case to recruit and appoint additional staff.
- Core Standards stated units with between one and 20 beds require one additional supernumerary registered nurse to manage a critical care unit. However, on the unit there was never more than one band six shift leader on duty, who could not always remain supernumerary due to the vacancies within the nursing staff levels. Therefore, additional staff were being recruited to rectify this issue.
- Admissions to the critical care unit should be within four hours of making the decision to admit. However, the unit had identified this was not happening on every occasion. To improve this, measures to improve the flow in and out of the unit had been implemented, as detailed below in the section on 'access and flow'.
- There were also standards which the unit was only partially compliant with, but staff were aware of what they were and what needed to be done to be fully compliant. All staff within the unit were fully committed to being compliant with national standards.

- Patients had their needs assessed and their care planned and delivered in line with evidence- based guidance, standards and best practice. The unit ensured patients were assessed by a consultant in intensive medicine within 12 hours of admission to the unit. Consultants worked in blocks of five days or across a weekend shift to deliver continuity of care.

- As detailed above, under the section 'assessing and responding to patient risk', the unit complied with NICE Guidelines CG92 (Reducing the risks for patients developing venous thromboembolism in hospital), GS86 (Falls in older people) and CG179 (Prevention and management of pressure ulcers). The unit ensured

practice on the unit complied with CG50 (Acutely ill patients in hospital) and QS90 (Urinary tract infection in adults). We saw examples of policies and practice which were compliant with guidance.

- The unit was compliant with some of the guidelines outlined in NICE CG83 (Rehabilitation after critical illness) as consultant-led follow-up clinics were offered to patients. This was for level three patients who had spent three or more days on the critical care unit. However, there were plans to extend the service to include more patients. The consultant was supported by two band six research nurses to deliver the service.
- As identified during our previous inspection, the unit was not fully compliant with CG83 as there were aspects of the physiotherapy provision that were not being delivered. Specifically, the rehabilitation requirements post-discharge from the unit or hospital were not being provided to patients. The unit was not providing structured and supported self-directed rehabilitation booklets for use with patients and those caring for them for at least six weeks after discharge from the critical care unit. However, the physiotherapists provided a rehabilitation program, which was to be followed while the patient was moved back to a ward and there was a verbal handover to nurses on discharge.
- Areas of non-compliance had been audited since our previous inspection, and the aim of the physiotherapists working on the unit was to comply with the guidance. However, staff felt this was not possible unless resources were increased. Improvements had been made as patients were now being assessed by physiotherapy within 24 hours of admission during the week, but not at the weekend due to the limited number of staff.
- All staff had access to trust policies and procedures. It had been highlighted in our previous report that some policies and procedures were out-of-date and possibly obsolete. As a result, the unit was updating and implementing new policies and procedures in use on a weekly basis. This was to ensure the guidance was in line with present guidance and best practice. We saw examples of the newly updated policies for basic ventilation, central venous catheters and prone positioning, among others.
- There was no discrimination on the grounds of age, disability, gender, race, religion or belief and sexual orientation when making care and treatment decisions for patients. All staff underwent equality and diversity training as part of the mandatory training programme.
- Guidance for the Provision of Intensive Care Services (2015) stated that all patients should be screened, on admission, for delirium. We saw the unit had a policy confirming that each patient was to be screened patients for delirium. Data submitted before our inspection told us the unit were compliant with guidance and their own policy. However, to record when delirium screening had taken place, a box on the electronic patient recording system had to be checked. When reviewing patient records, it was not always evident that patients had been screened was carried out but were told this could be due to nurses not ticking the appropriate box.
- The trust was part of the National Organ Donation programme and followed NICE guideline CG135 (Organ donation for transplantation). We reviewed data covering the period from April 2016 to March 2017 on donor outcomes. Throughout the period there had been four eligible organ donors which resulted in six patients receiving organs. We saw data which showed when a patient was eligible for organ donation a specialist nurse in organ donation was involved in 100% of situations where there had been brain stem death, against a national average of 93%. In cases where ventilated support was to be withdrawn from a patient, a specialist nurse in organ donation was involved in 82% of occasions, against a national average of 80%. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family.

Pain relief

- Patients' pain was effectively assessed and managed. Staff used a scale from one to 10 to score a patient's pain level if the patient was able to describe it to staff in this way. All pain scores were recorded on the electronic patient record system and we saw completed assessments. We observed staff assessing patients' pain levels during our inspection and confirmed this when speaking with patients.
- Most staff had received training to use patient controlled analgesia and the use of epidural pain relief (pain-relieving medicines injected into the space around the spinal cord). Staff told us they would not use the methods above if not fully competent to do so.
- Staff within the critical care unit, in partnership with other teams within the hospital, had developed a chest injury pathway. At the time of our inspection, the

pathway was going through the latter stages of the ratification process. However, the pathway was being piloted and so we saw it in practice during our inspection. The pathway was being used to overcome the challenges associated with rib fractures. It addressed the difficulties associated with patients who require advanced anaesthetic interventions, such as thoracic epidurals. The pathway allowed patients' pain to be treated more aggressively as the previous pain management pathway followed was slower in relieving patients' pain. We saw two good examples of immediate response and admission to the unit, involving two similar cases of rib fractures. These patients required thoracic epidural, immediate admission for observation, and chest drains. The swift admission to the unit and efficient pain management led to more effective outcomes. Both patients told us their pain had been addressed promptly and controlled effectively. One said their care had been "superb". A thoracic epidural is an injection of anti-inflammatory medicine into the epidural space to decrease inflammation of the nerve roots, hopefully reducing the pain in the mid back or around the rib cage.

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed and responded to effectively.
- The Guidelines for the Provision of Intensive Care Services stated all patients unable to take oral intake should have nutrition support (enteral or parenteral) commenced on admission, to ensure adequate nutrition to help rehabilitation. In line with the guidance, there was a designated dietitian assigned to the unit who was involved in the assessment, implementation and management of patient nutritional support.
- There was a referral process for patient assessment and review by a dietitian, which was followed when patients required specialist input. We saw within patient records that all nutrition and hydration assessments were complete and protocols were followed to ensure the response to patient needs were safe and appropriate. However, staff felt more dietitian staff were required to ensure patients received effective care and treatment, seven days a week.
- Fluid balance was calculated, recorded in patients' records, and analysed to provide the patient with the appropriate levels. We saw appropriate adjustments and consequent improvements being made when reviewing patients' records.
- We saw 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 and any recent weight loss, continence state, skin evaluation, mobility, age and sex.

Patient outcomes

- Information about the outcomes of patient care and treatment was routinely collected and monitored. The unit participated and contributed data to the Intensive Care National Audit and Research Centre (ICNARC). By participating, the unit could benchmark itself against units of a similar size and across all units nationally. The data contributed by the unit was of a high standard, meaning it was mostly complete and could be evaluated and compared.
- The outcomes for patients using the service compared favourably with other similar units and had remained consistent over time. Upon review of the most recent ICNARC data, concerning care between April 2016 and December 2016, there had been one patient transfer to another unit for non-clinical reasons (usually there not being a bed available). This was significantly lower (better) than the national average and across similar units. This number had remained consistent over the previous years.
- The mortality levels for patients admitted to the critical care unit were lower (better) than the national average. However, there had been an increase in the mortality rate from October to December 2016, but this had decreased over subsequent months. The number of patient deaths, post-discharge from the unit, was lower (better) than the national average.
- The number of early readmissions to the unit throughout 2015/16 and the first three quarters of 2016/17 (those readmitted for critical care within 48 hours of discharge to a ward) had fluctuated slightly above and below the national average but remained consistently low. An early readmission can indicate a patient may have been discharged from the unit too early.
- The critical care unit was part of the South West Critical Care Network. There had not been a recent review of the unit by the external members of the network, other than

the one which had been carried out in 2015 and referenced in our previous report. However, the unit's continued involvement with the group allowed them to share and adopt ideas/practices with the other network members to improve patient care. It also allowed the unit to benchmark themselves against the other units throughout the South West.

- The critical care unit participated in a comprehensive programme of clinical audit. There was a designated audit lead, a consultant in intensive medicine, who was responsible for the audit programme on the unit. Audit results were collated and discussed at clinical governance meetings. There were examples of actions being taken following audit findings, such as the introduction of the chest injury care pathway. Examples of audits included:

- Clerking and senior review of patients admitted to critical care within 24 hours of admission from the emergency department;
- International multi-centred prevalence study on sepsis;
- Assessing the antibiotic timings in patients admitted onto intensive care with sepsis;
- Department of Health Saving Lives audit;
- Ventilated associated pneumonia: Monitoring and diagnosis;
- Quality and patient safety improvement: Compliance with 22 critical care standards set by the Institute of Healthcare Improvement (IHI);
- Outcomes of patients after intensive care unit stay.

- Our previous inspection highlighted that the unit 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). However, the unit had now completed an audit of its and the hospital's practice to assess their compliance against the recommendations put forward by the national review. They had also produced an action plan to improve compliance and were part way through implementing it. Tracheostomy care had improved in the unit and throughout the hospital. Further staff training had been delivered and the outreach team was working with staff on the wards to improve referrals and offer advice when required.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities, and on a continual basis.
- Since the last inspection a dedicated clinical nurse educator had been appointed, who was responsible for coordinating the education, training and continuing professional development framework for the critical care nursing staff. This was in line with the Guidelines for the Provision of Intensive Care Services 2015. The clinical nurse educator had only been able to dedicate the appropriate amount of time to the role since the appointment of the matron, in October 2016. The role was still developing at the time of our inspection, although they had run study days, including cardiovascular and neurology, in that time.
- We saw data confirming that over 50% of registered nursing staff had a post-registration qualification in critical care nursing, which was in line with guidance. Staff told us it had been difficult to find and enrol nurses on a course, due to lack of availability in the South West, but the unit was enrolling four additional nurses on the course in the following 12 months.
- The pharmacy service provided to the unit was delivered by a pharmacist who was a critical care specialist and who provided training to rotational band seven pharmacists. However, there were no pharmacy technical staff to provide supporting roles on the unit. The pharmacist on the unit had specialist knowledge to provide the service to the critical care unit and could provide advice to on-call pharmacy colleagues if required.
- Not all staff had up-to-date training to safely use the specialist equipment within the department. Data submitted by the trust showed there were varying levels of staff trained to use specialist equipment with high levels of staff training being out of date. For example, only 37% of staff had up to date training to use the transport ventilator. The unit had assessed the training levels as being a medium risk within the department.
- There were arrangements for supporting and managing staff. Each member of the nursing staff underwent an annual appraisal. During our inspection, we saw data which confirmed 97% of nursing staff had undergone an appraisal for the period 2016/17. All the appraisals of nursing staff had been carried out by either the clinical nurse educator or the nursing operational lead, who were both band seven nurses. There were plans to

delegate this responsibility to appropriate band six nurses in future. Steps had been taken to implement the new process but it had not yet been fully embedded. We reviewed examples of recent appraisals which we found to be comprehensive, with clear objectives and good feedback on performance provided.

- Medical staff on the unit each received an appraisal in line with the requirement set by the General Medical Council (GMC). Their performance was reviewed and objectives set for the coming year.
- When a new member of nursing staff joined the critical care unit they underwent a one-week induction followed by a five-week supernumerary period of training. This was in line with Guidelines for the Provision of Intensive Care Services 2015. The new staff member was also assigned a mentor, who they could go to for additional advice and support. We saw data confirming there were 16 staff acting as mentors for new nurses within the unit.
- As part of the new staff training programme, the service followed the critical care nurse education standards step one competencies. The standards have been set by the Critical Care National Network Nurse Leads Forum (CC3N), who are one of three forums that represent the Critical Care Networks, alongside the network medical leads and the network directors/managers.
- At the end of the six-week supernumerary period new nurses could care for level two patients on their own but could only care for level three patients if supported by a colleague.
- Poor or variable staff performance was identified and managed. When identified, staff were supported by their senior colleagues to improve. Staff told us and we saw evidence that when a staff member's practice was below the expected standard, the senior team carried out a review on what additional training and support was required. The process was discussed with the member of staff and it was made clear they were there to support them and it was not a form of punishment. Staff were also given the opportunity to share their learning with colleagues at clinical governance meetings, if appropriate.
- Nurses were supported through their revalidation process by the trust and their colleagues within the critical care unit. Staff felt they were supported in their development and were given opportunities to attend additional training to improve their skills. Staff told us they had been funded to attend courses and some were booked to attend courses later in the year.

Multidisciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering patient care and treatment.
- On admission to the critical care unit all patients had a treatment plan discussed with a consultant in intensive care medicine, which was in line with the Guidance for the Provision of Intensive Care Services 2015. Within treatment plans there was input from the multidisciplinary team, including physiotherapy, pharmacy, nursing and speech and language therapy.
- There was a physiotherapist with suitable experience and seniority who could help and construct a suitable weaning plan for complex patients. This was a practice for taking patients off ventilators. Staff told us the working relationship with the physiotherapy team was good and they offered a good level of support to the unit.
- We saw a good example of multidisciplinary working on the unit involving a patient, who had mental capacity, wanting to discharge themselves. The team assessed the situation and it was determined the patient was not well enough to leave the unit without support. As a result, all staff involved in the patient's care developed a plan to allow the patient to leave by ensuring all the necessary safeguards were put in place. Consultants ensured the patient was discharged with all the necessary prescribed medication and nurses made the necessary calls to the local authority to ensure the patient had the appropriate support when returning home. The physiotherapist provided guidance to the patient on what exercises should be used to help with rehabilitation. All steps were taken quickly to meet the patient's needs and the cooperation between all staff members was effective.
- There were clear criteria for people who would and would not benefit from admission to the critical care unit. The criteria had been written by both the clinical lead and matron for the unit. The criteria had recently been updated and was going through the ratification process during our inspection. After which, we were told, the criteria would be shared throughout the hospital using the various governance processes.

- We saw the escalation policy for patients with sepsis which was appropriate and followed by staff. Patients were receiving prompt screening when escalated for sepsis by the multidisciplinary team. The escalation process included the critical care outreach team visiting the patient on the ward, within a certain time, depending on their early-warning score. Once in attendance, an assessment of the patient's condition and needs was carried out and decision to admit to the critical care unit was taken in partnership with the ward staff and the consultant intensivists.
- The development of the chest injury pathway was a quality improvement project which involved the critical care unit, emergency department, anaesthetic department, respiratory ward and pain team. Critical care staff, involved in the project, said working with the other teams around the hospital was effective.

Seven-day services

- The unit was compliant with the majority of the Faculty of Intensive Care Medicine Core Standards and Guidance for the Provision of Intensive Care Services in respect of the delivery of seven-day services. A consultant intensivist was available across the whole week, either in person or on call. Multidisciplinary clinical ward rounds led by a consultant intensivist occurred every day (including weekends and national holidays). The ward rounds included daily input from nurses, microbiologists, pharmacists and physiotherapists during weekdays but input from the multidisciplinary staff was limited at weekends.
- All patients on the critical care unit were seen and reviewed by a consultant twice daily and continuity of care was ensured as consultants worked in five-day blocks.
- When on call, consultants were within 30 minutes of the hospital. Junior doctors confirmed consultants were always available to attend the unit or take telephone calls.
- Pharmacy and microbiology services were available throughout the week during the day time. At night and at weekends, support was provided on-call.
- There was physiotherapy cover throughout the week but services were limited at the weekend, with only respiratory assessments and reviews taking place. Rehabilitation services were not available at weekends due to the limited amount of staff available to the unit.
- Access to clinical investigation was available across the whole week. Services 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).

Access to information

- All the information needed to deliver effective care and treatment was available to staff in a timely and accessible way. As described above, the critical care unit had an electronic patient record system that included all relevant information relating to the patient, including care plans, risk assessments, case notes and test results. The information was available at the bedside as there was a computer terminal at each bed space.
- As well as being able to access patient records at the bedside, staff could access guidance, standard operating procedures and policies using the computer terminals. This allowed staff to search for guidance on best practice or specific policies while with the patient, at the time the information was needed. This increased efficiently and effectiveness, which benefitted patient care.
- Staff said they could access information quickly and searching for information was aided by the fact it was stored on one system.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff could describe the process for completing a mental capacity assessment and how they would go about recording best interest decisions.
- Mental capacity assessments were carried out when appropriate and this was recorded within the patient records we reviewed.
- During our previous inspection we identified there was some inconsistency regarding the use of restraint. To address this, the unit had arranged for additional training to be provided by the hospital's aggression and violence team. Staff on the unit could contact the aggression and violence team if assistance or support was required.
- Staff had received training on deprivation of liberty safeguards (DOLS), specifically when an application

should be made and what process should be followed when doing so. Staff demonstrated an understanding of the process and provided examples of when applications had been made. There had been a recent example where the unit had made an application for DOLS, following assessment, for an intubated patient with a learning disability who had been resistant to treatment. However, following extubation the patient was compliant with treatment. The unit regularly made referrals to the psychiatric team for specialist advice and further assessment whenever required.

Are critical care services caring?

Good

We rated caring as good because:

- Staff on the critical care unit were compassionate, kind and sensitive. Patients, relatives and visitors were complimentary about the compassion and kindness they had been shown.
- Communication with patients was effective as they were kept informed of their condition, progress and treatment.
- Patients' privacy and dignity was maintained throughout their treatment and staff took all steps to protect confidentiality.
- Those close to patients were involved in their care and were kept updated on any progress or deterioration in condition.

However:

- The critical care unit was not using patient diaries but there were plans to introduce them later in the year.
- There were no formal arrangements for counselling services but the unit had developed close ties to the trust's chaplaincy service which provided patients with spiritual support.

Compassionate care

- Staff understood and respected patients' personal, cultural, social and religious needs and took them into account when delivering care. If changes in patients' conditions occurred, the patient or their families/carers would be asked if they had any specific needs and staff would endeavour to accommodate them.
- The unit had close links with the trust's chaplaincy service and made referrals to the service in all situations where patients had spiritual or religious needs. The staff on the unit communicated patients' needs to the chaplaincy service, which could then make the necessary arrangements. They would use their links with the community to seek advice and assistance, if patients' needs could not be fulfilled by the chaplaincy service themselves.
- Staff took the time to interact with patients and those close to them in a respectful and considerate manner. We observed staff communicating with patients, their relatives and carers in a kind and compassionate manner on many occasions during our inspection. A relative told us that staff had always been very patient with them when they were seeking advice or an update. Several patients and visitors told us that staff kept them regularly updated by telephone or in person and someone was always available when they called the unit to check on relatives.
- Due to the nature of critical care, the unit was unable to provide us with any NHS Friends and Family Test (FFT) data. Patients on the critical care unit rarely completed feedback forms because they were too unwell and unable to physically complete them. More significantly, patients were rarely discharged home from the critical care unit as they are usually transferred to other inpatient wards. The NHS FFT data was requested from patients only upon discharge.
- There were no relevant inpatient survey results for the critical care unit and there were no plans to implement any. However, the unit did have a visitors' book which recorded the experiences of relatives and visitors. All the comments we reviewed were positive and were complimentary of the staff and the care provided. A patient told us the care and treatment provided to them was "top notch" and doctors and nurses were "lovely".
- Staff ensured patients' privacy and dignity was always respected, including during physical and intimate care. At every opportunity, staff drew curtains around bed spaces when intimate care was being provided to the patient.
- Staff respected confidentiality by ensuring conversations about patient care took place in private or when at the bedside. Voices were kept low to minimise the risk of others overhearing. There was a relatives' room on the unit which was used when staff

discussed sensitive matters with relatives and carers. The room enabled privacy and we saw the room being used several times during our inspection for this purpose.

- We saw notices within the department publicising the opportunity for patients, family members and carers to discuss aspects of care with the senior nursing team. The notices provided details on how to do this. However, this service had not yet been used by any of the patients or visitors at the time of our inspection.
- The unit was compliant with NICE QS15 (Patient experience in adult NHS services), as patients were introduced to all healthcare professionals involved in their care and were made aware of their roles and responsibilities. We observed staff introducing themselves to patients and explaining what their role was. This happened regardless of whether the patient was fully alert, drowsy or sedated. Staff wore name badges displaying their name and wore an additional badge displaying their role.
- Patients' preferences for sharing information with their partner, family members and/or carers was established, respected and reviewed throughout their care. If patients were able to communicate, staff asked them who they could share information with. If patients were unable to communicate staff would contact a patient's GP to identify their next of kin. The unit could also make a referral to the independent mental capacity advocacy service within the hospital to provide support for the patient if they did not have the capacity to make their own decisions.
- The official visiting times for the unit were 2pm to 8pm and there were protected meal times between 12pm and 1pm. However, the unit was flexible to accommodate the needs of patients and their loved ones. As a ward round took place in the morning visitors were encouraged to visit in the afternoon. Relatives told us they could visit as much as they liked.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so they understood their care treatment and condition. Patients told us they felt involved in their own care and treatment. All patients who could speak with us were able to describe their condition, progress and current treatment. They said their doctors, nurses and physiotherapists explained what was happening to them and why. They felt able to discuss their treatment and any concerns with the medical professionals taking care of them.
- We observed conversations between staff and patients and noted that technical language was kept to a minimum and patients were invited to ask questions at every opportunity.
- Staff kept those close to patients informed of what was happening to them and involved them in their care. For example, relatives and carers of patients were asked what a patient's favourite music was and how they would like to be addressed.
- Staff ensured visitors were identified and checked whether they were entitled to receive any information before disclosing details on patients' condition, care or treatment. As identified during the previous inspection, the ward clerks were valued members of the team and were aware if certain information was confidential or sensitive so were vigilant when disclosing information to patients' relatives.
- If clinically appropriate, staff approached relatives to discuss organ donation when treatment was being withdrawn from a patient. Within the critical care unit there was a specialist nurse for organ donation who would discuss organ donation with relatives at appropriate times, in a compassionate manner.

Emotional support

- Staff understood the impact a patient's care, treatment and condition had on their wellbeing and on those close to them.
- The unit was compliant with NICE QS15 (Patient experience in adult NHS services) as staff ensured patients' physical and psychological needs were regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. It was evident in the patient records we reviewed that assessments for the above had been carried out and were being reviewed daily. Patients told us their pain had been adequately managed and staff were frequently asking them how they were feeling.
- Emotional support and information was provided to those close to patients. Following participation by the unit in the Provision of Psychological Support to People in Intensive Care (POPPI), three nurses from the unit had undertaken training. This enabled them to deliver psychological support to improve outcomes for patients

being discharged from the unit. The nurses in question were delivering this support to patients during our inspection. The nurses were also able to provide support to colleagues when required.

- Staff supported bereaved relatives and carers. Staff gave them time to be with their loved ones on the unit and made the area around them as quiet as possible. If appropriate, deceased patients were moved to one of the isolation rooms so relatives could spend time with them in private. Staff also accompanied bereaved relatives to their cars or waited with them if using public transport so they were not alone. Staff wrote and sent cards of condolence to the family, within two months of a patient death. Opportunities were also given to families to speak to a consultant to discuss what the circumstances of their relative's death.
- A member of the nursing team had recently returned from a secondment with the end of life team. Following their return, the nurse shared what they had learnt with the rest of the nursing staff. An initiative was also put forward to deliver additional support to bereaved children. We saw many tools to help children to cope with their loss. For example, the unit had invested in story books surrounding death. There were also puppets, colouring books and toys which could be used to distract and comfort children.
- There were no formal arrangements for counselling services for patients on the unit but as mentioned above, the unit had close links with the chaplaincy service, which was available 24 hours a day. Through this service patients could be supported by having someone to talk or sit with to provide comfort.
- At the time of our inspection the unit was not using patient diaries. Research has shown how patients who are 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 admission and post-discharge. They not only fill the memory gap, but can also be a caring intervention to promote holistic nursing. However, staff told us patient diaries had been discussed at clinical governance meetings and were thought to be a "good idea". The unit had plans to implement them in the future.
- There was a sensitive approach to relatives when a patient might be a possible eligible organ donor. We were unable to speak with the clinical lead for organ donation during our inspection but did speak with the specialist nurse for organ donation who described their approach. This was recognised as sensitive, understanding and caring. The specialist nurse for organ donation and clinical lead were involved with families of a patient who had died or was at the end of the life. They both and had a great deal of training and experience to deal with these situations.

Are critical care services responsive?

Requires improvement

We rated this domain as requires improvement because:

- Due to the lack of capacity within the hospital for beds, patients did not always receive optimal care at the right time. There were frequent delayed admissions, delayed discharges and discharges which took place out of hours.
- At times, level two patients were kept in the recovery area following surgery instead of being admitted to the critical care unit, due to the lack of bed capacity on the critical care unit.
- Patients were not always cared for in separate single sex areas due to patient flow issues.
- The unit did not routinely screen for patients living with dementia when admitted onto the unit.

However:

- The unit had introduced measures to ensure patient flow in and out of the critical care unit did not deteriorate. New systems for assessing bed capacity had been introduced which increased efficiency in the admission and discharge processes.
- Since our last inspection a critical care matron had been appointed which had increased the profile of the unit at daily bed meetings. The coordinators were now more aware of the capacity issues on the unit, which assisted in securing beds for critical care patients to be admitted to.
- The chief operating officer visited the critical care unit or had daily conversations with the critical care matron to assess the unit's bed capacity.

Service planning and delivery to meet the needs of local people

Critical care

- The facilities and premise were appropriate for the services that were delivered.
- The service was designed and planned to meet patients' needs. The unit was located close to the emergency operating theatres next door, which is recognised as good practice.
- Improvements had been made to the premises since our last inspection, which included the installation of shower facilities, as recommended by Department of Health guidelines for modern critical care units.
- During our inspection, we observed that staff took great care to ensure the noise level on the unit was minimal. Research has showed how sedated patients can be affected by unfamiliar or familiar noise. As identified during our previous inspection, the unit's equipment was relatively quiet (although alarms could be clearly heard for safety) and loud noises from bin lids were managed by replacing these with quiet closing bins.
- New clocks, showing the date and time, had been purchased and were positioned so that patients in all bed spaces could see them. This helped with patient orientation following sedation. The Department of Health recommended all patients in critical care units should be able to see a clock.
- The unit had continued to provide equipment to meet patients' health needs. 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 and also provided haemofiltration. Patients needing renal replacement therapy for acute kidney injury were able to be treated on the unit, and not transferred elsewhere for this specialist therapy.
- The unit provided discharged patients with access to a consultant led follow-up clinic, which was supported by two research nurses. At the time of our previous inspection this service was unfunded, but was now funded and made up part of the consultants' programmed activities.
- There were no facilities for relatives to stay on the unit overnight; however, in partnership with the chaplaincy service, arrangements had been made for relatives to stay at a local bed and breakfast free of charge, using charitable funds.

Meeting people's individual needs

- The unit demonstrated outstanding examples of individualised and multidisciplinary care for their patients. Several patients on the unit, who had been cared for on the unit for many months, had been supported and enabled to leave the unit on day trips. To do this, all staff on the unit went to great efforts to ensure the patient was safe and all necessary safeguards were in place. Consultants, nurses and anaesthetists came in on their days off to facilitate this.
- The unit was equipped to deal with patients with complex needs. Since our previous inspection, staff on the ward had worked, with speech and language therapist colleagues, to seek new ways of communicating with patients who had communication difficulties. They had identified applications (software which runs on a mobile phone or computer) to assist patients with communication. Staff said the applications had assisted in two-way communication which had helped patients understand their treatment and help staff to identify patients' needs. The unit had also arranged for one of the ward clerks to complete a sign language course to help communication with patients with hearing impairments.
- Translation services were available to assist communication with patients who did not speak English. Staff knew how to access the service and confirmed the service had been used when required. Leaflets and documents could be provided in other languages and formats, such as braille if required.
- The service had taken steps to support patients with complex needs, such as those living with dementia and patients with a learning disability. For example, patients living with dementia were placed in a bed close to the nursing stations so they could be monitored more closely. Staff knew how to access additional support from the trust's dementia champions. However, there was confusion as to when patients were screened for dementia. Staff did not think it occurred when they were on the unit but would be carried out before admission. This could present a problem for those patients admitted directly to the unit and not transferred from a ward.
- There were no obvious barriers to admission to the critical care unit on the grounds of age or gender. Intensive Care National Audit and Research Centre (ICNARC) data confirmed that the average age of patients admitted to the unit throughout April 2016 and

December 2016 was 59 years of age which was slightly below the national average of 61. Most patients admitted to the unit were male (58%), which was slightly higher than the national average (55.9%).

- The unit had close links with the palliative care team and could make referrals to this service when required. As highlighted during our previous inspection, the hospital had introduced treatment escalation plan (TEP) forms to replace resuscitation-decision forms (previously known as DNR or DNACPR forms). We saw these in use during our inspection.
- The unit was accessible to people who used a wheelchair. The doors were wide enough to admit a wheelchair, and there was flat access to the unit and patient areas.
- As identified at our previous inspection the unit was not always able to accommodate patients in single sex areas. However, staff on the unit continued to make efforts to segregate patients where possible. The north side of the unit had continued to be used primarily for level three patients and bed spaces were partitioned with walls. The south side of the unit, used primarily for level two patients, was an open area but staff endeavoured to maintain one area for female patients and the other for male patients. This was not always possible when the unit was full.
- The unit had improved the psychological support available to patients. Since our previous inspection the unit had sent three nurses to complete training to help distressed patients. The nurses were trained to have discussions with patients to help them cope with their distress.
- The unit had arranged for a masseuse to provide shiatzu massage to patients on the ward to help with muscular pain. The first session was paid from charitable funds and any additional sessions were paid for by the patient or their family.
- The service had purchased radios and disposable headphones for each bed space so that patients could listen to music or the radio.

Access and flow

- Patients did not always have timely access to initial assessment, diagnosis or urgent treatment. Critical care beds were not always available for those patients who needed this level of care. As identified during our previous inspection, there were occasions when patients had to remain in theatre recovery, while waiting for a critical care bed. Staff told us that patients requiring level two care could be kept on the recovery unit for up to 24 hours after surgery, if there were no critical care beds available. Throughout April 2016 and March 2017 there had been 92 patients who had an overnight stay in the recovery area due to a lack of beds in the critical care unit. Additional data showed there had been 44 patients who had an extended recovery stay, not involving an overnight stay, over the period from August 2016 to July 2017.
- Staff kept a record of patients in extended recovery and we saw two level two patients had been in extended recovery on one of the days during our inspection. To ensure patient safety, staff on the critical care unit were aware of the number of level two patients in the recovery area and the intensivist working on the unit had oversight of their care.
- We saw data confirming there had been no ventilated patients accommodated outside of the unit due to bed pressures throughout the period from July 2016 to July 2017. If ventilation was commenced on a patient on a ward or in the emergency department, a skilled doctor or critical care outreach nurse stayed with the patient until a bed became available. If no bed was available at the time, four options were considered and implemented as appropriate:

- Utilisation of theatre recovery, where lower dependency patients on the critical care unit were transferred to recovery to make space for the new admission.
- Additional critical care staff were repatriated if working elsewhere in the hospital.
- Non-critical care staff were requested to care for patients awaiting ward beds.
- Redeployment of staff who were attending in house study or were completing non-clinical tasks, such as audit or research.

- As identified during our previous inspection there were still too many delayed discharges from the critical care to a ward, when the patient was ready for transfer. The data in the ICNARC report, for the period from April to December 2016, demonstrated 6.7% of all patient discharges from the unit had been delayed by up to eight hours, which was higher (worse) than the national average of 5.1%. The number of delayed discharges had also been higher than the national average throughout 2015/16.

- The report further demonstrated that 3.5% of all discharges from the unit were delayed by up to 24 hours, which was higher (worse) than the national average of 3.1%. The results throughout 2015/16 were also higher (worse) than the national average.
- Delayed discharges prevented new patients being admitted to the critical care unit. Data provided by the trust confirmed there were an average of six delayed admissions per month throughout 2016 and an average of eight per month throughout the first five months of 2017. From the data provided, we could not see delayed admissions being reported as incidents but the unit were aware of when they occurred. Any delays in admission were thoroughly discussed at clinical governance meetings. We did not see any evidence that patients had been harmed as a result of the delayed admissions to the unit.
- At our previous inspection we identified too many patients were discharged from the unit out of hours (between 10pm and 7am). This remained an issue. The ICNARC report told us that 4.8% of all patients had been discharged from the critical care unit out of hours, which was significantly higher (worse) than the national average of 2%. Studies have shown discharges at night can increase the risk of mortality; disorientate and cause stress to patients.
- Steps had been taken to improve patient flow in and out of the unit, which are described below. The steps taken were also introduced to ensure the impact upon patients was minimal. There were external factors within the trust and community which made it difficult to ensure patients were admitted and discharged at the appropriate times.
- During our previous inspection we had identified the matron responsible for the critical care unit could not dedicate enough time to the management of the unit (including bed management) due to limited capacity. Since then a dedicated critical care unit matron had been appointed.
- The matron attended the hospital bed meetings every day at 8am, 12:15pm and 4pm. Before attending the meeting, the matron completed a list of all the patients ready for discharge. The list included the patient name, consultant, special requirements and time the decision to discharge to the ward was taken. The matron also recorded when the site office was told the patient was ready to be discharged and whether it resulted in a single sex breach. This information made it clear how the unit was performing and highlighted their requirements.
- To ensure beds were allocated for patient transfers out of the critical care unit, the matron sent copies of a list of patients ready for discharge to the chief operating officer and patient flow lead. In addition to this, the matron predicted which patients were likely to be ready for discharge on a certain day and confirmed this with the consultants at the start of the day and during handovers. This was done to minimise the risk of underestimating the number of required beds at the bed meetings.
- At the time of our inspection, the chief operating officer and patient flow manager was visiting the critical care unit every morning to assess the number of patients ready to be discharged to a ward. Senior staff told us this had improved the flow in and out of the unit and was to continue for the foreseeable future. The matron had regular contact with the chief operating officer to ensure their capacity and bed requirements were assessed throughout the day.
- To ensure there were minimal delays in patient discharge from the unit, a checklist had been developed. This acted as a checklist for nurses to follow to ensure all steps had been taken when it was decided a patient was well enough to be transferred to a ward. This had reduced the number of delays in discharging patients who were medically fit for discharge. For example, when it was likely a patient was going to be discharged from a unit, staff were reminded to ensure all documentation, including risk assessments and discharge summaries were up to date, arterial lines removed and to consider the removal of central lines. The checklist included additional reminders to ensure all steps had been taken prior to their discharge from the unit.
- Throughout 2016, the average bed occupancy rate in critical care was 95%. For the first five months of 2017, the critical care unit bed occupancy rate was over 91%. Both figures were over levels recommended by the Royal College of Anaesthetists (70%). Data provided demonstrated bed occupancy had been 100% for four months in 2016. The unit had identified this as a risk and had submitted a business case to have the unit extended to accommodate 17 patients.

Critical care

Learning from complaints and concerns

- People who used the service knew how to make a complaint or raise concerns and were encouraged to do so. The unit displayed posters publicising the complaints process to patients, relatives and carers in the visitors' waiting room and relatives' room. There were also leaflets in the visitors' room, providing advice on how to make a complaint.
- Complaints were handled effectively and confidentially, with regular updates provided and a formal record was kept. During the period from June 2016 to July 2017 the critical care unit had received two formal complaints. One complaint related to the effectiveness of communication between staff and relatives, and the other related to an issue regarding telephone contact. In both cases an investigation of the complaint had been carried out, within the timescales set out in the trust's complaint process. Where additional time was required for further investigation, the complainant was kept informed.
- The outcomes of a complaint were explained appropriately and there was openness and transparency about how complaints were dealt with. We reviewed the documentation relating to the complaints received and saw the process of investigation had been explained clearly and the outcome described in detail. The documents described the actions taken to improve patient care and an apology was offered to the complainants. The unit had offered the complainants the opportunity to discuss the response in further detail.
- Lessons were learnt from complaints and actions were taken as a result to improve the quality of care. We saw evidence in the minutes of clinical governance meetings that complaints were discussed at length. The attendees discussed what the complaint was about, what the cause of the complaint was and how the aspect of care delivered could be improved. The good aspects of care were also discussed. Actions taken to improve the care were shared with attendees and recorded in the minutes. For example, the unit changed its process for contacting relatives or carers by telephone to ensure similar issues were not repeated. Any changes in process were implemented promptly and staff were informed of the improvements at the earliest opportunity.

Are critical care services well-led?

Good

We rated this domain as good because:

- There was clear vision for the critical care unit and a realistic strategy for achieving it.
- There was an effective governance framework to support the delivery of the strategy and good quality care within the critical care unit.
- All staff working on the critical care unit shared values which promoted the delivery of treatment that was safe and of the highest quality.
- There was good nursing and medical leadership on the critical care unit. Managers were visible and approachable. Staff felt they could bring any concerns to their supervisors and they would be acted upon.
- The service was taking steps to ensure the sustainability of the critical care unit so that it continued to provide safe care and treatment to patients.

However:

- The critical care unit risk register did not highlight all risks identified by the service and some ongoing risks had been closed. There were also issues with the way in which risks were added and removed from the register.
- There was some uncertainty concerning the flow of data about the unit's performance to the hospital's executive team.
- The unit was not holding regular nursing meetings.

Vision and strategy for this service

- There was a clear vision and a set of values, with quality and safety the top priority. We were provided with the theatres and anaesthetics annual business plan for 2017 to 2019. The plan outlined specific goals for the critical care unit, including development of an educational programme for critical care nursing staff. It included maximising the use of the critical care outreach team and increasing critical care staffing to respond to the increasing demand for the service. There were clear actions which set out the objectives would be achieved, the timescale for completing actions, and the impact to the service.
- The business plan referenced the Commissioning for Quality and Innovation national goal (Adult critical care

timely discharge). The goal set out objectives for critical care units to achieve in order to ensure patients are discharged safely and promptly. The business plan set out actions to reduce the number of delayed discharges which included the need to work with site office and bed managers to expedite discharge.

- The business plan highlighted the recommendations set out in our previous inspection report, regarding patient flow and the need to reduce delayed admissions and discharges undertaken out of hours. The ways in which the issues were going to be addressed were outlined, including the need for a 24-hour critical care outreach service and continued collaborative working with the hospital site team to identify early discharges. The strategy was considered in detail as it was recognised that the improved recognition of patients at risk of deterioration may lead to increased demand for both the outreach service and the critical care unit.
- The critical care unit had developed its own mission statement which was "to provide excellent quality care for those who are critically ill. To enhance technology and knowledge with care and compassion for patients and their loved ones". This mission statement was displayed throughout the unit so staff could see it throughout their working day. The mission statement and strategy outlined above and below, had been developed in line with the theatres and anaesthetics business plan.
- To achieve all goals within the mission statement, the unit had developed a realistic strategy which involved the following steps:
- Achieving an establishment of staffing in line with Faculty of Intensive Care Medicine (FICM) Core Standards and British Association of Critical Care Nurses (BACCN). This would include all medical, nursing, allied health professionals, critical care assistants, administrative and secretarial, research, data collection and IT support. Medical and nursing staffing levels had improved but the allied health professional staffing levels were unlikely to increase unless additional funding was secured.
- Aspiring to excellence in all areas of care, including timely discharge and admission of patients so that there were never any night-time discharges, delayed admissions or cancelled surgerydue to the lack of a critical care beds. This was still an area for improvement.
- To provide a suitable level of care for a rapid turnover of a high volume of patients undergoing high risk elective surgery as recommended by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), The Royal College of Surgeons and The Royal College of Anaesthetists.
- Provide a 24-hour critical care outreach service, provided by suitably trained nurses led by and accountable to the critical care team. This had been achieved as the service had been extended in January 2017.
- Expand the critical care service to 17 beds, appropriately staffed as outlined above to provide seven level three and 10 level two beds. A business case had been submitted to request additional resources but it was not known if this had been successful at the time of our inspection.
- Develop and establish an intensive care course for new nurses. This had not been achieved at the time of our inspection as nurses were still being booked on courses provided by an external provider.
- Develop an educational programme for substantive staff to include simulation and scenario-based teaching to ensure skills were developed and maintained. Since the appointment of the new matron, the clinical nurse educator had improved the educational programme but this was still in development.
- Not all objectives had been achieved at the time of our inspection but it was evident that steps had been taken to progress through the strategy. We saw from the business plan that timescales for achieving the objectives had been set and realistic goals had been established.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of the strategy and good quality care within the critical care unit.
- Multidisciplinary clinical governance meetings took place monthly and were attended by a range of disciplines. Nursing attendance at the meetings was dependant on whether they were attending a mandatory training day. However, they were encouraged to attend and each nurse had the opportunity to attend at least once a year. Regular

invitations were sent to colleagues within different areas of the hospital to present on different subjects. For example, we saw that a presentation was recently given by the trust's lead antibiotic pharmacists.

- Clinical governance meetings were structured and followed a standing agenda, including items on the following;
- Safeguarding;
- Infection control and sepsis;
- Medicines management;
- Staffing and appraisals;
- Training and education;
- Intensive Care National Audit and Research Centre data (ICNARC); and
- Incidents and complaints.
- We reviewed three sets of minutes of clinical governance meetings in February, March and April 2017. All three sets of minutes were comprehensive, detailed, clear and included links to documents discussed at the meetings, which staff could use to further their learning. This included data relating to unit performance and examples of recently improved documents for staff to review. After each clinical governance meeting, the minutes were sent to all critical care unit staff by email. They were also sent to the divisional lead for the critical care unit.
- Staff were clear about their roles and they understood what they were accountable for. Within the critical care unit there was a consultant and a nurse clinical governance lead. Both leads were clear on their responsibilities and understood what areas of governance they were responsible for. The consultant governance lead was responsible for chairing the clinical governance meetings, writing and circulating of the minutes and collating all the relevant information ready for the meetings. The nurse clinical governance lead had overall responsibility for ensuring internal audits were completed and collated, to provide them to the consultant lead, ready for sharing at the clinical governance meetings.
- Our previous inspection report highlighted that regular nursing team meetings were not taking place. This had not improved. Managers and nurses told us there had been two nursing team meetings since the last inspection but there were plans to hold them on a bi-monthly basis. The bi-monthly meetings would follow an agenda determined by the nursing staff, on a meeting by meeting basis. The nurses would submit items for the agenda which were "hot" topics over the previous two months. The meetings would also allow nurses, who had recently attended training, to share their learning with their colleagues. As stated above, this had not yet been formalised and so nurses lacked a forum which was exclusively for them.
- Governance frameworks and management systems were regularly reviewed and improved. Within the critical care unit the roles of clinical lead, governance lead and audit lead were rotated roughly every three years. This was done to ensure each role was shared amongst the consultant intensivists to promote learning, development and improvement within each role.
- Quality and safety performance data was shared with divisional leads and at directorate clinical governance meetings. Data collected and discussed at unit clinical governance meetings was shared with the division lead for the critical unit every month. As part of the role of clinical lead, the consultant attended the divisional clinical governance each month. This provided the opportunity to discuss any performance issues in a forum which included leads for the anaesthetic and theatre departments. The discussion included ways in which the issues could be addressed.
- There were effective arrangements to ensure the information used to monitor and manage quality and performance was accurate valid, reliable, timely and relevant. The unit participated in a national data base for adult critical care as recommended by the FICM core standards. The service contributed data was to the Intensive Care National Audit and Research Centre (ICNARC) case mix programme for England, Wales and Northern Ireland. Data supplied was well completed and of good quality. The unit also collected data for the critical care unit dashboard every month. This data was reviewed at clinical governance meetings within the unit and at divisional level.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. The unit had a designated audit lead that was responsible for oversight of the audit programme. The lead was a consultant intensivist who was responsible for monitoring the progress of existing audits and assessing proposals for the implementation of new ones.

- There were arrangements for identifying and managing risks, issues and mitigating actions. The critical care unit maintained a risk register but the risk management process was not always effective. There was not always alignment between the risks recorded on the risk register and what staff said was on their 'worry list'.
- We reviewed the risk register in detail before and during our inspection and found there were continuing risks that had been closed. For example, the numbers of delayed admissions into and discharges from the unit had been closed as a risk. Managers told us during the inspection it was not known why the risk had been closed. There were also risks that had not been added to the risk register, such as the issues regarding the electronic patient prescription charts (reported above under Medicines), which had resulted in several incidents and had the potential to cause serious harm. However, all staff on the unit were aware there had been incidents related to this issue and the steps taken to mitigate the risk. As identified during our previous inspection and above, the unit's non-compliance with the Department of Health building note and the FICM Core Standards had not been included on the register.
- When a risk was identified by the unit it was rated in terms of severity, impact and likelihood of occurrence. The nurse clinical governance lead then submitted an electronic request to a central risk team, who then carried out their own assessment. Following which one of three events occurred; the risk was added as submitted; added to the register in an amended form or it could be rejected as a risk. If added in an amended form or rejected, the nurse clinical governance lead received an email, however, no one else was notified of the change or rejection. This created a risk the amendment or rejection could go unnoticed. There was a potential risk that appropriately identified and assessed risks were being amended or rejected by a central team who did not understand the seriousness of the risk.

Leadership of service

- Leaders had the skills, knowledge, experience and integrity needed when they were appointed and on an ongoing basis. In line with the Guidance for the Provision of Intensive Care Services 2015 there was a designated lead consultant for intensive care on the critical care unit who was a consultant specialising in intensive care medicine. Staff told us the clinical lead was well respected by all staff and had a great deal of experience.
- The critical care unit had an identified lead nurse, the band 8a matron, who was formally recognised with overall responsibility for the nursing elements of the service. Staff commented on her level of knowledge, experience and dedication. During our previous inspection, we highlighted that the previous matron had limited capacity to dedicate appropriate time to managerial responsibilities. As a result, a restructure of the unit had taken place and the matron now in post was responsible for the critical care unit and critical care outreach service only and therefore could focus her time and effort when and where it was needed.
- The matron was supported by a band seven charge nurse and a senior sister who each had separate roles, one for clinical governance/education and the other was operational lead.
- The leaders understood the challenges to good quality care and could identify the actions needed to address them. All leaders were aware of the challenges the unit faced and could describe the actions taken to address them.
- Leaders were visible and approachable. Staff told us and we observed leaders within the unit making themselves available to staff on the unit. Both junior doctors and nurses commented that they felt able to approach senior colleagues with questions or requests for further support. They felt their concerns would be addressed and they would receive feedback.
- Leaders encouraged appreciative and supportive relationships among staff. Nursing and clinical leaders were committed to ensuring their teams were providing safe and high-quality care and promoted cohesion between teams.

Culture within the service

- Staff felt respected and valued. Almost every member of staff, including nurses, consultants, pharmacists, physiotherapists and support staff, told us the critical care unit was a great place to work. They were proud to work on the unit and they were enabled to provide high quality care.
- The culture within the department was to be open and honest when things went wrong and staff were apologetic to those affected. Staff were open with us

during our inspection and were honest about the challenges in providing safe and high-quality care. Staff told us they could raise concerns with their senior colleagues on the unit and the wider multidisciplinary team.

- Senior staff members told us they regularly discussed concerns with colleagues within the medical and nursing teams and felt their concerns would be communicated to the appropriate individuals and addressed accordingly.
- Morale within the critical care unit was much improved since our previous inspection. Staff were now hopeful the challenges faced by the unit were being addressed and that their voice was now being heard in a wider range of forums. Although highly complementary of those previously responsible for representing them, staff felt the improved morale was in part due to the appointment of the matron. The matron now had the time to dedicate and the authority to represent them at all applicable meetings, and drive improvement.
- Managers implemented initiatives to improve staff wellbeing. The unit had arranged for an external provider to provide shiatzu massage to staff.

Public engagement

- As stated above, the unit did not collect data from the NHS Friends and Family Test. However, the unit were collating patient views and experiences to review feedback and improve their service. Patients', relatives' and visitors' views and experiences were collected from compliment cards and letters received by the unit. They were shared during clinical governance meetings. If specific care was identified as excellent or of high quality it would be highlighted and shared with the medical, nursing and allied health professional staff. If safety or quality issues were identified, actions were taken to address them.
- Patients were encouraged to raise complaints or express concerns they had about any aspect of care they received in the unit. Records of informal complaints were kept and shared with staff, at clinical governance meetings, to ensure issues were addressed or mitigated.
- There was a 'know how you are doing' noticeboard on the unit, which displayed information for visitors on how the unit was performing in certain areas. This included: staffing levels, the name of the nurse in charge, compliments from people and the results of recent audits. During our inspection, we observed this information was updated each day.
- The critical care unit had a visitors' book to allow people to leave comments about the care their loved ones had received. We reviewed a random selection of pages of the book, and noted all comments were positive and centred on the staff and the high-quality care provided. We also saw that messages had been recorded in the book by senior staff on the unit, following a recent complaint, providing information relating to changes regarding telephone communication. This was another way of ensuring visitors had the most up-to-date information on how they could contact and be contacted by staff on the unit.
- The department had recently given patients, family members and carers the opportunity to discuss aspects of the care provided with the senior nursing team. This opportunity was publicised in the unit by way of notices which provided details of how to contact the senior nursing team. We were told the initiative was to increase direct service user feedback; however, no one had yet asked to provide feedback to the senior nursing team at the time of our inspection.

Staff engagement

- The critical care unit used notice boards effectively to communicate information to staff in a quick and accessible way. They used the 'Hawkeye' system which communicated good news stories, results of recent audits, any associated changes and other key messages. The information was read out to nursing staff at each shift change and medical staff at handover. Staff were complimentary about the use of 'Hawkeye' and felt the information provided had improved safety and quality of care as they were aware of any issues on a daily basis.
- During our inspection, the unit was in the process of implementing an initiative called 'the tree of success'. This was a display, located at the entrance of the south side of the unit, of recent successes the unit had achieved. It was not fully completed prior to our inspection but had been by the last day. The idea was for staff to be able to submit items of success to the tree which each staff member would be able to see and

read. We saw examples of equipment being acquired which had directly improved patient care and articles in local newspapers complimenting care provided by the unit.
- Staff felt actively engaged so their views were reflected in the planning and delivery of the services. Staff had been involved in designing the logo for the critical care unit. This was done by staff submitting designs and a vote to determine the best one.
- A social network page had been created to allow communication between staff. The senior nursing team could communicate with staff when shifts were available and cover was needed. The page gave staff an opportunity to communicate with each other when not at work.

Innovation, improvement and sustainability

- Staff were focused on continually improving the quality of care. Staff recognised where improvements were needed and what challenges needed to be overcome to sustain the service delivered and improve patient care.
- Several business cases had been submitted following the development of the divisional business plan and critical care strategy. The business cases centred on increasing both nursing and consultant staffing establishment, both of which were successful. Recruitment of nurses and consultants was ongoing but establishment numbers (planned levels) had increased since our last inspection.
- Managers were aware of what actions needed to be taken to ensure patients were receiving safe and high-quality care. As outlined above, since our previous inspection a dedicated critical care and critical care outreach matron was appointed to support the unit. The matron has been able to dedicate her time to addressing patient flow issues and had introduced new processes, which laid the foundation for improvement.
- We were provided with examples of recent quality improvement initiatives over the previous 12 months. For example:
- The unit had introduced a new way of nebulising, using a synthetic porous ultralight material, derived from a gel, in which the liquid component of the gel has been replaced with a gas. Nebulisation is a method of converting a medicine or solution into an aerosol, which is inhaled directly into the lungs. The method was put forward by a staff nurse following her attendance at a conference and after discussion during her yearly appraisal. Following a successful trial, the unit was now stocking the products needed to use the method.
- New 'state of the art' equipment had been acquired to improve the physiotherapy care provided to patients on the critical care unit. It was recognised that neuromuscular complications were common after periods of critical care. The equipment allowed passive or active exercises to take place while patients were in bed. Funding for the machine was from charitable funds.
- The unit was using a local private ambulance to enable patients to go on day trips to local destinations. Nurses and doctors from the critical care unit would accompany them on these visits, following a thorough risk assessment process.The patients suggested the destination and the unit endeavoured to grant their wish. Payment for the use of their services came from the Charitable Fund.
- The critical care outreach team, critical care physiotherapy team and research nurses had embarked on a new project to improve the transition of longer-stay patients from the critical care onwards.The project was looking at how the unit currently prepared patients (and families) for the physical and psychological transition out of the critical care unit and how practices/processes could be improved to benefit the patient group.

Maternity and gynaecology

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

Information about the service

The Royal Cornwall Hospitals NHS Trust maternity services provide antenatal, Intrapartum and postnatal care in the Royal Cornwall Hospital and within local community settings. The maternity and gynaecology services are part of the women, children and sexual health division of the trust.

At the Royal Cornwall Hospital, consultant led care is provided for women in the Princess Alexandra Wing. The trust has a total of 46 maternity beds across the antenatal ward (Wheal Rose), the postnatal ward (Wheal Fortune) and the delivery suite, which had nine delivery rooms

The delivery suite comprised of six delivery rooms with shared en suite facilities. There was one obstetric theatre with an adjoining room which, though not a full theatre, was at times utilised as a second theatre, and a recovery area.

Wheal Rose ward has 11 beds and is for patients requiring pregnancy monitoring and for induction of labour. There are two four bed bays and three single rooms. The outpatient day assessment unit is linked to Wheal Rose. This unit monitors patients with acute problems relating to their pregnancy and accepts referrals either directly from midwives or GPs. The ward also has a one bedded bereavement suite and a licensed satellite (small) mortuary facility.

Wheal Fortune ward has five four bedded bays and six side rooms, all with shared shower and toilet facilities. The ward was refurbished at the end of 2016. It has a combined day room and discharge lounge for patients waiting space away from the bays or for patients waiting to go home.

Between April 2016 and March 2017 there were 4223 deliveries in Cornwall of which 3786 (89%) were at the Royal Cornwall Hospital (a 3% reduction in deliveries compared to the previous 12 months) with 4607 women booking antenatal care from the community midwives. The majority of mothers (77%) are aged 20 to 34 which is slightly higher than the national average.

There are three community midwifery teams and two free standing midwifery centres. Penrice, based at St Austell Community Hospital (see separate report for detail) and Helston, based at Helston Community Hospital. Women living on the Isles of Scilly used the one birthing room at St Mary's Community Hospital or transferred to the mainland. The maternity services achieved a high rate of home and birth centre births.

An unplanned pregnancy service was provided in a separate building on the Royal Cornwall Hospital site, known as the Hub. This was part of the sexual health services. Early medical terminations of pregnancy were undertaken up to nine weeks of pregnancy and surgical terminations up to 14 weeks of pregnancy. Women requesting terminations beyond these gestation dates were referred to a specialist service outside Cornwall. Some surgical terminations were also offered at West Cornwall Hospital. The sexual health services were last inspected as a separate core service in January 2016.

Maternity and gynaecology

The gynaecology outpatient service comprised general gynaecology and gynae-oncology clinics, an early pregnancy assessment unit, emergency gynaecology unit and foetal medicine unit. There were six consultation rooms and two scanning rooms. Treatments included general gynaecology, urogynaecology, fertility, endometriosis, colposcopy and gynaecological oncology.

The gynaecology team was partly integrated with the obstetric team. Six consultants worked in obstetrics and gynaecology, including a foetal medicine specialist. Four consultants worked in gynaecology only. Most patients undergoing elective gynaecological procedures had these on an outpatient or day case basis. Women having inpatient gynaecology treatment stayed in the 28 bed Eden ward, a women's surgical ward with eight designated medical beds.

We last inspected maternity and gynaecology services in January 2016 and rated it as requires improvement overall. Safe, responsive and well led were rated as requires improvement. Effectiveness and caring were rated as good. We identified 20 areas where the service should make improvement and two areas where the service must make improvement. Requirement notices were issued for staffing concerns and lack of staff engagement.

During our inspection we spoke with nine women, six relatives and more than 35 staff working in the gynaecology and maternity services. These included consultant obstetricians, gynaecologists and anaesthetists, registrars, senior house officers, sonographers, the head of midwifery, community midwives, screening, safeguarding, bereavement and risk leads, practice development and audit midwives, 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. We reviewed 21 sets of patient health records.

We inspected the maternity services at the hospital as part of our announced inspection between 4 July and 7 July 2017 and again in an unannounced inspection between 17 July and 18 July. Before, during, and after our inspection we reviewed the trust's performance information.

Summary of findings

We rated this service as inadequate because:

- There were not enough midwives deployed to provide a safe service in all areas at all times.
- There was no dedicated high dependency area for deteriorating women and no process to ensure that that there was always a nurse or midwife staff on duty with the necessary competencies to manage women in need of high dependency care. The service did not monitor the number of women needing this level of care.
- There was one theatre on the delivery suite with dedicated staffing. Contingency plans for using the adjoining room as a second theatre were not well set out or clearly understood.
- The environment of the postnatal ward was not fit for purpose in summer when the temperature was high.
- Not all midwives had the necessary skills, for example in neo-natal life support. Only 55% of midwives were up to date with training in neo-natal life support and training compliance for managing obstetric emergencies was 82%. The 85% target set for training completion in maternity was lower than trust target for training completion of 95%.
- Management of the maternity service was reactive in response to external reports or adverse events, but did not have internal systems for assessing, monitoring and responding to risks.
- Risks of harm to women in maternity services were not well identified, analysed and managed, and not all apparent risks were assessed and included on the risk register. The absence of comprehensive performance audit meant that service did not know its own performance in many areas. There was very little evidence of improvements by self-examination or benchmarking with other similar services.
- Bullying and undermining behaviour towards other staff, peers or juniors appeared to have been insufficiently challenged in the maternity service.
- The trust did not have mechanisms to audit patient notes to see if guidelines were followed. The delivery suite capacity was insufficient for the number of women giving birth. This resulted in a number of

Maternity and gynaecology

women labouring and giving birth on the antenatal ward several times a month, during which time they did not receive one-to-one care. This also impacted upon their privacy and dignity.

- There was no dedicated high dependency area for deteriorating women on the delivery suite and no process to ensure sufficient staff on every shift trained to care for such women.
- Induction of labour had increased at the trust and often more women were being induced each day than the agreed number. Planning for induction did not take into account activity or capacity on the delivery suite to ensure induction was safe.
- We could not be assured that community midwives had the necessary equipment and competences to manage obstetric or neonatal emergencies in the community in the event that an ambulance was delayed.
- The antenatal ward was not secure. The Day Assessment Unit adjoined the antenatal ward and the entrance doors were not closed except at night. This was a safeguarding risk to women and babies. Information sharing within the maternity service was inefficient. The different women's records in the maternity service were not linked and women's hand held notes and the hospital record held different information which meant it was not easy to see an overview of each woman's status.
- There is no credible statement of vision and staff were not aware of what limited vision there was. What existed was not underpinned by detailed objectives and plans.
- The governance arrangements and their purpose were unclear. The processes in place did not support a clear governance framework. There was insufficient collection and monitoring of performance and quality measures to ensure clear and accurate oversight or service development and improvement.

However:

- Safeguarding was well managed in an integrated hospital service. Staff in the unplanned pregnancy service were kind, non-directive and non-judgemental. They maintained women's privacy and confidentiality.
- There was an effective vaccination programme for pregnant women. Community midwives gave whooping cough vaccines to pregnant women and also administered flu vaccines.
- Midwives used a recognised communication tool when discussing a case with other professionals to make sure information they reported was structured and consistent.
- There was a good range of audits taking place in gynaecology and the service took action in response to the results.
- The maternity service generally achieved a better (lower) rate of emergency caesarean section than the national average, and a high proportion of women had unassisted births.
- Women had a choice of where to give birth. The community birth-rate was much higher than the national average.
- Most staff in obstetrics and gynaecology had an appraisal in the past year.
- There were good multidisciplinary working relationships in gynaecology. MDT meetings were held to decide on treatment for women with gynaecological cancers.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Inadequate

We rated safe as inadequate because:

- There were not enough midwives to provide a safe service in all areas at all times. Staff had to activate the escalation policy frequently to achieve safe staffing in the delivery unit. Staffing concerns were not on the risk register.
- Safe skill mix was not always achieved. There was no system to ensure that there was always a midwife or nurse on the delivery suite with skills in caring for a woman needing high dependency care.
- We could not be assured that community midwives had up to date skills. They did not have training to cannulate women, and not all were up to date with neonatal life support training. We could not be assured that community midwives had the necessary equipment to manage obstetric or neonatal emergencies in the community in the event that the ambulance was delayed.
- Guidance for midwives in critical areas such as escalation of deteriorating women was sometimes conflicting. For example the escalation instructions on MEOWS charts did not tally with the guidance on the policy on Managing the severely ill obstetric woman.
- Midwives required training and competency assessments in providing epidural top ups, in and in care of high dependency women. The overall 85% target set for training completion in maternity was lower than trust target for training completion of 95%.
- There was no dedicated high dependency area for deteriorating women and no process to ensure that that there was always a nurse or midwife on duty with the necessary competencies to manage high dependency women. The service did not monitor the number of women needing this level of care.
- One theatre on the delivery suite had dedicated staffing. The contingency plans for using the second theatre in an adjoining room were not clearly understood and an additional theatre team was not readily available, which could result in delays and potentially a risk to women and babies. The process for opening and staffing the second theatre were not well communicated and practiced.
- Risk assessment was poor at all levels. We saw inconsistent use of maternal early warning score (MEOWS) charts and partograms (a composite graphical record of key maternal and foetal data during labour) meant there was a risk that staff might miss signs of deterioration in a woman; on the postnatal ward emergency medicines had been taken off the ward because of the heat, without assessing the risk of doing this, should there be an emergency. Some risks such as staffing were not on the corporate risk register.
- The antenatal ward was not secure. Open access to the Day Assessment Unit (DAU) which was combined with the antenatal ward was a safeguarding risk to women on the ward. There was also a risk to women's privacy and dignity. These risks were not on the risk register.
- There were environmental risks on the hospital site: the delivery suite had cracked flooring and worn baths which presented an infection risk and the postnatal ward was uncomfortably hot in summer, with trip risks from fans in corridors, and reported problems with drainage and insects. The ambient temperature of rooms where medicines were stored was not always measured.
- The delivery suite capacity was insufficient for the number of women giving birth with the result that women laboured on the antenatal ward several times a month, often without one-to -one care from a midwife for the whole of their established labour.
- More women than the agreed number were being induced on some days, and these inductions were not planned to take into account activity or capacity on delivery suite to ensure that induction was safe.
- The handovers on the delivery suite were not multidisciplinary; there were multiple handovers several times a day, midwives to midwives and doctors to doctors at different times which was inefficient. Handovers did not clearly highlight risks. There were no safety briefs occurring in the maternity service.
- The different records about women in the maternity service were not linked. Women's hand held records and hospital records, and safeguarding information were held on a separate database which made it difficult for midwives to have an overview of women's health and social history.

- There was one never event of wrong site surgery in gynaecology.
- The threshold for incident reporting was high so not all incidents were reported. This was true in both maternity and gynaecology.
- There had been gaps in gynaecology on call cover which was a risk to women.

However:

- Safeguarding was well-managed as part of an integrated hospital safeguarding team. New safeguarding paperwork had been introduced to improve the quality of safeguarding records and a database enabled midwives to check safeguarding referrals.
- There was 60 hours consultant cover on the delivery suite which met the recommendations of the Royal College of Obstetricians and Gynaecologists for a maternity unit of this size
- Accommodation was visibly clean and equipment was well-maintained. There had been no incidents with a contributing factor relating to maintenance in the twelve months to June 2017.
- A new electronic maternity information system due in October was planned which would enable more comprehensive records to be kept and improve the accessibility of information.
- Staff reported the quality of training was high. Funds had been secured and dedicated for enhanced training over the coming year.
- Community midwives all carried a standard set of equipment.
- World Health Organisation (WHO) surgical safety checklists were used in the obstetric theatre and gynaecology theatres and we saw evidence of good compliance.

Incidents

- Staff we spoke with understood their responsibilities to raise concerns, record safety incidents, and near misses. However, the reporting rate appeared to indicate adequate reporting for a unit of this size. A total of 1119 maternity incidents were reported between June 2016 and May 2017. However, when asking staff about what they would report in certain scenarios, we found the threshold for reporting was high. This meant that staff were not reporting some types of incidents. For example, a parent walking a new-born around the ward without a pram or cot or when the ward was exceptionally busy and there were trip hazards were not routinely reported. Another example was described by an anaesthetist who noted that women with anaemia were presenting for elective caesarean section, which was a risk to mother and baby, and staff were not reporting this. Staff did not report transfers into the delivery suite from the community unless there was a problem with the transfer.
- Analysis of incidents between June 2016 and May 2017 indicated that 468 occurred during labour and delivery but there were also 277 incidents on the postnatal ward and 200 incidents on the antenatal ward including 26 births occurring there. (The dashboard displayed a lower figure (13) as it only reported on non- precipitate births). Maternity adverse incidents such as blood loss over 1000ml after birth and perineal tears from giving birth were consistently reported on the electronic system which was good practice.
- The serious incident framework described the processes and procedures to help ensure serious incidents were identified correctly, investigated thoroughly, and learned from to prevent the likelihood of similar incidents happening again. Between May 2016 and June 2017 the trust had reported five serious incidents requiring investigation in maternity, all of which were related to labour or delivery. In gynaecology three serious incidents had been reported, two were related to surgery and one was related to a patient fall. We reviewed the root cause analysis reports which were appropriately completed and showed evidence of duty of candour. They contained clear chronologies, and had been completed in a timely manner except for one case which had taken 100 days rather than the recommended 60 days. We saw there were acceptable reasons for this. Learning from maternity serious incidents requiring investigation was discussed at perinatal mortality meetings. The reports were also sent to midwives so they could be discussed in team meetings.
- A weekly multidisciplinary clinical incident review meeting considered delivery suite incidents. We reviewed the notes of the meetings held since January 2017. Staff attendance was not always recorded and some meetings referred to the absence of key people. There was no record of discussion at the meetings, only summary conclusions. Incidents where there may have

been practice weaknesses were discussed with those involved. In some cases midwives were asked to complete a practice checklist and reflection with their line manager.

- A monthly risk newsletter was distributed to all midwives with short articles to share learning from incidents. Midwives told us they found this useful and were able to give examples of learning. Monthly practice development newsletters provided a focus for discussion at local safety briefings and team meetings.
- Between June 2016 and May 2017 the trust reported no incidents classified as never events in either maternity or gynaecology. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- We reviewed the summary case notes from monthly perinatal mortality meetings which were well structured and clear. Obstetricians and midwives said staff debriefs were held after traumatic events which they found helpful. However both groups of staff mentioned that management reaction to adverse incidents had historically focused more on blame than learning, and some perceived this still to be the case. Other staff told us this had improved.
- There were 309 gynaecology incidents reported between June 2016 and May 2017. The main themes were falls (37) and unexpected re-admissions (35); other incidents covered a wide spread of activity. A monthly 'incidents, mortality and morbidity meeting' from July 2017 known as the 'clinical outcomes and audit meeting' reviewed incidents for the previous month: morbidity such as returns to theatre, re-admissions and other gynaecology issues such as junior doctor training. The meeting had a good overview of key issues in the gynaecology department. We noted that in April two ruptured ectopic pregnancies were not reported promptly, but there was evidence from meeting notes that appropriate action had been taken with the staff involved, including planned training to prevent recurrence. This was discussed at the clinical governance meeting and staff were reminded to report immediately.
- An example of learning from a gynaecology incident was a recent review of a delayed diagnosis of ectopic pregnancy that had led to a change in guidelines for staff in the emergency department (ED) and consideration of the need for gynaecology consultants to provide teaching sessions for ED staff.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires a provider to be open and transparent with a patient or other relevant person when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- Midwives and doctors we spoke with had a good understanding of the duty of candour and the need to apologise to mothers and families when things went wrong.
- Not all maternity staff had taken the trusts duty of candour training. The trust had set a target of 95% for this training. 91% of midwives had completed the training. Trust-wide 86 % of clerical staff and 87% of medical staff had completed the training. We did not have a breakdown of the number of obstetricians and gynaecologists who had duty of candour training. The root cause analysis of incidents showed that duty of candour letters had been sent out but we did not review any of these.

Safety thermometer

- The safety thermometer is a measurement tool for improvement that focuses on: blood loss over 500ml, perineal tears (tears to the area between the vagina and rectum during birth), maternal infection, the psychological well-being of the mother and the baby's health scores in the first 10 minutes after birth.
- The maternity service had made monthly trust-wide data returns to the NHS maternity safety thermometer since October 2016. However, we found ward staff had little understanding of the purpose of this, how this data was collected and presented, or of the national standards for definitions. They had not used the data to benchmark against other services or make improvement plans.
- The results of the safety thermometer were on display in Wheal Fortune ward and showed that 68% of patients were receiving harm free care in July 2017 compared to an average national score of 70%. When the first

monthly national return was made in November 2016 the ward had achieved 85%. However, the rate had declined since then and since March 2017 had fallen below the national average for each month.
- The gynaecology ward submitted data monthly to the NHS safety thermometer and results were displayed on the trust's 'Know how you are doing' boards. Falls were the main patient harm and pressure ulcers acquired in the hospital showed a variable trend during 2016/17. Harm free care information for May was displayed with Eden Ward showing a score of 92.6%. This was discussed at the clinical governance meeting where a higher number of patient falls were identified as the reason for a lower level of harm free care that month. Ward managers were responsible for investigating falls in line with the policy for the Prevention and Management of Falls.
- We did not see results of the safety thermometer reviewed at divisional level meetings in either maternity or gynaecology.

Cleanliness, infection control and hygiene

- The standard of cleanliness generally good in all the areas we inspected. We visited many areas of the trust providing maternity services, the delivery suite and obstetric theatre, wards and the two birth centres. We did not inspect other community locations where midwives gave antenatal and postnatal care. For gynaecology services we visited the outpatient department and Eden ward at the Royal Cornwall Hospital. We saw evidence that domestic staff followed guidance in regard to the required cleaning standards, practices and frequency of cleaning. Cleaning schedules and cleaning scores were on display.
- However we noted that cleaning standards had varied over the year. For example, an audit of the postnatal ward in February 2017 showed an overall score for cleanliness of 79%; lower scoring rooms had been the dirty utility room, kitchen and store room. We reviewed signed and completed daily cleaning records for three weeks in July 2017. These included twice daily checks of the temperature and contents of the patient's food fridge which confirmed that cleaning staff were carrying out regular checks to a satisfactory standard. Staff fridge contents were checked by ward staff.
- On the delivery suite, cleaners were available for 12 hours during the working day. Outside these times midwifery support workers undertook cleaning. Midwives or maternity support workers (MSW) cleaned all clinical equipment and labelled cleaned items, using green stickers to show they were ready for use.
- Infection control performance indicators were collected centrally. Hand hygiene audits in the antenatal unit and delivery suite wards scored 100% in the month ending 31 May 2017 but scores were lower for the postnatal ward with 90% for hand hygiene, 96% on the urinary catheter audit and 88% for the intravenous line audit.
- We observed staff washing their hands or using hand sanitising gel between examining women and giving care. Visitors to the wards were invited to use the sanitising gel to clean their hands, and leaflets for visitors about hand hygiene were on display. However, the hand sanitiser in the corridor leading to the antenatal ward was not well placed to encourage use, and we did not see visitors using it. We drew this to the attention of staff.
- Staff adhered to the trust's 'bare below the elbow' policy, and there was ready access to personal protective equipment, such as gloves and aprons, which we saw disposed of appropriately.
- The gynaecology outpatient area and Eden ward were visibly clean on the day of our inspection. However, Eden ward had scored 87% in the January 2017 cleaning audit and we did not see a more recent audit to indicated standards had improved.
- In the outpatient area the cleaning audit on display was not up to date, but the area appeared clean. However, we noted that in the gynaecology outpatient toilets, the floor covering was continued up onto the walls to replace skirting boards. This had peeled away from the wall making it difficult to clean, and leaving an inch gap between the wall and flooring, which was full of dirt and dust on the day of the inspection.
- Fans were used to help keep the environment cool. 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 the second obstetric theatre, we were concerned that the air flow systems in place were not adequate which posed a risk to infection control. In addition, on two separate occasions we found the door to this theatre propped open. We raised this with the trust following the inspection and a risk assessment has now been carried out.

- In terms of screening for infection, records showed that on gynaecology wards an average of 98% of elective patients were screened for MRSA and 49% of women admitted as emergencies.

Environment and equipment

- The access to the antenatal ward was not secure. The ward was combined with the day assessment unit (DAU) and jointly staffed. The DAU and ward shared an open office space at the front of the ward. The DAU, to which a large number of women came to for assessment (33 women on 3 July 2017), was just inside the entrance to the ward. Women or their partners as well as members of the public could inadvertently enter the ward. This posed a safeguarding risk to inpatients, as without controlled entry it was impossible to check who was visiting the area. The doors of the corridor to the antenatal unit were only closed at night.
- CQC had raised concerns about security in the antenatal ward at the previous inspection in 2016 but no action had been taken. We were aware that women had complained about security on the ward and some staff were concerned about it. We requested a copy of the risk assessment and the trust told us they could not find it. We were told the trust had completed a risk assessment after the inspection but they did not send this to us. This risk was not on the risk register at the time of the inspection.
- Access to the postnatal ward, the delivery suite and Eden ward was secure and restricted to staff with swipe cards. A member of staff using intercom released the doors of these areas to visitors once they had confirmed who was entering the ward. There was a receptionist on the postnatal ward during the week but not at weekends. When there was no receptionist, midwives controlled access.
- The decor in the delivery suite was in need of updating. However, the delivery suite itself was well organised and equipment was stored appropriately. There was appropriate equipment in the recovery room including a HDU mobile trolley and appropriate drug boxes for specific emergencies.
- We checked the resuscitation trolley and the neonatal resuscitation trolley on the delivery suite which were fully equipped, with drugs in date, and checked daily. We also saw that staff checked the resuscitation trolley daily on both wards and the daily checks were signed and dated. Staff carried out a full check of the sealed drawers once a week and changed the tags as per trust policy.
- The obstetric theatre was within the delivery suite. There was a main theatre, for which there was also dedicated theatre staffing. There was a large adjoining room which staff told us was used for suturing or other procedures about 13 times a month. We saw that the room had a ceiling mounted light and an anaesthetic gas scavenging system to collect and remove waste gases. However, the room appeared sparsely equipped on the day we inspected, the doors were propped open and it did not appear ready for use as a second theatre. We were later given assurances that there was an anaesthetic machine, diathermy machine as well as surgical operating sets for this theatre. The senior midwives told us that it was very rare to need two theatres at the same time and the trust confirmed that between April and July 2017 this theatre had been used on one occasion as an emergency theatre. There had been no risk assessment regarding its use and senior managers told us as this had not flagged as a risk because no incidents had been reported, the process in place had not been reviewed. However, some staff told us there were delays at times getting a second theatre team from the main site promptly.
- The neonatal unit was on the same floor as the delivery suite. This meant that paediatricians could reach the delivery suite quickly in an emergency. The neonatal unit was a level 2 unit, for babies needing short-term intensive care including some help with breathing and possibly tube feeding.
- The floor covering in the delivery suite was cracked and the surfaces of the baths were worn, which both presented a risk of infection. Staff were not aware of a risk assessment of this.
- We had concerns about the assessment of environmental risks. The postnatal ward, which had moved into refurbished accommodation in December 2016, was very hot at the time of our inspection. This was uncomfortable for staff and patients. The kitchen, which had no air conditioning or fan, was 40ºC. Patient areas were being cooled by portable air conditioning units and by free-standing fans on the floor in the corridors. There had been no risk assessment of the trip

risk of large freestanding fans in the corridors with trailing wires. Midwives showed us four letters of complaint from women on the ward about the temperature.

- Although records showed high ward temperature had been a problem earlier in the spring of 2017, there were no wall thermometers to enable staff to monitor the temperatures in different areas. Staff had to move the thermometer from the kitchen to the treatment room to measure the ambient temperature there. Temperature control had been added to the risk register after a meeting with Estates in late June 2017. We saw evidence of a plan to insulate the roof and provide reflective covering, to start in late July 2017.
- Staff told us several other environmental problems had come to light on the postnatal ward. These included blocked toilets and poor drainage which had led to showers overflowing and the floors were squeaky when walking, increasing noise at night. Discussions being held with estates to seek solutions. During our inspection one room was taken out of use because a midwife reported seeing ants. A woman on the ward and a staff member also mentioned having seen silverfish. The trust told us an investigation by contractors had found no evidence of infestation of either ants or silverfish.
- Equipment maintenance was managed centrally. There had been no incidents with a contributing factor relating to maintenance in the twelve months to June 2017. All items we looked at had been safety tested and calibrated where appropriate.
- A co-located, midwife led birth centre with four en-suite rooms was under construction. The expectation was that the birth centre would open in late September 2017. The centre would increase delivery capacity at the hospital, improve choice of place of birth for women in central Cornwall and enable more women planning birth at the hospital to experience a birth with low intervention. The trust was aware that the 1960's building housing the service did not meet current standards as described in the Department of Health's building notes and technical memoranda, particularly for the delivery suite The limited size of the site was recognised in the trust's longer term estate strategy. We saw evidence that the trust had obtained derogations for some standards in the new co-located birth unit that was under construction.
- The standalone birthing centre at Helston was equipped with oxygen, gas and air and suction, and a neonatal resuscitaire as well as evacuation equipment in the event of maternal collapse in the birthing pool.
- Following a serious incident investigation, we saw evidence that all midwives now had thermometers and stethoscopes as part of their standard equipment. There was an up-to-date policy on equipment to be carried by community midwives. A new equipment asset register was under development to monitor midwives' equipment.
- The gynaecology ward was spacious and appeared clean and well maintained. There was a light and private waiting area in the outpatient area for gynaecology, but the corridor with clinic rooms was quite dark and in need of updating.

Medicines

- Arrangements for managing medicines, did not always keep people safe. On the postnatal ward, staff had moved emergency drugs temporarily to the adjoining ward because of the high ambient temperature in the treatment room where they were stored. They rightly identified the temperature might affect the efficacy of the medicines. However storage of emergency drugs on another ward would cause delay in access to drugs in the event of an emergency such as a postpartum haemorrhage (PPH). This also meant staff would have to leave the ward to collect and sign out medicines which could leave too few staff on the ward if other staff were on breaks or if the ward was already short staffed. This temporary arrangement had not been risk assessed, and although staff told us they were bringing the medicines back to the ward immediately because of the potential risk, this had not happened when were visited the ward again two days later.
- Tags placed on grab boxes for emergency treatment of post partum haemorrhages and eclampsia were hard to open without scissors which could delay access in the event of an emergency. We did not see a risk assessment of these concerns. We escalated this to the senior staff at the time and were assured this had been rectified.
- We also had concerns about temperature control in the rooms where medicines were stored. The treatment

room on the postnatal ward contained IV fluids which could potentially be affected by storage above certain temperatures. There was no thermometer in this room to measure the ambient temperature.

- On the delivery suite we found tranexamic acid (used to control bleeding) stored in the fridge on the delivery suite, despite a label staying it should be stored at room temperature. We drew this to the attention of staff who removed it from the fridge.
- Medicines requiring cold storage were stored in dedicated fridges in locked treatment rooms. Some of the medicine fridges, but not all, were checked remotely by pharmacy. However, not all staff were aware they had a responsibility to monitor fridge temperatures. This meant that medicine fridges needing daily ward checks could be overlooked, and if there was a fridge fault the cold chain could be broken, and medicines rendered less effective.
- We found medicines in wards, theatres and treatment rooms were securely stored in locked cupboards, in locked treatment rooms. The separate controlled drugs cupboards and the logbooks were correctly completed and drugs were clearly labelled.
- Staff were aware of the importance of documenting allergies and we saw evidence of this in women's notes.
- Midwives could administer drugs covered by midwives' exemptions which allowed them to give timely medication, such as pain relief, to women without the need to involve a doctor. Midwives only used Patient Group Directions (PGDs) for the whooping cough vaccine given from 20 weeks pregnancy. We saw that the PGD for whooping cough was up to date. All other prescribing was done by doctors.
- However, the anaesthetic team had raised concerns about midwives not having up to date training or competencies in administering epidural top ups, but they were still expected to administer the medication. No action had been taken as a result of their concerns. This was a risk to women in receipt of an epidural and also meant midwives were conducting practices which put them in breach of their Nursing and Midwifery Council Code of Practice. Staff we spoke to confirmed this and the practice development midwife told us they were planning to put a training course in place. We raised this as a concern with a senior manager who had been aware of the issue, however, it was not on the risk register, a risk assessment had not been undertaken and there were no mitigating actions in place until training had been completed.
- In the unplanned pregnancy service clinicians administered medicines in accordance with the requirement of the Abortion Act. A doctor was present at clinics to prescribe abortion inducing medicines for early medical abortions.

Records

- We looked at 21 sets of women's health records of which only five were fully complete. Many omitted confirmation from the midwife that certain checks had been done, some were signed but not dated. Some did not record carbon monoxide testing, regular urine tests or customised growth charts carried out in the antenatal period. There was no routine audit of maternity notes to monitor whether key elements were included. A few women's case notes were looked at each week in relation women requiring a higher level of care in delivery. These notes were reviewed by the clinical incident review group in the context of risk management; the quality of notes was incidental to the purpose of that meeting and staff did not review the women's antenatal notes.
- We noted that documentation was identified as an issue in a number of cases reviewed at this meeting. For instance of the 22 cases reviewed in March 2017, half had documentation mentioned, and in April 2017, seven out of 27 case notes mentioned documentation such as not recording blood loss, not giving reasons for decisions or for delays. Senior staff told us they were aware of the value of auditing notes to monitor quality throughout the maternity pathway, and were developing a generic tool to use for this when staffing and time permitted. The tool would be piloted in August 2017.
- The service did not utilise integrated care pathways (ICP) for specific conditions, for example, bereavement care, pre-eclampsia or women requiring high dependency care. Use of ICP's helps to ensure that planned care is consistent and appropriate.
- Women carried their own records throughout their pregnancy and postnatal period of care. The unit used the 'Personal Child Health Record' (known as the 'red

book'). This was given to women before the new born examination. We were aware from documentation that midwives had not always completed the books, but we did not identify a problem on inspection.

- There was a lack of linkage between the different types of maternity records. Mother's hand held records contained different information from the hospital record. After women had given birth the hand held record should be merged with the hospital record and filed, but we saw evidence that had not happened, with the risk that only incomplete records might be available when needed for reference in a future pregnancy. We saw a complaint from a woman who was concerned that midwives had not taken note of her previous pregnancy history when she came to the delivery suite. However a Standard Operating Procedure for merging of hand held records with the hospital record had been developed as an interim solution pending the introduction of a new electronic maternity information system.
- Women's health records were stored securely in lockable notes trolleys on the wards to ensure confidentiality, which was locked during our inspection.
- We checked 10 sets of notes on the postnatal ward and five on the antenatal ward. We saw evidence of the initial risk assessments, taken at the booking appointment, including for the risk of venous thrombo-embolism or VTE, (blood clots). Trust guidelines required risk assessments to be carried out at subsequent appointments such a blood pressure measurement and urine test and a schedule of screening tests as set out in the trust policy Antenatal Booking, Antenatal Care and Information - Clinical Guideline. Midwives signed and in most cases dated records, but did not always print their names. Only one of the 10 postnatal notes contained a completed partogram to record progress of labour.
- During the unannounced inspection we checked a further six sets of notes. Only four of six sets of notes contained MEOWS charts, and these had been commenced after delivery and not on admission. There was potential for duplication as some midwives recorded observations on the partogram and not on MEOWS charts. Only three of these six sets of notes had completed partograms.
- The five babies' notes we reviewed were correctly completed. In 2016 it had become trust policy for all babies to have a full set of observations completed and documented, and for centile charts to be in babies' notes to help identify those below the 10th centile because of the additional risks faced by small babies, and the importance of monitoring weight gain. All records reviewed contained these.

Safeguarding

- A CQC inspection in 2015 of safeguarding and looked after children had made a number of recommendations. As a result, safeguarding arrangements had been strengthened. A deep dive review had been undertaken by the Designated Nurse from the clinical commissioning group, NHS Kernow, in February 2017. We saw the safeguarding leads had produced an action plan showing the main actions were on target except for the delay in introducing the electronic maternity information system. The trust's Safeguarding Children's Operational Group was monitoring progress.
- Two midwives shared the post of midwife for safeguarding. Since February 2017 they worked as part of an integrated hospital adult safeguarding team, with the RCHT learning disabilities' service the mental health and well-being specialist nurse from another trust and Cornwall social services. New safeguarding paperwork had been introduced to improve the quality of safeguarding records.
- The safeguarding midwives were planning to provide regular input to the maternity newsletter to help midwives understand the many recent changes in the approach to safeguarding women and their unborn children. The Chief Nurse was the named nurse for safeguarding in the trust.
- There were on average 29 midwife safeguarding referrals a quarter in Cornwall.
- All midwives we spoke with were aware how to report concerns about vulnerable women at risk during the antenatal, labour and postnatal period. Unless the concern was very urgent, midwives first discussed it with their team leader to avoid unnecessary contact with the multi-agency safeguarding team. Midwives told us they now asked expectant mothers about domestic violence and about males living in the family home, however compliance with this was not audited. These questions were added following the clinical commissioning group's safeguarding review in February 2017. We saw information about support services for domestic violence on display in the hospital, and in antenatal and postnatal clinics held in the community.

- All permanent staff providing direct care to pregnant women should have face to face level 3 safeguarding training. Most staff were up to date with safeguarding training, although below the trust target of 95%. Compliance was 88.5% for safeguarding children Level 3, and 88% for safeguarding adults (level 2). Safeguarding training had been strengthened in April 2017 by the addition of a mandatory half day training about learning disabilities and bespoke midwife training on safeguarding vulnerable adults.
- All midwives had access to a database of safeguarding referrals and concerns so they could check whether women or families were subject to a child protection or children in need plan. This was an interim arrangement because the current maternity information system could not flag safeguarding concerns. Work was underway to ensure the new maternity information system, due to be available in October 2017 would flag up issues such as child sexual exploitation, female genital mutilation, honour-based violence, forced marriage, human trafficking and preventing radicalisation as well as children in need or where the unborn baby was subject to a child protection order.
- The handover to health visiting in the postnatal period incorporated safeguarding. Since April 2017 midwives informed health visitors electronically of all pregnancies at 25/28 weeks. There was an 'exceptional reporting form' to alert health visitors to post-natal issues at discharge.
- Midwives had group safeguarding supervision, although if a midwife making a referral could have one-to-one supervision. Staff could request one-to -one safeguarding supervision in other circumstances.
- No teenage pregnancy clinics were run in Cornwall because of the geographical spread of such cases. Young women saw midwives in their local area to minimise travel. In 2015/6 there were 10 births to young people under 16 and 49 births to those under 18 across Cornwall. Midwives had links with the charity Addaction for young people misusing alcohol and drugs.
- The unplanned pregnancy clinic staff saw a small proportion of young people under 16. They were aware of the need to involve the safeguarding team for all young people under 16 or those who were otherwise vulnerable. Victims of assault were referred to a specialist centre in Truro and they were aware of the signs of child sexual exploitation. All women attending for a procedure were encouraged to bring someone with them so they would be safe on travelling home.
- We noted that when the clinical commissioning group reviewed in February the trusts response to CQC's recommendations in the previous inspection, the 12 recommendations which the trust had rated green for progress, were rated as red. However, we also saw the trust had taken immediate action taken to improve these scores. The named doctor for safeguarding had three programmed activity sessions a week, which is about the national average. There was no one in the trust with responsibility for domestic violence, so referrals were made to local support organisations. The named doctor for safeguarding had an allocation of three programmed activities a week for safeguarding across the trust.

Mandatory training

- All new staff received a trust induction, which included statutory and mandatory training.
- The trust had revised mandatory training for midwives in 2017 to include some new topics including safeguarding and responding to obstetric emergencies. In many cases mandatory training compliance was below 85%.
- Mandatory training included infection prevention, fire safety, manual handling and basic life support, however it did not include sepsis identification and management. Some training was online and some face to face. Midwives were responsible for monitoring their own compliance. A practice development midwife oversaw the training database and had an overview of compliance. However, we did not see any discussion of low mandatory training rates at operational maternity meetings. The section on Action to Improve Attendance in quarterly Maternity Training reports repeated the same wording each quarter. This did not convey the impression that any urgent action was being taken. Mandatory training reports to the board in the integrated reports were trust wide and in July 2017 reported 86% training compliance overall. There was no mention of maternity compliance being lower.
- In addition to trust mandatory training, an annual maternity update day was compulsory for midwives. This covered antenatal screening, blood transfusion competency, smoking cessation, healthy weight, new

born feeding, mentorship, diabetes and bereavement, delivered as a monthly rolling programme. 79% of maternity staff (trust-wide) had attended this by May 2017. New topics were added to remind staff of points that had arisen from incidents, for example a recent training day had included a half hour session on the importance of risk assessments for venous thromboembolism (VTE).

- The (Practical Obstetric Multi-ProfessionalTraining) PROMPT training was introduced in April 2017, replacing Training for Obstetric Emergencies (TOME). The training was run monthly for obstetricians as well as midwives and included response to maternal collapse, massive obstetric haemorrhage, sepsis and intrapartum foetal monitoring and resuscitation. 86%% of midwives were up to date with this (July 2017) and 70% of doctors. Staff told us there was high quality emergency simulation training. Maternal resuscitation was included within the PROMPT training as part of the half-hour allocated for maternal collapse. However, there did not appear to be any practical application of maternal resuscitation training.
- All clinical staff working in the delivery suite, including obstetricians were required to attend training in the use of cardiotocography (CTG) interpretation and foetal electrocardiogram (ECG) (known as STAN monitoring) 84% of acute midwives had attended CTG training in 2016/17 however, only 67% had attended STAN training. STAN is a type of CTG that uses computer analysis of the baby's heart rate and heart muscle function, to give clinicians an idea of how the baby is coping with labour, and assists in reducing the risk of unnecessary intervention. Training was four hours annually including competency testing, supported by CTG review meetings.
- STAN sessions were also included in the newly rolled out PROMPT training. Community midwives had not been offered STAN training at all. We were told community midwives did not care for high risk women using STAN on delivery suite. However, community midwives we spoke with told us in practice they had to care for high risk women on the delivery suite during times of escalation. This meant some women were at risk of receiving care by midwives who were not trained to interpret the foetal heart patterns. These midwives also had no training on drugs used in the delivery suite or the hospital computer systems.
- The trust had only made neonatal resuscitation compulsory training in 2017. As a result, only 54% of midwives were up to date on attendance at the Resuscitation Council (UK)'s Newborn Life Support (NLS)course. This competence was particularly important for those attending births in the community who would not have the support of paediatricians, should resuscitation be required.
- Maternity training records going back to May 2015 indicated there was a high percentage of non-attendance at maternity update days. For some sessions this was as high as 20%.In the current year, 18% of midwives working in the acute unit and 23% of community midwives had failed to attend the update days.
- Human factors training had been held to help staff understand how and why teams make errors. Further human factors training was planned for up to 24 staff later in the year.
- A multidisciplinary training day had been held covering obstetric emergencies in the community. Another date had been set for the autumn to include paramedics, including those who manned the air ambulance and would reach 20 staff. As there were 56 community midwives in July 2017, not all community midwives would be able to have this training.
- Community midwives competencies were being reviewed and as a result, training was being offered on topics such as suturing and cannulation. Not all hospital based midwives were confident in cannulation. We raised this as a concern. As a result, a risk assessment was carried out after our inspection, and plans were put in place to offer on line training for cannulation for midwives to access. However, we were not assured that on line training would ensure practical application or competence.
- There was a high transfer in rate (50%) of women who had been booked to deliver in the community. Midwives described this as being due to them being extra cautious due to geographical location and lengthy transfer in to the acute unit in the event of an emergency. In view of this potentially lengthy transfer time, we were concerned that women and their babies could be at higher risk if an emergency situation developed and the midwives did not have the skills, equipment or confidence to respond whilst waiting for ambulance support.

- Maternity support workers had five days mandatory training on joining the trust, including manual handling, supporting breastfeeding, sepsis training, safeguarding and tissue viability. They also attended an annual update day.
- There was a practice development and audit midwife in post who was very enthusiastic and committed to the role; a number of deficits had been identified in relation to training and were being included on an annual training plan. A large amount of funding had been secured from an external source, and we saw evidence that this was being put to good use with a significant number of training events planned in the near future and over the next year.
- Mandatory training in gynaecology outpatients was 88.7% in June 2017. This was also below the trust target of 95% target.

Assessing and responding to patient risk

- We had concerns about aspects of risk management on the delivery suite, the wards and in the community. Tools such as maternal early warning score (MEOWS) charts and partograms (a composite graphical record of key maternal and foetal data during labour) were not routinely used. It is recommended safe practice that every woman should have a MEOWS chart. The trust guideline on admission of women to the delivery suite required measurement of temperature, pulse and blood pressure but staff were not following this.
- Midwives told us the escalation policy to ensure there were enough staff to cover labour and delivery was not working well as there was not always the right skills mix on the delivery suite. The delivery suite coordinators monitored the complexity of women in the delivery suite and used an escalation algorithm to maintain staffing levels when the unit was busy. However staff did not use a recognised acuity tool to record staffing, skill mix and activity such as the national patient safety agency (NSPA) intrapartum scorecard. The first point on the escalation policy was to redeploy midwives in the hospital to support staff in the delivery unit, first from the antenatal ward, then from the postnatal ward. The second level was external escalation. This involved on-call community midwives being called in to support the delivery suite. This occurred mainly, though not exclusively at night. Data showed two external escalations for 5.35 hours and 4.15 hours in May and two external escalations in June 2017 for 3.15 hours and 1.15 hours had occurred. The escalation plan was activated 65 times in 2016/17 in the year from June 2016 to May 2017 and 15 times between April and July 2017.
- The inclusion of community midwives not trained in STAN and other processes used on the delivery suite was a risk, and we saw an incident had been reported that related to this. We did not see a risk assessment of this or a plan for community midwives to have appropriate training.
- There was no system to ensure there was an identified, high dependency trained member of staff on duty at all times on the delivery suite. Some midwives were not aware of the guidelines on managing high dependency patients. The policy stated there was high dependency unit in the delivery suite for women requiring a high level of monitoring and observation in recovery after caesarean section. However, a senior manager said the delivery suite did not contain a high dependency unit but either a nurse or midwife would manage level two patients (those classified as requiring high dependency care) in a room on the delivery suite. Registered nurses managed the elective theatre list, and these had some high dependency training. However there was not always a nurse or midwife on duty on the delivery suite with these skills. We asked the trust to provide us with training information to demonstrate staff had competence in these skills. They provided us with a training competency dated 2010 and were unable to state how many staff had this level of training. The trust did not collect data on the number of women needing high dependency level 2 care to be able to review the staffing needs to respond to this demand. Analysis of the incident reports indicated seven women had required high dependency care since March 2017 with three women transferred for level three care in 2016, and one between April and July 2017.
- The process for identifying and escalating women to level two care was through the MEOWS charts which would be completed for any woman thought to be at risk in the delivery suite. A MEOWS score of 5 would trigger consideration of high dependency care. The policy said a woman stepped up to high dependency care would have a high dependency chart commenced, to replace the MEOWS chart. However the MEOWS chart instructions were not aligned with MEOWS management as stated in the Severely ill Obstetric Woman policy. As a result there was a risk that staff would not necessarily

know which guideline to follow. The process for escalation was covered in the policy: Severely ill obstetric women - clinical guideline, as well as related guidelines on Maternal collapse and Obstetric haemorrhage. Anaesthetists were available 24/7 to provide supervision or to arrange transfer to intensive care if necessary.

- Inconsistent use of MEOWS charts and partograms meant there was a risk that staff might not spot signs of deterioration in a woman. In the records we reviewed, MEOWS charts were not always used, and in some cases MEOWS observations were recorded on the partogram rather than the MEOWS charts. MEOWS charts are designed to give a clear visual record to help staff identify deterioration at a glance. This visual aid is not present on partograms
- Labour and birth on the antenatal ward was recognised as a risk 'outside tolerance' on the risk register, although the identified risk was 'high risk women labouring on the antennal ward'. Birth on an antenatal ward should only happen in exceptional cases, yet this was accepted and supported by a policy 'Labour on the antenatal ward – clinical guidelines for the care of women'. We were not assured midwives followed this policy, designed to ensure women's safety. An audit in March 2017 had shown that only 20% of women birthing on this ward had a partogram, and that the recognised communication method, SBARD, was used in only 3%of cases during escalation to the delivery suite. Senior managers told us they did not think a reduction in the number of babies being delivering on antenatal ward was possible due to the capacity of the delivery suite. Midwives said that the capacity issue was primarily about staff numbers rather than the availability of a delivery room.
- The risk of birth on the antenatal ward was increased by the growth in the number of inductions. There were often more inductions than the agreed limit of four per day on the antenatal ward. Staff could not explain why inductions were not spread more evenly or why capacity and staffing on the delivery suite was not taken into account before deciding whether to induce a woman. As a result some women who had their labour induced, laboured and gave birth on the antenatal ward because of lack of capacity in the delivery suite. There was no data on whether inductions of labour were ever delayed when the delivery suite was busy. Nor was there evidence that delivery suite staff took account of activity on the antenatal ward and Day Assessment Unit, to plan ahead for staffing needs in the delivery suite each shift. Staff recognised the desirability of auditing the reasons for induction but stated they could not spare staff time to undertake this work. Staff told us outpatient induction was not appropriate at this hospital because of the long travelling distances for many women. Induction in hospital was considered safer.
- Risk assessments for women in antenatal care were adequate. The initial booking appointment included a detailed risk assessment, in line with national guidance. We observed part of a booking appointment. Midwives assessed whether pregnancy and labour were likely to be low or high risk and whether a home birth or midwife-led birth was appropriate through maternity history, multiple birth, previous caesarean section, weight, age, risk of venous thromboembolism (blood clots), blood pressure and conditions such as diabetes or high BMI. On-going risk assessments were documented at subsequent antenatal visits. Midwives referred women who they identified as high risk for any medical reason to consultant led clinics.
- Smoking status was part of the risk assessment and midwives were encouraged to offer women a breath test for carbon monoxide in their bodies at booking, and 36 weeks gestation because of the impact of smoking on the baby's growth. Detection triggered a growth assessment as women smokers were at risk of having small babies. However, not all midwives carried out this test in pregnancy.
- A foetal medicine unit supported the identification of potential birth complications. Consultants told us they could identify and manage most problems of pregnancy, for example women with serious placental adhesion complications (placenta acreta). Women with known placenta acreta, which is be detected by ultrasound scanning, were not delivered in the obstetric theatre but in the Newlyn suite at the hospital, which had interventional radiology. This facility meant women with this condition did not need transfer outside Cornwall. Obstetricians referred women with cardiac problems to hospitals outside Cornwall. Some mothers whose babies were expected to need a higher level of care after birth, including occasionally when the hospital's own neonatal unit was closed, were also referred to other hospitals.

Maternity and gynaecology

- There were protocols to deal with obstetric emergencies within the maternity unit, although the policy for massive obstetric haemorrhage expired in March 2017 and needed updating.
- The World Health Organisation (WHO) surgical safety checklists were used in obstetric and gynaecology theatres. Audit for 2016 covering documentation, distractions and clinicians not present showed a score of 96% compliance. However this was below the trust average of 98%. We reviewed audit returns for May and June 2017. Here, the department scored 100% compliance for sign in, time out and sign out stages in the process.
- We reviewed the criteria for women wishing to give birth in a birth centre or have a home birth, which were strict and in line with national guidance. If women wanted a home birth midwives undertook an environmental risk assessment of the home and birth space, lighting and equipment in the home. Assessment included access for emergency services.
- Women giving birth at home or in a birth centre were transferred to the delivery suite if midwives had concerns about the progress of labour. The transfer rate of women from home or birth centres was higher than national average at 50%. Midwives explained they had to take account of the ambulance response times and travel distances in a rural county as it could take an hour to reach the hospital after an ambulance arrived.
- The hospital had reached an agreement with the ambulance service for community midwives to request a purple (category 1) emergency response in an immediately life threatening obstetric situation. An ambulance called under this category would not be diverted to other serious incidents.
- We had concerns that, not all community midwives were trained in cannulation which would limit their ability to provide first line support to mothers and babies while waiting for an ambulance. Following our concerns being raised, the trust conducted a risk assessment and told us of plans to train midwives in the skill through the use of an on line training resource. It was not clear how midwives would obtain the practical skills to undertake this. Midwives were to be issued with boxes containing equipment to allow them to cannulate, however, they did not carry the necessary intravenous fluids to administer following their insertion. The risk assessment did not include means of mitigating the risk in the interim.
- We asked the trust to provide evidence that they were sighted on the reasons for the transfers in to the obstetric unit from the community and to provide assurance that all women had been correctly booked as low risk for births in the community. Between January and June 2017, 51 women had been transferred in and the data collected indicated that none of the risk assessment boxes had been completed. In many cases, midwives had indicated that it was 'unknown' if the women met the criteria for birth in the community. The length of time taken to get to the hospital was not recorded in some cases and a retrospective review of the notes had not been undertaken as required in the majority of cases to identify issues and ensure learning.
- We asked for evidence that the issues around delays in ambulances attending in the community had been risk assessed and for any formal agreements with the ambulance service. No formal agreements or risk assessments were in place, but the unit had received some information from the ambulance about how to make emergency calls and ensure the correct level of response. This information had been sent in a letter to community midwives and we were told was available for reference in the birthing units. However, it was not formally included in an approved document, and we were not assured that all midwives were able to access it, for example staff new to the community teams.
- The fans in the corridors of the post-natal ward were a trip hazard for parents walking with their babies. This had not been risk assessed. The senior midwives we spoke with told us it was policy not to carry babies, but to always ensure they were wheeled in cots. However, a glossy information document provided to staff by the trust to prepare for the CQC visit included a photograph of a doctor carrying a new-born in his arms. Staff had not advised parents to wheel their babies in a cot when moving around the ward until we suggested this.
- In the gynaecology ward, staff used the national Early Warning Score (NEWS) for monitoring women to detect deterioration. Staff were aware of emergency risk management in gynaecology such as ectopic pregnancy and miscarriage, or sudden bleeding.
- Women seeking an abortion had their medical history taken, known allergies identified and an ultrasound scan to confirm pregnancy dates. Before undergoing a termination of pregnancy, all women were required to

have their blood checked for rhesus status. Where a rhesus negative blood group was identified, an injection of anti-D immunoglobulin was administered to protect against complications in any future pregnancy.
- We saw completed World Health Organisation (WHO) checklists in the notes of women who had been taken to theatre. Staff in the delivery suite did not complete the WHO checklist for suturing but used a proforma that included a needle and swab count. The use of the WHO checklist in gynaecological theatres was audited as part of trust wide audits.

Midwifery staffing

- There were not enough midwives to ensure safe service at all times. The trust data for March 2017 indicated a 5% vacancy rate among midwives in the acute hospital. There were three whole time equivalent midwife vacancies in the community in July 2017 although staff also told us of staff retirements in June and July and vacancies being held for student midwives when they qualified. These would have increased the vacancy rate. Managers acknowledged that lean staffing meant they did not have enough staff to carry out audits of practice, performance and outcomes.
- Midwifery staffing was reviewed every six months, using a recognised midwifery staffing tool. The policy on Safe Staffing Levels for Midwifery, Nursing and Support Staff policy said a full staffing assessment was planned for the autumn 2017 recognising that although the birth rate continued to fall, the increasing complexity of the women cared for, and the additional duties required of midwives such as NIPE (the Newborn and Infant Physical Examination) and administration of vaccines, added significantly to midwifery workload.
- Staff on the delivery suite frequently used the internal escalation policy to achieve safe staffing levels on the delivery unit at the expense of staffing levels on the wards. This created a risk to women's care in the areas from which staff were taken. On the maternity wards the midwife fill rates averaged 89% in April and May 2017. We attended a senior midwives meeting where staff described the escalation arrangements as 'not working'. We also saw that midwives on the delivery suite often did not get breaks.
- At times, community midwives called into the hospital during the day. Some midwives expressed concerns that the delivery suite was sometimes not safe because of low staff numbers and skill mix in relation to the level of clinical activity. The use of community on-call midwives in the delivery suite, although infrequent was a concern. These staff lacked training on aspects of delivery suite activity, such as STAN monitoring. In addition, some had to travel long distances to come into the delivery suite. The trust told us community midwives were rostered to be on call prior to an admin day or day off whenever possible. However, midwives told us that if they worked on the delivery suite at night, they still had to work their shift next day, which left them stressed and tired.
- The trust was not fully able to comply with 'Safer Childbirth: minimum standards for the organisation and delivery of care in labour', and the NICE guideline 'Safe midwifery staffing for maternity settings', both published in February 2015. These recommended one to one midwifery care in labour. Midwives provided one-to-one care on the delivery suite, and to women giving birth at home or in birth centres, but they did not generally provide one-to -one care in established labour to all the women who laboured on the antenatal ward.
- The trust calculated the ratio of midwifery staff to births within the service on the basis of funded establishment rather than midwives available to work clinically. We were told the position in May 2017 was one midwife to every 31 births, and that some shifts were filled by bank midwives to achieve a final ratio of 1:30. However this ratio did not take account of sickness absence and vacancies so did not show how many midwives were actually available to work clinically. We requested the ratio of midwives to births taking account of sickness, maternity leave and vacancies but did not receive this.
- There were 152 whole time equivalent midwives budgeted for in May 2017, and 35.75 maternity support workers. We had only partial information about vacancies, such as that were 19 midwife vacancies at Band 6. There were no vacancies for support workers. In June and July 11 staff had left the trust or retired. Some posts were being held for newly qualified midwives when they finished their training which intensified the current shortage of staff. A high proportion of midwives were employed part time, which created a tension between midwives wishes for a work life balance and national drivers that expect services to ensure that women saw only one or two midwives throughout pregnancy.
- There were a small number of specialist midwife roles, practice development, risk, foetal monitoring, screening and midwife sonographers. There were no consultant

midwives. The practice development role included an element of oversight of audit, however staff told us there was no surplus capacity within their roles to be involved in audit.

- About a quarter of midwives were aged 51-55 years and 12% were older than this. Some staff returned to work after retiring, at a lower band and often in a different area. However, the midwife skill mix was changing rapidly with the loss of experienced staff and replacement with mainly newly qualified midwives. There was little evidence of succession planning. Three staff we spoke with had taken up post without overlap with the previous post holder to provide continuity. There was no successor for the governance lead for maternity and gynaecology who was leaving two weeks after our inspection in July 2017.
- We noted that more midwives would be needed to work in the alongside birth centre when it opened, but staffing for this (a band 7, three midwives and an MSW) was already included in the establishment). Given the apparent pressure on hospital midwives already, we were concerned that staffing pressures would increase when the centre opened. Staff did not yet know who would be working in the centre even though it was scheduled to open in late September 2017.
- In the community teams there were 2.2 vacancies in the West Cornwall team, where one midwife was acting up as team leader and 0.6 vacancies in the Central team. Staff in the West Cornwall team considered the establishment was too low to cover the workload in the region because of its remoteness and travelling times. We were not aware of this being factored in to staffing calculations. There were no vacancies in the North Cornwall team. These midwives had caseloads of 1:98 in line with recommended practice. This caseload was the number of women to whom they provided antenatal and postnatal care, but did not deliver because the women had planned hospital births.
- The day assessment unit was jointly staffed with the antenatal ward, although one midwife and midwifery support worker was allocated to triage and cover assessment of women referred. There was no dedicated triage midwife in post. During our inspection, it was agreed that a midwife at Penrice birth centre would take triage calls between 5pm and 8pm. We but did not see a contingency plan in the event that a Penrice midwife was supporting a woman in labour and therefore unable to take the triage calls.
- Central rostering was planned to commence in September 2017. This was occurring trust wide. Midwives and midwifery support workers would be on a different roster, and the built in allowance for annual leave had reduced from 18% to 15%. Staff had raised concern about difficulties in approving rotas with the right skill mix if staff were on two different systems, but this was not on the risk register and did not seem to have been discussed at governance meetings.
- We attended a midwives ward handover on the postnatal ward, Wheal Fortune. A standard handover sheet had prompts for tasks such as checks on the resuscitation trolley, resuscitaire, sepsis box and emergency drugs, and to highlight women with intravenous drips, site checks for infusions, catheter care plans and babies needing special care. There was a quick staffing review, including staff who had been re-deployed that day, and mention of housekeeping points, including equipment problems. Despite a prompt for a safety briefing on the handover sheet no safety briefing took place. A safety briefing is very short update on anything that might present a risk to patient care in that clinical area on that shift, such as short staffing or a near miss on an earlier shift, or a piece of equipment that was out of order.
- The maternity service did not use agency midwives. There was a bank of midwives, some of whom worked only as bank staff, as well as permanent staff who worked extra shifts.
- Red flag staffing events, alerts on occasions when patient safety was compromised due to staffing issues, such as delay in suturing or being unable to facilitate a home birth were on the trigger list for reporting incidents and near misses. We saw that these were reported. However, we considered that staff did not always anticipate staff shortages, which was the intent behind the NICE red flag scheme, in taking account of the needs of the women being cared during the shift, such as the number of women being induced on the antenatal ward who would go into labour later that day. We did not see daily records of any differences between the number of midwives needed and those actually available for each day or shift.
- Staff told us recruitment in Cornwall was difficult. Many people did not want to relocate to such a rural area and shortlisted applicants did not always come for interview.

Nurse staffing

- Band 5 nurses worked in the obstetric theatre and in recovery, although not all had training on caring for high dependency women. We were told there was a registered nurse on every shift in the delivery suite unless there was sickness; however other staff told us this was not the case. If there was a caesarean section at night, a midwife would be required to scrub for theatre, which in turn compromised the midwifery staffing numbers on the delivery suite.
- There was no operating department assistant or second theatre team allocated to the second theatre. Staff were not aware of a standard operating procedure to identify how a team should be released at short notice from main theatres if required.
- The gynaecology service was proactively seeking to fill vacancies for gynaecology nurses. For example they had been able to fill a post in the Emergency Gynaecology Unit (EGU). Meeting notes indicated that the service was looking at adapting the role to attract more applicants. The Early Pregnancy unit (EPAU) was staffed by a nurse and a sonographer. In the event of staff sickness or annual leave women were seen in the Emergency Gynaecology Unit. A review of the principles of an efficient gynaecology outpatient service was underway.
- We noted that on Eden ward the fill rate in the day time of registered nurses was 88%. The ward had not been able to recruit to establishment. The nurse in charge told us safe staffing was reviewed three times a day in the light of patient acuity and dependency. And bank and agency staff were regularly used to fill gaps in shifts.
- Clinical nurse specialists were widely used in gynaecology, for example in gynae-oncology, and fertility. Three fertility nurse specialists worked in the Cornwall Centre for Reproductive Medicine (Wheal Unity).

Medical staffing

- There was 60 hours consultant cover on the delivery suite since March 2016. This was provided by nine consultants. We were told that consultant on duty did not cross-cover with gynaecology, although we noted one incident reported on Datix where this had occurred. The level of cover met the recommendations of the Royal College of Obstetricians and Gynaecologists for a maternity unit of this size. A duty anaesthetist was available in the obstetric suite for 12 hours a day, including weekends, and an on-call rota ensured there was anaesthetic cover out of hours. There was always a resident registrar and resident junior doctor, both working 12 hour shifts.
- The delivery suite consultant was different each day. This worked well because women were rarely in the unit for longer than a day. Out of hours a consultant was available to attend and could be in the unit within 30 minutes.
- The handovers on labour ward were not multidisciplinary. There were five different handovers a day, midwives to midwives and doctors to doctors at different times. This appeared inefficient and time-consuming. We attended a doctors' handover. Doctors did not sign in to confirm attendance, but introduced themselves and stated their shift length. The delivery suite coordinator did not highlight any key risks for the shift, such as women having their labour induced risks on the delivery suite or on the antenatal ward. There was an update on the progress of women in each delivery room, but the handover did not mention women who required review on the wards. The SWIFT board showing women on the delivery suite was minimised during the handover so doctors could not read it, and no updates were recorded during the meeting. We did not see doctors reviewing patient notes at this time. This did not follow the process in the hospital guideline on handover of care in the maternity setting. This meant there was a risk that doctors would not be allocated clear responsibility for following up higher risk women.
- Two consultants ran a reproductive medicine unit, Wheal Unity. There were two specialists in foetal medicine who were hospital based, and some women were able to attend clinics held in local community hospitals if they had complications or conditions which required more detailed assessment.
- Some of the consultants within the maternity and gynaecology service worked in both obstetrics and gynaecology (O&G). Others worked as gynaecology sub specialists, concentrating on a specific area of practice such as urogynaecology or gynae-oncology. An additional gynaecology consultant had been appointed in spring 2017 to help reduce the waiting lists within gynaecology for both outpatient appointments and procedures.
- We noted there had been gaps in gynaecology on-call cover and we that this had been a factor in an incident.

We saw this was being discussed in clinical review meetings and solutions such as extra pay for attendance out of hours had been tried and a business case was being made for extra costs for covering this on-call.

Major incident awareness and training

- Staff knew how to access the trust's major incident plan. Clinical staff and incident commanders had annual training.
- Staff said they had not been involved in practical drills or table top exercises to plan emergency responses to an incident in the Princess Alexandra Unit.
- Staff showed awareness of the action to take in the event of fire.

Are maternity and gynaecology services effective?

Requires improvement

We rated effective as requires improvement because:

- There had been a programme to update guidelines in the maternity service through a multidisciplinary group. However, we found some guidelines contradicted others and not all midwives seemed to understand the importance of adhering to guidelines. Some guidelines, such as the use of a partogram to show the progress of labour were not followed in many women's deliveries.
- More babies than the trust target were readmitted to hospital within 28 days because of feeding concerns, however there was no clinical guideline on this or evidence of plans to reduce this.
- We were not assured that all staff were up to date with recent guideline changes, particularly community midwives who did not have remote access to the guidelines.
- There was a maternity audit schedule for 2017 but no effective process to ensure that cyclical improvement was established and ongoing. Audit plans did not include audit of risks rated as high on the risk register.
- Changes were made in response to external factors and the service did not always plan these systematically.
- There was no dedicated triage midwife, contrary to NICE guideline CG190.
- Community midwives were not trained to work in delivery suite so did not have the right skills to be fully part of the hospital team. No rotation program was in place.

However:

- The maternity service generally achieved a lower rate of emergency caesarean section than the national average (9.6%), and a high proportion (70%) of women had unassisted births. The community birthrate was 11.4% which was much higher than the national average of 2.4%
- The trust took part in national audits, including the new RCOG National Maternity and Perinatal Audit (NMPA), and the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK). They were an early adopter of the Saving Babies Lives care bundle.
- The service was proactively promoting techniques to avoid third and fourth degree tears and the care bundle to support this, as recommended by the Royal College of Obstetricians and Gynaecologists (RCOG).
- Most staff had an appraisal in the past year: 96% of midwives. 90% of obstetrics and gynaecology staff.
- Staff in gynaecology described good multidisciplinary working relationships and good communication. MDT meetings were held to decide on treatment for women with gynaecological cancers.
- There was a good range of audit taking place in gynaecology leading to changes in practice.

Evidence-based care and treatment

- Guidelines were developed in line with the recommendations of National Institute for Health and Care Excellence (NICE) and those of the Royal College of Obstetricians and Gynaecologists (RCOG), for evidence-based care. A multidisciplinary guidelines group identified and produced new guidelines, in the light of new evidence. All existing guidelines were expected to be reviewed within a 3 year time scale and training requirements arising from new guidelines identified. Of the 104 sets of guidelines the majority were in date, though not all. Those out of date included a guideline for the management of shoulder dystocia (an obstetric emergency) which had been due for review in 2015, Intraoperative cell salvage and hypertensive disorder, and a guideline relating to the management of sepsis.

- Some policies were not detailed enough. For example the severely ill obstetric woman policy did not mention community emergencies. There was no policy for women needing high dependency care.
- There was no policy or standard operating procedure for recording maternal early warning scores (MEOWS). The chart itself had instructions but these conflicted with the MEOWS management policy as stated in the severely ill obstetric woman policy
- The Maternity Risk Management Strategy required every policy to be monitored through agreed compliance monitoring indicators, but this was not happening. Midwives said they did not have time to carry out these audit checks which meant that deficiencies and variance in practice were not being systematically identified.
- The hospital took part in national maternity audits, including the new RCOG National Maternity and Perinatal Audit (NMPA), of which the hospital had been part of the pilot, and the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK). They also took part in initiatives such as Sign Up to safety from which they had obtained funding for CTG interpretation and the introduction of the STAN foetal monitoring system.
- Audit plans were not related to risks on the risk register. For example there was no audit of CTG interpretation and the use of fresh eyes, even though the risk of CTG misinterpretation was a on the risk register as a high risk.
- There were 20 audits planned for 2017, whilst the majority were on track for completion, five were past their anticipated end date. We reviewed an audit 'Diabetes in pregnancy' that benchmarked the hospital's performance with other hospitals in the South West. The trust scores were lower than other hospitals for encouraging women to take folic acid and to control blood sugar levels. Staff told us this was because of a lack of pre-conceptual counselling from GPs. The action from this audit was to share the results with GPs, and this was in hand.
- On reviewing the list of clinical audits for 2016/17 we found some had been abandoned because of staff leaving, such as two induction of labour audits and an audit of maternal readmission with sepsis. The dates of others had slipped by several months, and a few by more than a year.
- There were a number of women who were Jehovah's witnesses, living in central Cornwall The hospital had a specific clinical guideline relating to Women Declining Blood Products which covered the needs of this group of women. The guideline referenced the Royal College of Surgeons Code of Practice for the Surgical Management of Jehovah's Witnesses (RCS 2002). This had been superseded by a good practice guide in 2016; however the clinical guideline had not been updated to reflect that.
- Community midwives did not have remote access to maternity guidelines. Remote access would not be possible until the new maternity information system was introduced, due October 2017. Midwives had paper copies of relevant guidelines, but there was no process to ensure midwives were following guidance through audit.
- Midwives followed hospital maternity guidelines for antenatal and postnatal care which referenced NICE Quality Standards 22 (antenatal care) and 37 (postnatal care). First time mothers would normally have nine antenatal visits and mothers with a child already would have seven appointments. Women identified as higher risk would have more appointments, including appointments with an obstetrician. Women had three planned postnatal visits. We spoke with two parents about post-natal checks from their midwife, but we did not see audits to show the numbers and frequency of post natal visits were taking place.
- Staff did not always follow guidelines in the delivery suite. For example trust guidelines required midwives to complete a partogram when a woman was in established labour, both on the antenatal ward and in the delivery suite. This had been part of NICE guidelines since 2007. The audit of births on the antenatal ward showed partograms were rarely completed for those women, and of 10 records we reviewed on the postnatal ward only one contained a partogram. There was no routine audit of maternity notes to check whether midwives were giving care in line with guidelines.
- Staff told us fresh eyes was used in CTG interpretation. 'Fresh eyes' means another midwife or obstetrician reviews the CTG trace on an hourly or two hourly basis. Whilst we saw evidence of this in practice, there had been no audit of how well this was working.
- There was no dedicated triage midwife, contrary to NICE guideline CG190. During the day women were triaged by

their community midwife. Out of hours triage was provided by a midwife at the birth centre from 5pm to 8pm and then by the midwife assigned to work on the Day Assessment Unit.

- The unplanned pregnancy service met the guidelines set out by the RCOG and by the Human Tissue Authority. The service audited its work in line with Recommended Standard Operating Procedure (RSOP) 16. For example, to ensure that methods of contraception were discussed and women could choose between various methods. There was good uptake of long acting reversible methods of contraception (LARC) which are considered the most effective.
- There were systems to document the legal requirements for termination of pregnancy and processes to ensure records were stored correctly and returns made to the Chief Medical Officer in accordance with the law. There were arrangements to obtain two signatures by doctors as required by the Department of Health form (form HSA1), confirming the grounds for carrying out a termination of pregnancy. Following procedures, staff gave women verbal and written information about what to expect following a procedure, in line with good practice. The proportion of medical terminations compared to surgical terminations was similar to the national average. Women were tested for chlamydia and were offered an HIV test.
- There are few nationally required audits for gynaecology, although there are opportunities to take part in regional activities, and gynaecologists at the hospital were active in the wider region. One gynaecologist had developed a NICE approved urinary incontinence service and linked with multidisciplinary teams across the South West. Another was a member of the South West Peninsula gynae-oncology MDT.
- The gynaecology department made returns to national datasets such as the NHS Cervical Screening Programme in England (Colposcopy KC65) and to the British Society of Uro-gynaecologists. Audits were centrally registered and conformed to trust audit protocols.
- Clinicians had identified a lack of gynaecology and early pregnancy guidelines on the intranet. The development of a full set of guidelines had started in May 2017. Meeting notes recorded that the guidelines project was expected to take two years.

Pain relief

- Women considered pain relief as part of their birth plan and received information about options in the antenatal period. Women told us that they were able to obtain pain relief during and after birth, usually in a timely way, except for women in labour on the antenatal ward.
- Some women were given epidurals after induction, but before they were in established labour. This is not good practice, unless in severe pain. Anaesthetists set up epidurals and midwives gave top-ups. The hospital did not have infusion pumps for epidurals. Women who had epidurals were reviewed the following day on the postnatal ward.
- In 2016, 24% of women had epidurals in labour. Of these, 84% of women considered the quality of pain relief good and 93% were satisfied with the epidural. Of women having spinal anaesthesia for caesarean section, 95% considered they had good quality pain relief. In the Helston birth centre and for home births women could use Entonox (a mixture of nitrous oxide and oxygen) and pethidine injections. The birth centre had a birthing pool for pain relief and water birth. Some women used birth pools at home. The number of women choosing water for pain relief at delivery was not monitored or recorded on the maternity dashboard.
- No alternative therapies such as water birth, hypno-birthing or aromatherapy were offered in the delivery suite. There were no audits of pain management other than epidural analgesia.
- Anaesthetists provided 24 hour cover for epidurals for pain relief. The hospital did not collect data on waiting time for epidural analgesia but staff told us it was often not possible set this up within the target of 30 minutes, the nationally recommended time. This delay was not reported as an incident. Anaesthetists only gave epidurals to women on the delivery suite, for safety reasons, so women in labour on the antenatal ward or in the bereavement suite were not able to have this form of pain relief.
- Staff prescribed pre and post procedural pain relief for women having a termination of pregnancy and warned women about the levels of discomfort to expect, as well as simple analgesia they could take at home.

Nutrition and hydration

- Breast feeding rates had fallen since the start 2015/6. Current figures for breastfeeding from January to March 2017 were 74% at birth and 70% by the time women left hospital. The maternity services held full accreditation

(level 3) from the UNICEF baby friendly initiative in 2014. Breast feeding initiation was slightly better than the England average of 72.9%, but it was a little low for a service with a level 3 accreditation, and in the context of the Public Health Outcomes Framework to increase breast feeding.

- Woman received a guide to feeding and caring for their baby as part of their antenatal information and midwives gave new mothers guidance before discharge from the postnatal ward. Community midwives advised mothers who had their babies at home or in a birth centre about infant feeding.
- Women on the postnatal ward told us they had help with breastfeeding. An infant feeding specialist provided advice and support on the ward. There were sufficient breast pumps for women to use where required, and a dedicated baby feed fridge for storage of expressed breast milk. The temperature and contents of milk fridges and freezers were checked by ward staff daily.
- Women said the hospital food was reasonable, and told us they were regularly offered hot and cold drinks. Snacks and drinks were available to purchase in the hospital outside meal times. In the PLACE assessment for 2015 the hospital scored 84.5% for quality of food which was below average.
- Women required a period of fasting prior to elective caesarean section. The unit's policy was to ensure that women had pre-operative carbohydrate drinks. At times there were delays in some elective procedures being carried out. Audits had not been undertaken to provide evidence that these were being given to avoid periods of prolonged fasting.
- The gynaecology ward used the Malnutrition Universal Screening Tool (MUST) for patients who were at risk of malnutrition. Those at risk of dehydration also had fluid balance charts to monitor fluid intake and output.

Patient outcomes

- The RCOG Good Practice guideline No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity clinical dashboard to monitor outcomes in a maternity service. The maternity service maintained a primarily clinical score card. There was no information about staffing such as staff sickness, use of bank staff or vacancies. We did not see evidence of scrutiny of performance recorded on the clinical scorecard in meetings. We expected to find a review of items rated 'Red' in any of the parameters, and action planned to restore parameters in this or in the amber zone to expected values.
- We reviewed the dashboards from April 2015 to May 2017. On key indicators the service was meeting or doing better than national goals. For example, between January and December 2016 the rate of emergency caesarean sections was 9.6% which was below the national rate which of 14.7%. The rate for elective caesarean sections was similar to expected results. However the caesarean section rate fluctuated and the combined level rose to 25.5% in May 2017 which is about the national average.
- The normal delivery rate for the year 2016 -2017 was 70%, significantly better than the England average of 59%. There was a lower use of instrumental delivery than the national average.
- The unit had a good uptake of vaginal birth after caesarean section (VBAC) at 76% which exceeded their goal of 69%. Staff were considering using midwife VBAC champions to lower the elective caesarean rates of women who had had one caesarean still further. There were no cases of VBAC uterine rupture.
- Managers said they prioritised one-to-one care of labouring women. However, a retrospective audit of delivery and birth on the antenatal ward showed 30 births on that ward in 2016, with only 64% of those women having one-to -one care in established labour. A further 33% were recorded as having one-to -one care in late established labour. Late established labour is outside the normal definition of one-to -one care. In over a third of cases where babies were born on the antenatal ward, staff had not contacted the delivery suite. In thirteen cases staff had recorded that activity on the delivery suite was high, but it was not clear whether the capacity limitations were the number of delivery rooms or number of staff available on the delivery suite.
- The rate of epidural analgesia had increased from 24% in 2016 to 31%, slightly higher than the national average (30%). We were told an audit of the rates and reasons for epidurals was planned but this might not be possible until the new maternity information system was in place in October 2017 as staff could not easily extract this information at present.

- There were few unplanned transfers of babies in utero to another hospital. We saw that this only happened if the neonatal unit closed.
- The third or fourth degree tear rate was 2.7% of women, which about the same as the national rate of 2.9%. The trust aim was to keep the tear rate between 1.5 and 3.5%. We saw that the practice development newsletter for April focussed on promoting techniques to avoid injury to the anal sphincter as recommended by RCOG and there was a care bundle to support this.
- Post-partum haemorrhage rates were within normal range although results were slightly above the hospital's goal of fewer than 12% of women experiencing a haemorrhage between 500 and 5000mls. Their score for this was 13%.
- The rates of babies born after 37 weeks of pregnancy and transferred to the neonatal unit were monitored. During 2016/7 89 full term babies were transferred. The monthly numbers varied from three to 14. This represented 2.4% of births and was better than the national average of 4.4%.
- The hospital had a high rate of mothers smoking at delivery: 14.4% in the seven months from November 2016. This was higher than the trust target of 13% and significantly higher than the national rate which is below 11%. Despite cessation of smoking during pregnancy being a key target of the Saving Babies Lives care bundle, little action was being taken to improve the rates.
- In the 2015 National Neonatal Audit programme the hospital did not fully meet all national standards. For babies of less than 28 weeks gestation having their temperature taken within an hour of birth, the hospital scored 87% which was below the standard of 98-100%. 72% of mothers who deliver babies between 24 and 34 weeks gestation received antenatal steroids. The trust target for this was 85%. In addition, only 94% of babies born prior to 32 weeks gestation received Retinopathy of Prematurity (ROP) screening, against a standard requiring this to occur in 100% of cases. The trust took part in the 2015 Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE audit). Their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) classified the trust as having up to 10% higher stillbirth, neonatal and perinatal death rate when compared to the average for trusts of similar size. This was an error in data management, which we saw MBRRACE acknowledged. The data used for the calculation excluded births at Penrice birth centre and some home births, thereby understating the total number of births at the trust by 509 births. The issue was identified too late to amend the published report. By comparison with similar maternity units the trust had one of the lower rates of stillbirth and perinatal death. Between April 2016 and March 2017 there were 10 stillbirths and 13 early neonatal deaths.
- In the year 2016/7 109 babies were readmitted to hospital within 28 days of birth because of feeding concerns. This was above the trust target. An audit of readmissions was listed on the audit plan but was ten months past its anticipated end date at the time of the inspection. There was no trust guideline for this topic, but managers felt all community midwives knew to refer a baby with 10% birth weight loss to the neonatal unit. Babies were seen on the same day as an outpatient, where they were reviewed by a paediatrician made an individualised plan of care and undertook blood tests to ascertain whether the baby was dehydrated. Where appropriate, babies returned home with a specific feeding plan and review 24 hours later, or admission to either the postnatal or the paediatric ward was arranged.
- CQC's Intelligent Monitoring had not identified any maternity outliers for the trust.

Competent staff

- A one year preceptorship programme supported newly-qualified band 5 midwives in gaining skills to practice. Student midwives reported the preceptorship resource pack as being very useful. Mentoring was provided for junior staff, but there was no formal mentoring for new staff in senior posts, although staff said they were able to receive informal support from other hospital staff at the same grade.
- All staff were offered a 'midwifery training passport' which identified annual training which was required. This included a list of mandatory training and desirable training.
- A recent change of policy meant that midwives could work in the community after one year's experience. The practice development midwife recognised that this would require additional bespoke support for these midwives. This change had been made because of the

shortage of community midwives; however there were concerns about the resilience of some midwives in the community to provide the additional support that would be required.

- In order to develop competencies some band 6 midwives were shadowing coordinators on the delivery suite There were specialist midwives for antenatal screening, diabetes, infant feeding, risk management, governance and bereavement as well as midwife sonographers.
- Established staff reported having good quality study days. Some external training was available and the service had recently been awarded a sum for training from Health Education England.
- We saw evidence that training needs identified from incidents, complaints and claims were incorporated in training sessions as needed. For example training to support women who had learning disabilities, and more training for community midwives to ensure consistency of foetal measurement as part of the Growth Assessment Protocol (a national programme to improve patient safety by identifying small babies at risk).
- In anticipation of the opening of the new midwifery led birth centre, some midwives were due to receive training in water birth from experienced community midwives working at the Penrice standalone birth centre.
- Some staff working on the delivery suite had obstetric high dependency skills gained through the maternal acute illness management course.
- Staff had training in the communication tool known as SBARD (Situation, Background, Assessment, Recommendation and Decision). We saw this being used in practice between professionals.
- A training programme for New-born and Infant Physical Examination (NIPE) checks had been introduced, although it not commenced until after GPs had stopped carrying out the checks in April 2017. The impact of taking on the work had not been risk assessed in advance. Training was available for 12 midwives a month. The trust expected there to be sufficient numbers of midwives trained to do this by the autumn. Each midwife attending training needed to complete 30 baby checks before being deemed competent. There was concern that the monthly number of births was too low to enable every midwife to achieve this number of checks. NIPE checks were an addition to the workload of midwives but there were no additional staff.
- Hospital paediatricians were carrying out some NIPE checks and midwives who already had NIPE training were carrying out the checks. Until sufficient community midwives were trained, some women had to bring their baby to the hospital for the baby's check-up.
- Community midwives gave whooping cough vaccines to pregnant women from 20 weeks up to 32 weeks to help protect babies from this disease. They also administered flu vaccines. Midwives were also being trained on giving BCG immunisation to babies for whom this was indicated (about four babies a week).They also administered flu vaccines. Although staff had been trained in administering the vaccines they had not yet been trained in making the required returns to NHS England and commissioners. This had come to light in July 2017 and training was planned.
- Some training was planned that had not been included in the training matrix. For example, midwives had no face to face training in giving epidurals but were expected to administer top ups. Anaesthetists were concerned that some midwives were not fully aware of the associated risks and often asked them to site an epidural without giving them relevant history or background about the woman. When we raised this as a concern, we were told anaesthetists were in discussion with the practice development midwife about formal anaesthetic-led epidural teaching for the newly qualified midwives, and updates for established midwives, though dates for these had yet to be arranged.
- There had been no review of the skills that remote lone working midwives needed in life threatening emergencies. Clinicians told us that midwives in the hospital were not confident in cannulation. The practice development midwife had recognised the need for cannulation training for community midwives, although not for hospital midwives. This training need was also not identified in the training needs analysis matrix. We were told it would take six months to train all community midwives. Online training was available and the practice development midwife told us they were considering adding in practical training to this. Midwives in the community relied on paramedics to cannulate This was a risk to women living in geographically distant areas as a delay in ambulance arrival would delay the patient receiving potentially lifesaving treatment.

- There was no overall induction programme for new consultants. We saw from minutes of meetings that consultants were considering what approach would be most helpful.
- Staff we spoke with said they had an appraisal in the past year. The data for May 2017 showed most staff had an appraisal in the past year: 96% of midwives. 90% of obstetrics and gynaecology staff. The target was 100%.
- A rota of on-call senior midwives to provide 24 hour support to midwives had replaced the former supervisors of midwives on-call since statutory supervision had ceased to exist in April 2017. The trust had also set up a local practice programme for midwives needing support with practice. Monthly group supervision was available to all midwives and this was reported as being well-attended. The maternity service were not taking part piloting the new model of clinical supervision, called A-EQUIP (Advocating for Education and QUality ImProvement) which was expected to be rolled out nationally after the pilot to replace statutory supervision.
- Junior medical described feeling well-supported by the consultants with opportunities for learning.

Multidisciplinary working

- Although we saw obstetricians, anaesthetists and midwives working together on the delivery suite, some staff reported tensions. A system had been introduced to allow staff to report on their feelings after a shift and to try to understand the reasons for tensions. This system was in its early days but we saw that it had potential to identify and address problems that prevented productive team work.
- We observed effective multidisciplinary working on the day assessment unit and antenatal ward. Teams worked well together and there was good communication.
- There were several handovers a day on the delivery suite, though they were not multidisciplinary. . Medical handovers took place after midwife handovers. There were three midwife handovers because midwives worked three separate shifts, early, late and night. Good practice would be multidisciplinary handovers and safety briefs at each handover.
- We perceived some divisions and mistrust between community and hospital midwives. Efforts were being made to rotate staff to different roles, to increase understanding of different staff roles and responsibilities.
- Many women had their antenatal care in GP surgeries. No problems were reported about communications with GPs during antenatal care and discharge, but we saw that midwives did not always complete the child health record (Red book) to handover care to health visitors, which risked health visitors not being alerted to concerns. A process had been introduced in April for midwives to inform health visitors electronically of all pregnancies at 25-28 weeks with an exceptional reporting form to alert them to post-natal issues at discharge.
- Staff in gynaecology described good working relationships and good communication. MDT meetings were held to decide on treatment for women with gynaecological cancers.

Seven-day services

- Consultants covered the delivery suite for twelve hours a day Monday to Friday and in the mornings at weekends. A consultant obstetrician and an anaesthetist was on-call out of hours. There were always two doctors present in the maternity service.
- The delivery suite at the hospital could not close as it was the only one in Cornwall. However, the two birth centres and the home birth service for women occasionally closed out-of-hours when on-call community midwives were called into the delivery suite, or there was staff sickness,
- In gynaecology there was a policy that all gynae-oncology inpatients had a consultant review daily by the on-call consultant when their own consultant was not working. Staff told us this was being taking place but we did not see any audit to demonstrate this.
- The gynaecology service had tried to provide a six day emergency gynaecology and six day Early Pregnancy Unit, which women had found helpful, but had not been able to recruit sufficient staff to continue this. When the clinics were not available women we seen in the Emergency Department with referral on to gynaecology.
- There was access to ultrasound scanning was available every day of the week.
- On occasions elective gynaecology surgery on Saturdays to reduce waiting lists.

Access to information

- Guidelines were stored in an electronic resource on the trust's intranet, known as the 'Sisters Shelf' that hosted

links to policies, guidelines and paperwork. The midwifery section of this was under-developed; however community midwives did not have access to this from their community bases.

- Pregnant women carried their own hand held records, starting at the booking appointment. After the baby was born, a new record was made for the baby. The trust wide maternity information system held some electronic information.
- Staff told us the existing electronic information system in maternity was not fit for current recording needs. The trust was procuring a replacement system due to be introduced in the autumn. We saw staff were being issued with new laptops to enable access to the new system which would have greater functionality.
- Community midwives handed over information about mother and baby to health visitors at 25-28 weeks and to the GP and health visitor when the woman was discharged from the maternity service.
- On the delivery suite an electronic board had been introduced, to replace the former delivery suite whiteboard. This provided an immediate visual overview of a women's progress in labour for the delivery suite coordinator, and doctors. The large board was situated just of the main corridor so could potentially be seen by women and their partners coming into the ward and as such posed a confidentiality risk. However we did note that it shut down after a few seconds of inactivity, therefore reducing the risk of information being seen whilst the board was unattended. However, this system was in use across the trust, meaning any member of trust staff could log on, regardless of where they worked and view information about women and babies. The system had an audit facility which allowed a review of access; however, no audit had been conducted at the time of the inspection.
- Some midwives thought the electronic board was a retrograde step as it depended on midwives in the delivery room with the mother updating records on computer promptly. If this did not happen the overview was not fully up to date. Some midwives thought an electronic board made it less easy to update points during handover, for example. However, the introduction of the board had enabled on-call consultants to be able to view the board, as well as foetal heart traces from laptops at home. This enabled them to give telephone advice, or decide on the need to come in. Consultants considered the board a valuable addition to information sharing.
- Other information sharing within the maternity service was inefficient because it was often paper based. For example, we noted from minutes of the senior midwives meeting that there had been issues about triage calls and switchboard call handling since April. It emerged in June that although the switchboard were notified of changes to the on-call rota, the Day Assessment Unit who were handling triage were not always told. There were sometimes several paper lists of on-call rotas in existence because the delivery suite, Day Assessment Unit , Penrice birth centre and switchboard staff all needed this information. This could cause a delay to women being seen promptly and unnecessarily using clinical time to chase the correct doctors. It was suggested that all midwives should refer to the master lists on the shared drive. We saw that the issue was still not fully resolved by July, nearly three months later.
- The bereavement midwife explained she reviewed the notes of all women who had experienced pregnancy loss and prepared a 'suggested next pregnancy management plan' which was documented in a woman's notes and women were offered a copy.
- A replacement to the current electronic information system was due to be introduced in October 2017 as it was felt not to be fit for purpose. For example, doctors reported frustration about the lack of advance information on why patients had been referred to an antenatal clinic.
- Hospital medical records were generally available for gynaecology clinics, and incident reports showed only two occasions when notes had not been available.
- Whilst there was good sharing of information in gynaecology, staff respected the decisions of women who did not want their GP to be aware of their termination of pregnancy in line with Required Standard Operating Procedure 3.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Arrangements were in place to seek consent for surgery and other procedures, including screening. Consent

forms were appropriately signed in the maternity notes we reviewed. Staff told us they considered capacity to consent and demonstrated a working knowledge of the Mental Capacity Act and its implications.

- Consent was audited trust wide. The latest annual consent audit was undertaken in June 2015. In that survey we saw there were specific consent forms for gynaecology and obstetrics. The survey reviewed 10 cases in each discipline and results indicated that processes were adequate. We noted that staff did not normally give women written information to supplement the information given verbally, in line with good practice. We asked about the consent process for young people in relation to termination of pregnancy. Staff we spoke with had a good understanding of Gillick competence and Fraser guidelines. Gillick competence is used in medical law to decide 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. It is lawful for doctors to provide contraceptive advice and treatment without parental consent providing certain criteria are met. These criteria are known as the Fraser Guidelines. In the unplanned pregnancy service we saw that sufficient information was given to all women to ensure they were certain of their decision and understood its implications.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- Care delivered was kind and compassionate. Women we spoke with and their families spoke well of the care they received.
- Specialist midwives, helped women understand the specific needs of managing conditions such as diabetes alongside pregnancy.
- The Friends and Family test results were generally good both in maternity and gynaecology.
- Women had reasonable continuity of care before and after birth from a local team of community midwives which enabled them to establish trusting relationships.
- Staff were kind and non-judgemental in the unplanned pregnancy unit.

However:

- Women were less satisfied with their experience of care on the postnatal ward, particularly during the high temperatures that prevailed during our inspection.
- Although there was supportive care for women immediately around the time of bereavement there was no follow up or counselling provided by hospital staff.
- Privacy and dignity was not always fully maintained as two delivery rooms on the delivery suite did not have blinds for privacy when the lights were on at night.

Compassionate care

- We saw evidence of care being delivered that was kind and compassionate. The Friends and Family Test is a measure of patient satisfaction. Feedback from this survey between April 2016 and March 2017 showed the percentage of women who would recommend the trust for antenatal treatment for friends and family was similar to the England average at 96%, although the numbers commenting on antenatal care were low,(for example, only 7% compared to a national expectation of 15% response rate). The Friends and Family antenatal questionnaire was still in most women's records we looked at on the postnatal ward, indicating that midwives had not given it to women to complete.
- The score for women's experience of birth was 97%, the same as the national average in May 2017. However the results for the postnatal ward were mixed over the year to May 2017, averaging 90% compared with the England average of 98%. However, many positive comments were seen in the free text section: ' midwives have given me and my husband fantastic support during and after delivery, 'friendly and reassuring midwife' although a minority mentioned that staff were 'overstretched' and indicated that some staff were more helpful than others.
- Women at the hospital took part in CQC survey of women's experiences of Maternity services in 2015 when the hospital was among the best performing trusts for staff introducing themselves during labour and birth, and women feeling involved in decisions about their care. However, it was among the worst performing trusts

for women feeling they had enough information and treated with kindness and understanding during their postnatal stay. The results of the 2016 survey were not available at the time of the inspection.

- Women and their partners we spoke with on the postnatal ward reported that midwives had been supportive and they appreciated that staff were trying to reduce the ward temperature to make them and their babies more comfortable.
- We noted that two delivery rooms on the delivery suite did not have blinds for privacy when the lights were on at night. We were told blinds were on order, however no alternative arrangements had been made to ensure privacy and dignity was maintained.
- We spoke with staff in the unplanned pregnancy service and observed they were kind, non-directive and non-judgemental. This was borne out by feedback forms. They sought to maintain women's privacy by running small clinics (10 women) and allocating appointment times so women rarely needed to wait with others. We saw evidence of very positive feedback from women who had used the termination of pregnancy service, with over 95% rating this as excellent.
- A trust audit of 2016 data on ambulatory care in gynaecology had responses from 90% of some 2000 patients treated, of whom 99.9% considered treatment good or very good, and 75% were extremely likely to recommend the service to family and friends if they needed treatment.
- Responses to the CQC inpatient survey 2016 had been received from 605 patients at Royal Cornwall Hospitals NHS Trust. The results were about the same as other trusts. This survey covered all inpatients and was not specific to gynaecology. Gynaecology patients we spoke with were generally content with the care they had received.
- The Friends and Family response rate on Eden ward was about 16%, but of the 45 women who responded in May 2017, 100% recommended the care on the ward.

Understanding and involvement of patients and those close to them

- Women we spoke with said midwives had supported them in making decisions about their care. They felt able to ask staff if they were unsure about something.
- Women had continuity of care before and after birth from a local team of community midwives which enabled them to establish trusting relationships.
- Women seeking termination of pregnancy were offered counselling and time to reach their decisions. They were able to make an informed choice about the method of termination and about the disposal of foetal remains.
- Diabetes specialist midwives worked alongside women with diabetes to support them in the management of their condition during pregnancy.

Emotional support

- We spoke with two mothers in a community antenatal clinic. They described receiving clear and helpful advice and reassurance. Women could access support for specific health issues such as diabetes or mental health needs. Midwives assessed women's mood during antenatal visits in line with NICE clinical guideline 192 and were able to signpost women to sources of help for anxiety and depression. A perinatal mental health team from another trust supported women affected by moderate to severe mental health illness during pregnancy and after birth.
- When a woman transferred into the hospital from the community during labour, her midwife accompanied her and often stayed with her in the hospital, thus providing the reassurance of a familiar face.
- We saw that a specialist bereavement midwife provided sensitive and compassionate care to women or couples, as well as practical support while they were in the hospital. However, there was little counselling or follow up for women who suffered bereavement.
- All women seeking terminations of pregnancy were encouraged to have discussions with an accredited counsellor. Women were routinely offered follow up appointments, and had telephone follow up. Post termination support was also available.

Are maternity and gynaecology services responsive?

Requires improvement

We rated responsive as requires improvement because:

Maternity and gynaecology

- There were regular delays in transfer of women to the labour ward because of capacity on the delivery suite, both from limitations of accommodation and staffing.
- The service did not run a dedicated elective caesarean list. This could mean woman scheduled for elective surgery had to wait if there was an emergency underway on the day they were admitted.
- The day assessment unit only had two scanning slots a day. As a result, some women who attended for reduced foetal movements had to return for scanning on another day.
- Not all women were able to give birth in the community as planned as there was a low threshold for transferring women into the main consultant led unit.
- There was a risk to women's privacy and dignity on the antenatal ward as some women gave birth on the ward. The ward did not have closed doors and was merged with the day assessment unit.
- Few partners were able to stay overnight on the postnatal ward as space was limited.
- Some services had to be closed at times because of staffing, such as the homebirth service, birth centres, early pregnancy unit and emergency gynaecology unit.
- There were long waiting times for referral to treatment for some (non-cancer) gynaecology procedures.

However:

- Antenatal and postnatal services were provided in community locations as far as possible, reducing women's need to travel to the hospital.
- Women deemed low risk could choose to birth at home, at freestanding birth centres or at the hospital delivery suite.
- Midwives assessed women's mood during antenatal visits and were able to signpost women to sources of help for anxiety and depression.
- The unplanned pregnancy service was discreet. Staff were non-judgemental and women gave very good feedback about their care and treatment. Women could access the service in both Truro and Penzance.
- There was a good range of information leaflets for women with early pregnancy problems detailing ways of managing these.
- Good use was made of Facebook to communicate with women and young people.

Service planning and delivery to meet the needs of local people

- The maternity service was designed to avoid women having to travel too far from their homes. Antenatal care was delivered in GP practices, children's centres and a birthing unit. Some midwives visited women at home. Women attended the hospital for their anomaly scan. Sonography was available in Penzance for women living in the west of the county.
- Women could obtain translated maternity information documents and easy reading information through the hospital. There was access to interpreters both in person and through telephone support; although staff said the need for an interpreter was rare. Foetal medicine clinics and the joint diabetic antenatal clinics were held in the hospital, but some doctors held clinics in the community for women who needed medical oversight in pregnancy. There were weekly clinics held mainly at community hospitals in the county.
- The Day Assessment Unit was an appointment only service, on referral from a doctor or community midwife. It was open 9am to 9pm but had only two slots a day for scanning women, which were mainly used for women reporting reduced foetal movements. This meant some women had to return another day.
- Between April 2015 and December 2016 the bed occupancy levels in the maternity wards was slightly lower than the England average. The trust had 54% occupancy in December 2016 compared to the England average of 59%. This correlated with a fall in the number of births over that time. There were slightly more bookings reported in mid-2017 which indicated there might be a small increase in the birth rate in 2018.
- The delivery suite did not have enough rooms to accommodate the numbers of babies born at the hospital. The delivery rooms were too small to accommodate many birthing aids to support women with pain and labour, which meant women were more likely to need intervention in their births.
- Not all women were able to give birth in the community as planned as there was a low threshold for transferring women into the main consultant led unit and at times the birth centres were closed.
- Three-week pre-birth classes were run in children's centres throughout Cornwall. The classes called Bump to Baby were designed to increase the knowledge, confidence and aspirations of expectant mothers and their partners.These were delivered by children's centre staff, midwives and health visitors.

- Weekly breastfeeding peer support groups were held at local children's centres. These were advertised on Facebook and in antenatal clinics and GP surgeries, and were supported by infant feeding support workers in the hospital who gave advice.
- No local surveys of women's expectations of maternity services had been undertaken. However a Facebook page for the hospital was used to publicise information about the maternity service, and there was also a closed group where women could discuss their experiences. We reviewed the Happy Birth project page which had nearly 900 followers.
- The Cornwall Centre for Reproductive Medicine (CCRM) was based at the hospital. Treatments such as IVF were offered in partnership with other centres outside Cornwall.
- A referral based unplanned pregnancy service was available at The Hub on the hospital site. Terminations for foetal abnormality were managed on the antenatal ward in the bereavement room known as the Daisy suite.
- Most surgery for gynaecology was provided at the main hospital site, but consultant led clinics took place in seven locations across Cornwall. This allowed women e access to clinics closer to their home.
- Ambulatory gynaecology care was a growing area of clinical activity. Most gynaecology surgery was performed as day case surgery.

Access and flow

- The maternity service saw a slight increase in the number of births in the summer months when the population of Cornwall increased through tourism. This put pressure on the service at a time when many midwives also wanted to take annual leave. We did not see evidence that this pressure was taken into account in the staffing review.
- The second theatre on the delivery suite was only used for emergency procedures when the main theatre was in use. Staff opted to use the main theatre wherever possible for emergency caesarean sections. This meant that sometimes a woman expecting an elective caesarean section had to wait until later in the day after an emergency case was completed. Midwives said there was not always sufficient staff cover when elective caesareans were carried out later in the day as staffing levels were weighted towards the mornings.
- The Day Assessment Unit (DAU) assessed women referred by community midwives, because of complications in pregnancy. There was no dedicated medical cover for the DAU and midwives told us they warned women they might have to wait for a medical review. Data was not collected about waiting times in the DAU. Midwives told us doctors were usually available to review women.
- The flow from the antenatal ward to the delivery suite was poorly managed. In 2016, 19 women arriving in the Day Assessment Unit in established labour were admitted to the antenatal ward rather than being transferred immediately to the delivery suite. This affected women's experience of privacy and of supportive care. Thirty babies in 2016 were delivered on the antenatal ward and larger numbers of women were in established labour on that ward. Of those who delivered on the antenatal ward, only 57% of women gave birth in a single room and two gave birth in a bathroom.
- Communication sometimes hindered access and flow. Anaesthetists said midwives did not always alert them to high risk women in the delivery suite. Community midwives told us it could be difficult to make appointments for women to be seen in the Day Assessment Unit, and their judgements on the need for referral were questioned. A midwife on the antenatal ward said it was not always easy to persuade delivery suite staff to accept a woman from the antenatal ward and, we witnessed a member of staff seeking to transfer a labouring woman to the delivery suite being told that they would need to wait 'because CQC were on the delivery suite'. Midwives told us they got round the obstructions by phoning again at different time to find someone more responsive to speak with.
- The average length of stay on the postnatal ward was up to two days. Discharge from Wheal Fortune ward took place between 10am and 6pm. Most women having elective caesarean sections were discharged within 24 hours. There was a discharge lounge so women and babies could leave the ward freeing up beds for other women.
- Expectant mothers who were judged to have a clinical need for their labour to be induced came to the antenatal ward for induction and stayed on average for

24 hours. We were told that as far as possible, high risk mothers were induced on the delivery suite but that it was not always possible. This was not audited to provide any assurance that this was the case.

- Mothers giving birth at the birth centres were discharged two hours after birth. In line with trust guidance, women birthing at home or in a birth centre were given information about the signs and symptoms of potential life threatening conditions in the postnatal period.
- It was unclear how many women in the delivery suite were seen by a midwife within 30 minutes or seen by a consultant within 60 minutes as this data was not audited.
- The service did not measure the percentage of pregnant women accessing antenatal care within 10 weeks. National targets are to increase the proportion of women accessing maternity services by 10 weeks to avoid delays and ensure early antenatal screening standards are met.
- From April 2015 to March 2016 (the latest data provided by the hospital), there were 498 medical terminations and 369 surgical terminations. We reviewed the gynaecology dashboard dated April 2016 to March 2017 and some data for April 2017. During this time the hospital had not cancelled any planned gynaecology operations on the day of surgery for a period of several months, until there were 12 cancellations during March 2017. We were told that cancellations on the day were prioritised and re-booked within 28 days in line with NHS standards and the trust's Access Policy.
- Overall, records of cancelled gynaecology clinics showed there had been a significant reduction in in cancellations with less than six weeks' notice, and a reduction in on the day cancellations. However we noted from the incident report that administrators sometimes overbooked clinics without consultation with the clinician. One clinic had a considerably increased number of patients booked which led to late running and a poor patient experience because of waiting times. This was one of several examples which showed the need for better internal communication between administrative staff and clinicians.
- Gynaecology outpatients were reminded of appointments through an automated voice reminder.
- Women with extreme vomiting in early pregnancy were managed on the antenatal ward if they were at risk of dehydration.
- In the emergency gynaecology unit women were given choices about treatment for miscarriage: expectant management, surgical management or evacuation under general anaesthetic. For ectopic pregnancies, women had choices of medical or surgical treatment, as appropriate in their individual case.
- Gynaecology outpatients were reminded of appointments through an automated voice reminder. There was a 5.4 % 'did not attend' (DNA) rate for new gynaecology clinic appointments and a 7% DNA rate for appointments in 2016/7 for women with benign conditions. Attendance was higher for gynae-oncology clinics: between 3% DNA for first appointments and 4.8% for follow up appointments, which is within the expected range.
- The hospital was performing better than average for treating patients needing medical rather than surgical treatment within **18 weeks of their referral date with a performance of 99% in 2017, above the target of 95%.**
- **However, only** 89% of **p**atient seen within 18 weeks of referral - below the standard of 92%. The longest wait for general gynaecology patients was 44 weeks. There was a backlog of 171 patients waiting to be seen in March 2017.
- Cancer treatment times had worsened over the past year. 76% of gynaecology cancer patients were treated within 62 days from referral to treatment in March 2017 which was below the target of 85%. However they were performing above the target of 96% for women being treated within 31 days.
- An emergency gynaecology clinic was open five days a week for women referred by their GP to the gynaecology registrar. About 225 women attended the clinic each month.
- The early pregnancy unit was a specialist assessment and scanning service for women who were up to 14 weeks pregnant and had experienced pain or vaginal bleeding. This was open four mornings a week and all day Friday. Women were referred by either a GP or midwife and it saw approximately 188 women a month. When it was closed women were referred to the emergency gynaecology clinic for assessment.
- At weekends or at night when the clinics were closed women attended the emergency department. Women could be referred to the gynaecology ward for ultrasound scanning at any time. In order to staff the emergency gynaecology unit, the lead nurse had

worked over their contracted hours since January 16. In order to take annual leave, it was likely the clinic would have to close as additional staffing had not been secured despite raising this to divisional leads. Closure would impact on the women needing to attend, the wider gynaecology service and the emergency department.

Meeting people's individual needs

- Information on the website and in the hospital was all in English. Staff told us information could be provided in other languages although this facility was not often required.
- There was no written information for parents in the postnatal ward beside the beds about the ward routine. This was left for midwives to explain.
- When community midwives were called into the hospital to support hospital deliveries, women in the region covered by that on-call midwife were unable to have their choice of birth. The Helston birth centre had closed once in 2017, although midwives anticipated more closures during the summer of 2017 because of midwives holidays and vacancies in the community team for West Cornwall.
- There were six reclining chairs for fathers to stay overnight. There was a shower and toilet for their use, and they could have drinks but were required to provide their own food. There were no amenity rooms for women. Amenity rooms are single rooms, common in maternity, for which women can pay to have greater privacy after birth
- Daisy suite on the antenatal ward was for women who had a miscarriage or whose baby had died before birth. Women whose baby had died in the womb could deliver in this suite and had one-to -one care. The antenatal screening midwives would inform the bereavement midwife of problem pregnancies in advance so she could make arrangements to speak with the mother. An additional room next to the suite could be used if there was more than one woman requiring the facilities at the same time. The suite was attractively decorated and had access to a garden. Women could enter the suite through this entrance, rather than through the antenatal ward.
- The bereavement midwife organised an annual service at Truro Cathedral for bereaved families, attended by a representative of the Trust board and that some parents attended year after year. There was a small garden with a tree of remembrance, where families could decorate and leave painted stones.
- The hospital had cold cots so the baby could stay in the Daisy suite with the parents. There were remembrance boxes for families to take home following bereavement, and these were very nicely put together and contained equipment allowing the option to take a cast of their child's hands and feet. A number of local organisations provided support and counselling.
- We asked about the possibility of women on the Daisy suite who wanted to have an epidural for pain relief. We were told this would normally only be relevant women who were at full term. An anaesthetist had risk assessed offering an epidural service for women here, but felt the risk was too high as it would be difficult to monitor women safely in a ward on a different floor from the delivery suite. Where women requested an epidural, they were transferred to the delivery suite they were able to birth in a quiet delivery room at the far end of the delivery suite.
- There was a small satellite mortuary (with an up to date licence from the Human Tissue Authority) used when women had experienced the loss of a baby. The location was the opposite side of the ward from the Daisy suite so staff transporting a baby from the mortuary room to the Daisy suite, carried a covered Moses basket along a ward corridor.
- Midwives did not run Birth Reflections clinics, but said as a general rule they would debrief a mother after a difficult birth though this was not structured and relied upon the woman making a request.
- There were a number of Jehovah's witnesses in the community and hospital staff had developed separate documentation for this group with advice from community leaders. Staff we spoke with had a good understanding of the needs of these women.
- The postnatal ward had two beds for transitional care which enabled women and babies to remain together rather than being cared for in the neonatal unit. Babies who needed treatment such as antibiotic medication stayed with their mothers.
- The infant feeding midwife ran a tongue tie clinic in the hospital. Some community midwives offered tongue tie release where babies had trouble feeding, in line with NICE guidance.

- Women with mental health issues or learning disabilities were supported by hospital services and by social care. The maternity system was able to flag women with specific needs.
- We saw from audits that women were very positive about their experiences of the unplanned pregnancy service. The confidential service was available downstairs in the sexual health clinic, to provide privacy for women away from the main clinic waiting area. Referrals were made by GPs or from the sexual health clinics. The service was well-advertised in a range of locations, including schools, colleges and sexual health clinics.
- Women under 14 week's gestation could choose between a medical or surgical termination of pregnancy as appropriate. There was no scanning facility in the clinic. These were carried out in the emergency gynaecology unit in the main hospital to have the pregnancy dated.
- Women found to be more than 14 weeks pregnant were referred to independent providers outside Cornwall. Early medical terminations (up to 10 weeks gestation) could be carried out on the same day. Surgical terminations were carried out as day procedures. The waiting time for manual vacuum aspiration (MVA) (up to 12 weeks gestation) was 2.4 days, and the waiting time for surgical termination of pregnancy under general anaesthetic (STOP), for women up to 14 weeks gestation, was 8.7 days. These waiting times were within the limits recommended by the Royal College of Obstetricians and Gynaecologists. The majority of women using the service were aged between 20 and 30 years. There were 498 medical abortions between April 2016 to March 2017 and 110 surgical abortions. There were also 259 surgical abortions at West Cornwall hospital in the same period.
- The gynaecology service had arrangements for women with special needs including those with language barriers, in line with RCOG guidance. Interpreters were available.
- The service could arrange contraception for women having terminations. The method was generally long-acting reversible contraception (LARC), given following surgical terminations. For convenience some women preferred to visit their own GP or local community contraceptive service.
- Cornwall's rate of abortions was 13.3 per 1000 women which was lower than the national average of 16 women per 1000.
- Termination of pregnancy for foetal anomaly was available to women having maternity care at the hospital. Women were given options about the disposal or pregnancy remains in line with the guidance from the Human Tissue Authority. The trust arranged a monthly cremation attended by the chaplain and there was a memory book in the hospital chapel. The trust did not offer burial but families could arrange this themselves.

Learning from complaints and concerns

- Information about how to report concerns was available to women and families.
- Between April 2016 and March 2017 there were 20 formal complaints for gynaecology and 12 for maternity. Five of the maternity complaints concerned pregnancy loss. Themes of complaints were communication, including failure to communicate in a timely fashion or failure to communicate compassionately. Even with a relatively low number of complaints, not all women had a response within the 25 day deadline. The mean time to respond to complaints was 74 working days.
- The majority of complaints (74%) were partially upheld or upheld. Complaints were discussed in the obstetrics and gynaecology directorate meeting.
- A database of complaints made informally by telephone or email showed 63 complaints in the same reporting period. Only 10 of these were about maternity services. The themes in gynaecology were mainly about waiting times with some about medical and nursing care.
- We saw that for maternity complaints, staff often invited women to come to the hospital to discuss their concerns with a senior midwife or doctor, depending on the nature of the complaint.
- Staff were aware of the themes of complaints in the year April 2016 to March 2017: the top two themes were communication (24%), failure to communicate in a timely way and to communicate compassionately. The next most common complaints were about clinical treatment and patient care.

Are maternity and gynaecology services well-led?

Maternity and gynaecology

Inadequate

We rated well-led as inadequate because:

- There was no clear vision or strategy for service development in either the maternity or gynaecology service.
- Management of the maternity service was reactive in response to external reports or adverse events. At times the service focused on solving immediate issues without risk assessing the consequences of these actions on the wider service.
- The governance processes did not ensure quality, performance and risk were managed. The maternity dashboard held predominantly clinical information with no staffing information included.
- There was an absence of comprehensive performance and quality audit plan. Several significant risks were identified which were not on the register and risk assessments had not been undertaken.
- There was very little evidence of improvements by self-examination or benchmarking with other similar services. The limited range of audits restricted the scope of quality monitoring and meant there could be little assurance that practices followed guidelines.
- Decisions in the maternity service were traditionally made at the top and then communicated to staff. Staff had become accustomed to a top down leadership style, however, efforts were being made to effect a change in this.
- Some staff continued to feel the culture of the maternity services was punitive despite actions to involve more staff in open discussions about the service culture.
- Bullying and undermining behaviour towards other staff, peers or juniors appeared to have been insufficiently challenged in the maternity service.
- This meant that there was not a clear reporting line of key clinical issues affecting the maternity service. The operational decision-making group for midwifery did not feed into either the obstetrics and gynaecology meeting or the maternity forum.

However:

- New management appointments in maternity had the potential to change the culture and involve staff more in decision making over time.
- A senior leadership programme for all senior managers had taken place which was in the process of being rolled out to other staff to strengthen staff understanding of leadership and develop skills.
- A variety of staff engagement activities following from the cultural review had tapped into staff views about the service and opportunities for improvement, and staff were taking forward some of these.

Leadership of service

- The head of midwifery was supported by two matrons, one for the hospital service and one for community. Until shortly before our inspection two matrons had been managing the service for some time, but both matrons had left within the previous two months. A new hospital matron had been appointed who had previously been a community midwife at the trust. The second was an outside appointment who had not yet taken up post. A number of staff we spoke reported feeling encouraged by the management changes, which had the potential to make wider service improvements over time. We were given examples where the previous community matron had already begun challenging processes and ways of working in their new post.
- In 2016 both the head of midwifery and clinical director had a wide brief including gynaecology, sexual health, children services and maternity. When the head of midwifery resumed her midwifery duties in May 2017, after working on another hospital project, her role had been redefined to focus primarily on maternity. This allowed the lead to focus their efforts on managing and improving the midwifery service.
- The clinical lead for gynaecology, obstetrics and sexual health was an obstetrician who had been in post for 10 years. In obstetric anaesthetics, a new consultant obstetric anaesthetic lead had taken up the role in May 2017.
- The trust had run a senior leadership programme for all senior managers including clinical directors, associate directors and senior midwives, with the aim of improving leadership skills within the trust. Similar leadership training was now to be cascaded to other staff. A bespoke programme for matrons and band 7 midwives with leadership responsibility was planned to start in August 2017 to strengthen staff understanding of leadership and develop skills.
- Consultants provided leadership to junior doctors. However, there were some indications that some

consultants worked individually rather than as a cohesive maternity and gynaecology team. Clinicians did not necessarily follow the same processes. For example, the clinical director could not assure us that all the consultant obstetricians followed the same practice as they did in relation to patient's fasting times before caesarean sections. No audit had been undertaken to test this.

- Staff told us decisions in the maternity service were traditionally made at the top and then communicated to staff. Staff had become accustomed to top down leadership and some responded to our questions by saying 'the head of midwifery would know' rather than suggesting an answer themselves. Reflecting the need for more devolved management, an increase in the number of delivery suite coordinator posts had been agreed to ensure these staff had protected management time built into their roles. However, no additional appointments had been made at the time of our inspection.
- We saw that this top down approach was changing. As a result of the cultural review, undertaken in 2016, there had been many 'listening in action' events to support midwife led improvements including the setting up of development groups. Examples included the introduction of the practice development and audit midwife and midwife involvement in the development of the new birth centre. In the delivery suite we saw a large board where staff were able to write suggestions for improvements, and we were able to track some of those suggestions through for example, mood lights and fans in the delivery rooms.
- There were plans in place to develop band 6 midwives, and we were told that each ward manager had a deputy in place to assist with succession planning and developing a competent and sustainable workforce. We were told these deputy posts would be for 12 months at a time, to allow other midwives to develop, and there was a financial incentive for taking on this role. We were not able to corroborate this on inspection as it was a new venture.
- A lead consultant and a gynaecology clinical matron led the gynaecology service. A gynaecology risk manager supported the lead gynaecologist for risk management.

Vision and strategy for this service

- There was no written vision for the maternity and gynaecology services. Both services had a 'plan on a page' which was a list of various areas of focus for the year ahead. Staff we spoke with were not aware of this plan, or how it translated into their daily work. For the maternity service we also saw an undated document 'Striving to be the best maternity service in the country' which appeared to be a briefing document for midwives in advance of the CQC inspection. We saw no reference to the 5 year vision set out in the National Maternity Review 'Better Births' 2015 for maternity services to improve outcomes for mothers and babies, and become more personalised.
- Consultants' ideas about the service varied with their interests and we saw no shared medical and midwifery vision for either the maternity service or gynaecology.

Governance, risk management and quality measurement

- The governance processes did not ensure quality, performance and risk were managed. The governance lead for obstetrics was the clinical lead for gynaecology, obstetrics and sexual health. We reviewed a range of meeting notes including the monthly divisional review meeting, the obstetrics and gynaecology directorate meeting, and risk management and clinical governance meetings. From the meeting notes, it was not clear how effectively the different meetings related to each other.
- The limited range of audits restricted the scope of quality monitoring and meant there could be little assurance that practices followed guidelines.
- The top level governance meeting was the monthly divisional review meeting covering maternity, gynaecology, children and young people and sexual health departments. This was a strategic trust level meeting to which the maternity service submitted a report as part of the divisional internal assurance process. We noted in the April 2017 minutes that figures were quoted from the 2015/16 dashboard rather than the 2016/17 dashboard indicating preparation for the meetings might not always be thorough, or robustly challenged.
- An obstetrics and gynaecology (O&G) directorate meeting was held once a month. This meeting had a set agenda including ratifying guidelines developed in the monthly guidelines meeting, reviewing clinical dashboards, finance, risks and serious incidents. Meetings had a formal action log with named individuals to take forward actions. The notes of the monthly meeting were factual and brief. There was little

detailed discussion of risk. A matron and the head of midwifery represented midwifery at that meeting. The maternity and gynaecology clinical scorecards were considered by exception and we saw no discussion of the maternity dashboard, but more action in relation to points on the gynaecology dashboard, such as reviewing handover sheets to identify complications, or returns to theatre. For two successive meeting there had been no foetal medicine dashboard. There was little evidence of challenge in the brief notes of these meetings, and it was not clear how actions were taken forward where compliance was not meeting the set targets.

- The main maternity meeting was a maternity forum held every two months. At this meeting there was evidence of a review of the maternity clinical scorecard, although no specific focus on improving the red and amber scores. There was some discussion of risk themes. The notes of the April 2017 meeting showed the standard agenda items were all discussed. However at the June 2017 meeting some standard items were not discussed and carried forward to the next meeting. There was no community midwifery update, no update on the new maternity information system or NIPE update which meant staff had to wait another two months for discussion of these. The maternity forum feedback was reported on at the obstetric and gynaecology meeting, but the only feedback recorded in the minutes was that the meeting had been well-attended.
- The operational decision-making group for midwifery was the monthly senior midwives team meeting. This group had been set up in April 2017. There were no standard agenda items. Minutes and action points were recorded. This meeting did not appear to feed into either the obstetrics and gynaecology meeting or the maternity forum. This meant that there was not a clear reporting line of key clinical issues affecting the service.
- The practice development midwife led a monthly guidelines review meeting as the maternity service was following through a project to update all guidelines.
- The maternity dashboard held predominantly clinical information with no staffing information included.As a result, these did not receive scrutiny through the governance process and managers were not held to account for performance.
- The head of midwifery was responsible for ensuring risk management policies and procedures were in place within maternity services .The risk midwife reviewed all maternity incidents and ran weekly meetings to review the more significant incidents. She produced a risk newsletter each month to share learning from incidents and complaints which she emailed to all midwives. We saw copies on display on noticeboards. A link midwife from each of the three midwifery teams had been nominated to attend the monthly risk management forum to report back to their teams, however in talking with staff we did not consider that all understood and were aware of their role in minimising clinical and non-clinical risks.
- We were not assured that the management of risk was joined up or well-coordinated. The risk midwife had been in post for over a year, and was very keen and enthusiastic. At the time of our inspection, she did not have management responsibility or review of the risk register as part of her remit, and had only the month before been able to access the risk register. We were told this was due to change in the near future as the person responsible for the risk register was leaving.
- Not all high level risks we identified were on the maternity risk register and action to manage risks was slow. Risks described as 'above tolerance', or too high, on the risk register included the impact of attempts to change the culture following the culture review, the risk of staff misinterpretation of CTGs and the risk of high risk women labouring on the antenatal ward caused by lack of capacity on the delivery suite. Midwifery staffing was not on the risk register, despite the ageing workforce and number of retirements, sickness level (5%) and vacancies. The risk from staff retiring was predictable and could have been mitigated well in advance of their departure. There was little evidence of robust succession planning in either maternity or gynaecology.
- Senior leaders had no assurance that local level risks (those classed as eight on a scale up to 20) were managed appropriately as there were clear gaps in the capturing of risks. We were told that the ward managers managed their local risks. When asked how staff knew that the grading was appropriate we were told ward managers tended to rate risks higher than they should be and have them downgraded, rather than have a discussion about all risks on the risk register. The risk midwife did not have oversight of these and it was not velar where challenge and monitoring of actions to mitigate such risks occurred.

- Excessive temperatures in the postnatal ward had been identified as a risk in spring 2017. We were told this risk was only added to the risk register shortly before our inspection in July. At the time of our inspection in July 2017, when the weather was again hot, we found there was no system to monitor temperatures and the mitigating actions on the risk register were limited to the provision of portable air conditioning and arrangements to make working conditions more tolerable for staff such as wearing scrubs. Although we saw that discussions with Estates were potentially leading to a more permanent solution, this was not mentioned as mitigating action on the risk register.
- Maternity and gynaecology dashboards presented information alongside trust targets and national comparisons. The dashboards did not contain staffing information or information about staff training which would have enabled managers to have a comprehensive overview of performance. The maternity dashboard was discussed in the multidisciplinary maternity forum, and the gynaecology dashboard in the clinical incident meetings. Dashboards were tabled for information at the obstetrics and gynaecology meeting but the meeting notes did not indicate discussion or challenge. The maternity dashboard was also tabled quarterly at the Quality Assurance Committee, but this appeared to be as a presentation for assurance rather than a discussion. Absence of detail such as training compliance meant the division had no oversight of areas where there was a shortfall in order to hold local managers to account. We found management in maternity to be reactive rather than responsive. Although some of the entries on the maternity dashboard were benchmarked against national goals, we saw little benchmarking of other aspects of the service for quality comparisons.
- We observed that some changes in the maternity service were made without full consideration of the wider implications. For example responsibility for 'out of hours' triage was given to the Day Assessment Unit without recognising the peaks of workload. We saw there had been at least 10 occasions in the previous six months when triage calls were diverted to Penrice birth centre midwives because of pressure on the Day Assessment Unit midwife. In July it was decided that Penrice would in future take all triage calls from 5pm to 8pm to relieve the pressure. We were not aware of any formal monitoring of the pressures before the decision was made or that the activity at Penrice had been taken into account to ensure that staff at that unit had capacity to take those calls. Similarly, the decision to place floor fans in corridors to help cool the postnatal ward had been taken without assessing the trip risk to mothers and staff, or the increased risk around infection control from their use.
- However, we saw evidence that the service had made changes because of external reviews, such as the standardisation of community midwives' equipment as a result of the recommendations from the local supervising authority (LSA) following an infant death.
- In gynaecology the meeting structure was more coherent. The associate medical director chaired a quarterly clinical audit and outcomes group which was the quality improvement vehicle for the service. The gynaecology consultant held monthly clinical incident review meetings, attended by the matron, gynaecology governance lead, ward sister and doctors. This meeting also reported on recent audits. A presentation to this meeting gave an effective overview of incidents and an update on other activities. However, there was no gynaecology risk management newsletter to keep staff in the department up to date as the presentation was considered to cover this, and some issues we identified were not on the risk register.
- Correct processes were in place to ensure that legal processes were followed in relation to the Abortion Act 1967. Two medical practitioners signed the certificates of opinion (HSA1) and a process was in place to ensure the doctor taking responsibility for the termination notified the Chief Medical Officer through the Department of Health within 14 days.

Culture within the service

- Concern about a long-standing negative culture in the maternity services in 2016 had led to an external review by a senior independent maternity adviser, known as the 'Cultural review'. The review, carried out in May 2016, involved observation, discussions with staff and a staff survey. We saw evidence of a number of initiatives taken since this review to provide opportunities for midwives to discuss their concerns, and become involved in changing the culture within the service. Midwives had attended 'listening in action' events to support midwife led improvements including the setting up of development group workshops between October and December 2016. Such workshops were a

well-recognised approach used in the NHS for listening to staff, and supporting them to make the changes in the way the service worked. The Royal College of Midwives had run behaviours workshops and reported observing some improvement.

- Monthly reports of progress following the cultural review were made to the board, and a 'palpable improvement' had been reported at that level. However, some senior managers in maternity felt there had been a six month period where no progress appeared to have been made. They recognised that there had been action more recently.
- Some midwives we spoke to did not fully understand the purpose of some of the activities and workshops and wondered whether the approach could be sustained. However, we noted that the Listening in Action events had revealed areas where midwives thought the service could benefit from changes in practice and we saw these were being taken forward. For example giving band 7 coordinators more management time, and extending the role of the MSWs. There appeared to be strong leadership at the top of the midwifery service but relatively little sharing of information and plans, or devolved decision-making. We found a gap between senior managers' views and the feelings staff on the ground. Trust and respect, included seeking consensus, was one of the trust's values, but midwives, especially those in the community, did not feel they were trusted to give a view. A recent example of where staff had not felt consulted was the decision to reduce the service at Penrice birth centre. Staff felt managers had not listened to staff concerns about lone working at that location at night. The birth centre was separate from the main hospital building with no security guard on site. The ability of staff to challenge is a well-recognised component of a safety culture. The lone working risk was not on the risk register.
- A few staff appeared reluctant to speak openly and some were visibly upset that some midwives had left or been dismissed for a variety of reasons. Midwives spoke to us on an individual basis, however only six midwives, all of whom senior, attended the focus groups which run throughout the inspection. We were told staff that had raised concerns with the CQC at the previous inspection had been penalised. Some staff described a 'reluctance put their head above the parapet'. We noted that 30-50 midwives chose not to respond to several of the questions in the cultural review, and 140 did not comment on the question about how they were treated in an investigation. Midwives told us this was in case they could be identified from their responses.
- We spoke with as many staff as we could that were on duty and found perceptions were very varied. Some staff expressed varying degrees of frustration about it being difficult to get their view heard and not enjoying their roles. On the other hand, we met many other staff, mainly newer staff from outside Cornwall, who were very positive about working at the hospital or in the community. In some instances, it was as though we were speaking with staff from two different hospitals in terms of their feedback to us as to what it was like to work at the trust and about the culture.
- The cultural review had highlighted challenging behaviour between peers, and we observed examples of this. Staff told us that when referring a woman between services, for example to the Day Assessment Unit or the delivery suite, the response depended on 'who you speak to'. Midwives told us they would often call again later and receive a different response.
- Bullying and undermining behaviour towards other staff, peers or juniors appeared to have been insufficiently challenged in the maternity service. Confrontational behaviour was not challenged and the service seemed to accept that some staff 'are just like that'; but such behaviour was a poor role model for other staff. A senior member of staff told us there were 'some challenging individuals' in the service and another described forceful people, some of whom were resistant to change. We noted that junior doctors had reported issues of undermining and poor communication from some of the midwives on the delivery suite. Midwives also gave us examples of their peers questioning their clinical judgement in a way they considered unfair and undermining.
- Some feelings of 'them and us' appeared to exist between community and hospital midwives. We had noted that community midwives did not have the same training as hospital midwives, and they worked in small dispersed groups, because of the geography of Cornwall, which meant some were somewhat cut off from the hospital. We were told a working group had been set up to identify the reasons for barriers and make proposals. Solutions included proposed changes in rotation patterns to improve both sides understanding

of the different working environments. An external facilitator had been appointed to work with staff on issues of communication between teams but this work had not started at the time of our inspection.
- An unnecessary irritant for some clinicians was the lack of communication from hospital managers about making changes. Equipment was moved without consultation. For example the computer from the anaesthetic office had had been given to midwives, leaving anaesthetists without a computer. In gynaecology outpatients, a desk and computer had been moved from the colposcopy clinic to the hysteroscopy clinic without consultation with the lead for the service or advance warning to staff that were then left with too few desks.

Public engagement

- There was limited formal public engagement in the maternity services. The former Maternity Service Liaison Committee (MSLC) had not operated for some time. There was an intention to re-launch this as Maternity Voices. Initial work included making videos of the stories of women who had made complaints and sharing these with midwives for learning.
- Midwives acknowledged that the geography of Cornwall made it difficult to bring together a wide range of views and find out what women wanted in their antenatal and postnatal care, and to design the service around their needs. Maternity services, events and fundraising were advertised on Facebook which was a medium suited to communication to women within the county, who were geographically dispersed over a wide area
- Midwives started 'The Happy Birth Project', to appeal for funds to improve the ward environment for women and families. This enabled the refurbished post-natal ward to have wall decorations, improvements to the day rooms on both wards, mood lights for the delivery rooms and birthing balls, mats and other aids. Following from this, 'Project 55', was a user group bringing together staff and volunteers to design aspects of the new alongside birth centre in the year leading up to its opening.

Staff engagement

- There were many long serving staff. The hospital provided the only maternity service in the county. As a result, most staff had limited opportunities to experience work in other hospitals.
- Morale was mixed. Maternity support workers appeared to enjoy their roles and said midwives had begun to involve them in more activities over the past year. Community midwives working at a distance from the acute site seemed more positive about their roles, despite some frustrations about unfilled vacancies in the west of the county. Among hospital midwives some staff were very positive and confident about their roles, whilst others seemed rather disillusioned.
- 'Listening in action' events, which had started as a result of the cultural review gave midwives and support workers the opportunity to have their voices heard and to participate in service development and improvement.
- Practice development and risk newsletters were issued monthly to keep staff to date and provide a focus for discussion at local safety briefings and team meetings.
- A number of staff had taken part in a workshop in July 2017 ('Whose Shoes', based around a board game) which included the managerial teams, midwives, community midwives and women, to capture women's experience of using the maternity services. This acted as a culture building session and a set of actions for all staff to complete. Staff spoke highly of this and said it had gone some way to breaking down the barriers between them.
- Staff on the delivery suite and the antenatal ward reported often missing breaks. Staff did not always record this on the incident reporting system, but band 7 midwives had recently started to collect data on missed breaks in the delivery suite. They were also monitoring staff views of their experience of their shift on the unit to identify issues about teamwork and interpersonal behaviour.

Innovation, improvement and sustainability

- Facebook was well-used as a communication tool about the maternity services and staff were using it to seek women's views of the service.
- Sexual health had used Twitter and Facebook to good effect to encourage Chlamydia screening and other services for young people to promote free online test kits and events in different locations.
- In order to ensure a stable senior midwife team a project had begun to train midwives on a rotational basis to be senior midwifes. While they were on their rotation they would receive additional training and support and have a small payment uplift to compensate for the added responsibility and work.

Services for children and young people

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

Information about the service

Services for children and young people at the Royal Cornwall Hospitals NHS Trust are part of the Women, Children's and Sexual Health Division. The hospital provides services for children up to the age of 18 years on the children's inpatient wards, the high dependency unit, the paediatric assessment unit, the day case unit, children's outpatient department, community paediatrics and the neonatal unit.

Acute paediatrics offers a service for new, follow up, elective, planned and emergency admissions. The majority of admissions are unplanned and come through the paediatric assessment unit.

There are 41 inpatient beds which cover medicine and surgical patients, day case work and an outpatients department. The paediatric wards are situated on the fifth floor of the hospital and are divided into areas with a paediatric assessment unit, Polkerris ward and the high dependency unit (HDU) being on the west wing of the unit and Harlyn ward, Cancer and Leukaemia In Children (CLIC) ward and Fistral ward situated on the east wing.

The paediatric assessment unit provides four side rooms for admission and observation for children and young people. Polkerris has 12 beds comprising of eight side rooms and one four-bed bay providing care for children and young people aged 0-11 years with medical and surgical conditions, trauma and orthopaedics. Paediatric HDU is a three-bed bay providing high dependency care for children and young people aged 0-16 years.

Harlyn is an eight-bed ward providing day case, general surgery and specialties, trauma and orthopaedics elective surgery on Monday to Friday from 7.30am to 10pm. The CLIC ward has four side rooms for the treatment of children and young people with cancer and leukaemia. Fistral ward is a ten-bed area providing care for children and young people aged between 11 and 16 with medical, surgical and mental health conditions.

Paediatric surgical services are provided by the general surgical and trauma consultant led teams.

A surgical theatre and recovery area are specifically for the use of children and young people. These services are managed within the surgical division. However, children who require inpatient care will be admitted to the appropriate paediatric ward.

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

An outpatient department is situated on Gwithian ward on the floor below the children's wards and is dedicated for use by children and young people. This has four day 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.

There is a large playroom and play specialists who also provide activities at the bedside. A school service is available in the school room during term time for all children in hospital for five days or more.

Services for children and young people

The neonatal unit is located on the first floor of the Princess Alexandra building of the hospital. There are a total of 20 cots, four intensive care cots, three high dependency cots and 13 special care cots. The level two unit i**s** designated a local neonatal unit within the south west neonatal network framework. It provides care for babies above 27 weeks gestation, stabilisation of babies born before this gestation prior to transfer to network units, and short term (typically less than 48 hours) intensive care. The majority of admissions to the unit are via the labour suite although some are transferred from elsewhere in the network. Babies who require ventilation for longer than 48 hours are transferred to a more specialist unit.

The unit has a neonatal outreach service that offers specialist nursing support to babies who have been discharged from the neonatal unit with ongoing additional needs, such as home oxygen or tube feeding. The team works closely with community colleagues to promote an earlier discharge where possible. The paediatric community therapy team also provide support to the unit during babies' admissions and in outreach clinics alongside the neonatal outreach nurses.

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

The trust provides a comprehensive community child health service covering the whole of Cornwall and the Isles of Scilly supporting a population of over 110,000 children, with close links to the acute service. Community child health is supporting the government's special educational needs pathfinder project. The service offers support to children with neuro-disability, physical disability with therapy and dietetic needs, autism, developmental delay, long term life limiting conditions and safeguarding concerns. Community therapists work across the community providing physiotherapy and occupational therapy to a range of children. There is also a child in care team who monitor and assess the health needs of children in care.

We visited the paediatric and neonatal areas as well as facilities for adults which were also used by children and young people between 4 and 7 July. We also made an unannounced visit in the evening of 17 July to the paediatric emergency department and during the day on 18 July to the child development centre.

During our inspection we spoke with 17 parents and nine children and young people. We also spoke with over 40 members of staff, including nurses, consultants, doctors, therapists, administration staff, support staff and cleaning staff. We observed how babies, children and young people were being cared for, handover meetings between staff teams, and looked at care and treatment records, and other documents provided by the trust.

Services for children and young people

Summary of findings

We rated the services for children and young people as good because:

- Risk was managed and incidents were reported and acted upon with feedback and learning provided to staff. Staff adhered to infection prevention and control policies and protocols.
- The units were clean, organised and suitable for children and young people.
- Treatment and care were effective and delivered in accordance with best practice and recognised national guidelines. There was excellent multidisciplinary team working within the service and with other agencies.
- Children and young people were at the centre of the service and the priority for staff. Innovation, high performance and the high quality of care were encouraged and acknowledged. Children, young people and their families were respected and valued as individuals. Feedback from those who used the service had been consistently positive.
- Care was delivered in a compassionate manner. Parents spoke highly of the approach and commitment of the staff that provided a service to their children.
- Children received excellent care from dedicated, caring and well trained staff that were skilled in working and communicating with children, young people and their families.
- Staff understood the individual needs of children, young people and their families and designed and delivered services to meet them.
- There were clear lines of local management in place and structures for managing governance and measuring quality. The leadership and culture of the service drove improvement and the delivery of high-quality individual care.
- All staff were committed to children, young people and their families and to their colleagues. There were high levels of staff satisfaction with staff saying they were proud of the units as a place to work. They spoke highly of the culture and levels of engagement from managers.
- There was a good track record of lessons learnt and improvements when things went wrong. This was supported by staff working in an open and honest culture with a desire to get things right.

However:

- There was no clear nursing observation area on the high dependency unit and this represented a risk to children who were not visible to nursing staff at all times.
- There were insufficient numbers of suitably qualified nursing staff in the paediatric emergency department to provide safe care at all times. There were also no formal processes in place to ensure appropriate cover was in place in the department at all times, particularly during periods when the qualified nurse was temporarily absent from the department.
- Although safeguarding training compliance had improved it remained a challenge and required continued improvement.
- Completion of some mandatory training was below trust target and required improvement.
- There were delays in completing discharge summaries and performance required improvement.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We rated safe as requiring improvement because:

- There was no clear nursing observation area on the high dependency unit and this represented a risk to children who were not visible to nursing staff at all times.
- There were insufficient numbers of suitably qualified nursing staff in the paediatric emergency department to provide safe care at all times. There were also no formal processes in place to ensure appropriate cover was in place in the department at all times, particularly during periods when the qualified nurse was temporarily absent from the department.
- Although safeguarding training compliance had improved it remained a challenge and required continued improvement.
- Completion of some mandatory training was below trust target and required improvement.

However:

- There were systems in place for recording and learning lessons from incidents and staff told us they were encouraged to report incidents.
- Nursing and medical records had been completed appropriately and in line with each individual child's needs.
- Staff we spoke with were knowledgeable about the trust safeguarding process and were clear about their responsibilities.
- The units were clean and well organised. Staff adhered to infection prevention and control policies and protocols.
- Systems were in place for the safe storage and administration of medicines and appropriate audit trails were in place for controlled drugs.

Incidents

- Staff were open, transparent and honest about reporting incidents. There were systems to make sure incidents were reported and investigated appropriately. All staff received training on incident reporting and risk management. Staff were able to show us the incident reporting policy which contained incident classification and actions for managers. Most staff said they would have no hesitation in reporting incidents and were clear on how they would report them.
- All incidents were reported directly onto the incident reporting database which was available from all networked computers within the trust. Any person directly employed by the trust or who was working on a temporary, locum, or agency basis, including placement students, were able to complete an incident form. The appropriate manager was notified of the incident by email and required to carry out an investigation. Once reported, incidents were reviewed by the appropriate clinical manager and where necessary investigated. Most staff said they were able to get feedback on incidents they reported.
- There were procedures for the identification and follow-up of all serious patient safety incidents and non-clinical incidents. These procedures defined the roles and responsibilities of those involved in a comprehensive root cause analysis investigation.
- Incident reporting activity was reviewed and discussed at management and governance meetings. We saw evidence that learning was discussed through action plan review meetings.
- There was a monthly review of incidents and a newsletter was produced which was provided for all members of the team. The newsletter highlighted any themes, actions required and hot topics.
- There had been several incidents where serum bilirubin levels (heel prick blood levels) had been plotted on the wrong chart. As a result a new checking system had been introduced where the doctor was required to write the gestation of the baby on the page next to the printed gestation. Another example related to an old resuscitaire that was identified as unsafe because staff were not familiar with its use during a training simulation exercise. As a result all doctors received one-to-one training and this was checked every morning prior to starting work. A bid for a replacement had also been made.
- There was one serious incident reported by children's services under the Strategic Executive Information System (STEIS) for the period June 2016 and May 2017.This involved an accidental sharing of confidential

information. There had been a full investigation and the report was presented for review to the operational governance meeting and actions were put in place to prevent a reoccurrence.

- The incident reporting policy set out the processes for reporting and managing incidents. The serious incident reporting policy and procedure set out how the trust reported investigated and managed any serious incident. The key features included which incidents would be graded as serious incidents, and application of the duty of candour for incidents which caused severe harm or death. The policy described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process.
- Although we did not see any examples of where duty of candour had been applied, staff demonstrated an understanding of their responsibilities. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person. Duty of candour was also covered in the mandatory training programme and the induction for new staff.
- To ensure compliance with the incident reporting process, serious incidents resulting in significant, major harm or death were tracked through the serious incident process where assurance was received at the fortnightly executive-led serious incident review panel. Minor harm was tracked by the record of each qualifying incident and overseen by the division and recorded on the electronic reporting system. The medical director had overall responsibility for compliance supported by the head of clinical governance.
- Between June 2016 and May 2017, the trust reported no incidents which were classified as never events for children's' services. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The children's services held paediatric mortality and morbidity meetings and minutes showed that cases were discussed and learning points and actions taken were documented.

Safety thermometer

- There was a good safety performance on the units. The service participated in a paediatric specific safety thermometer in the form of paediatric and neonatal early warning scores as well as the national safety thermometer performance. 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; patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis).
- From April 2016 and April 2017 harm free care was consistently maintained across the service. Data from the patient safety thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections for children's services.
- Safety bulletins and national and local alerts were discussed at weekly leadership team meetings and disseminated to the teams.

Cleanliness, infection control and hygiene

- The units and most clinical areas were seen to be visibly clean, well-organised and tidy to make cleaning easier and optimal. There were reliable systems in place to monitor and maintain standards of cleanliness and hygiene.
- In all areas we visited, the floors, walls, curtains, trolleys and areas in general were visibly clean. Bed and cot spaces were also visibly clean in both the easy and hard to reach areas. Bed linen was in good condition, clean and free from stains or damage to the material. Notices and posters were laminated and stuck to walls or noticeboards with pins or reusable adhesive.
- However, some areas in the wards were showing signs of age, wear and tear, which was making them harder to keep clean.
- All areas had a dedicated team of cleaners during the day who ensured the areas were clean and tidy. There were daily schedules and weekly tasks, alongside deep cleaning as and when required. Cleaning staff were able to show us their work schedules Cleaning equipment was colour coded, clean and well maintained, and stored in a locked area.

- The cleaning staff were fully integrated with the clinical teams and one member of staff said "I like to be thorough and take pride in my work." However, workloads were high in all areas and not all shifts were covered during periods of absence leaving areas compromised on occasions. Nursing managers liaised closely with cleaning supervisors to mitigate any risks to areas. Cleaning staff did not work in the evenings and nurses said they routinely emptied clinical and non-clinical bins and topped-up paper hand towels during their night shifts.
- Disposable items of equipment were discarded appropriately, either in clinical waste bins or sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.
- We observed all clinical staff, including doctors, nursing staff and therapists washing their hands and using anti-bacterial gel in line with infection prevention and control guidelines. Non-clinical staff including reception and administrative staff and cleaning staff were also observed to be following the guidelines. Children and their parents were asked to wash their hands and use alcohol gel when arriving on the units and this was freely available and clearly visible. All staff, as required, were bare below the elbow when working on the units.
- The children's ward was well equipped with hand wash basins with good access to liquid soap and paper towels for staff to use. There were wash hand basins at the entrance to the neonatal unit and visitors, including CQC staff, were asked to wash their hands before entering the unit.
- There were regular monthly environment audits undertaken for all units looking at the general environment. This included the visible cleanliness of walls, windows, ceilings and floors, hand basins being equipped with liquid soap and paper towels, and availability and replenishment of alcohol gel bottles. Furnishings and fittings were examined to check they were in a good state of repair. Clinical rooms, bathrooms, toilets, bed spaces, the use of personal protective equipment, waste disposal, linen management, the sluice rooms, store rooms, kitchens and equipment were also checked. Scores ranged from the lowest score of 85% to the highest score of 92% against an expected internal overall audit score of 85%, and issues and recommendations were highlighted. Comments included a hand wash basin not being plug free; a bottle of body wash being found in the female shower room; bed/couch/trolley frames appearing to be dusty and chairs appearing damaged. Other comments related to plastic covers on pillows not being sealed or intact, paper posters on display being fixed with sticky tape; and temporary closure mechanisms not being used when bins were not in use.
- Recommendations from the audit included ensuring **c**linical staff were aware of their cleaning responsibilities. The hand wash basin was replaced in the treatment room with one that was plug and overflow free; staff were reminded to remove items if they were found in the bathroom to ensure they were not used by other patients and to use a bed space checklist on patient discharge and to discuss cleaning frequency with the cleaning supervisor. A replacement programme of chairs and a review and replacement of pillows was also recommended. Staff were reminded to ensure posters were laminated and fixed with reusable adhesive and to operate the temporary closure device when bins were not in use.
- There were no unit-acquired methicillin resistant Staphylococcus aureus (MRSA) infections or incidences of unit-acquired Clostridium difficile during the past year. Infection control performance indicators from 30 April 2017 which included all reportable bacteraemia, Clostridium difficile, hand hygiene compliance, intravascular line, urinary catheter compliance, elective and emergency screening were found to be 100%, apart from the intravascular line audit compliance which was at 90% in Harlyn / Fistral and 98% in the neonatal unit.
- The most recent CQC children's survey was completed outside of the reporting period April 2016-April 2017 as it was conducted in 2014. The results of this survey showed the trust scored 8.79 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.

Environment and equipment

- The design and use of the facilities in most areas were suitable for children and young people. In some areas the design required improvement to ensure people were safe.
- The neonatal unit was bright and welcoming and suitable for babies and their families.
- The Polkerris ward area was tired and with areas that were cluttered, and parents commented that there were

not enough toilets and showers. The high dependency unit was situated at the far end of the ward with no clear nursing observation area and this represented a risk to children who were not visible to nursing staff at all times despite staff best efforts to remain in the bays whenever possible. This had been identified as a risk by ward managers and the repositioning of the unit was a priority to ensure observation at all times.

- Fistral ward was designed as a result of feedback from young people and their families and funded through charitable funds and the hospital's league of friends. There were separate bays for boys and girls.
- A bell had recently been fixed to the ceiling in the CLIC unit for children to ring when they had a good news story i.e. completing their course of treatment. They would remove their photo from the board and place it on a painting of a pirate ship on the opposite wall to signify sailing away.
- A surgical theatre and recovery area were specifically for the use of children and young people. with specialist equipment designed for children, including for resuscitation. Curtains provided privacy for children. Day surgery theatre undertook dedicated children's lists and had bays for children with paediatric equipment. Separation for children was achieved with curtains dividing bays.
- There was a dedicated outpatient area for children with six consulting / treatment rooms and waiting and play areas.
- In the child development centre there were therapy rooms and large areas for physiotherapy occupational therapy, an orthotics room, a soft play area and a garden. Most treatment rooms had ceiling tracks for hoists to enable easy transfer.
- There was a large hydro-therapy pool with two levels and an observation trench area for parents to stand. The pool was well-equipped with floats, flippers and hoops. A manual hoist enabled transfer from the poolside to the pool and pool evacuation processes were practised regularly. Sessions were held every Thursday at 1pm.
- There was a dedicated playroom and sensory room. Play areas with a wide range of toys and activities were available in all areas. There was a plethora of art work and notice boards in all main areas.
- There was a well-equipped school room on the main site and also in the child development centre.
- There were security systems to ensure the safety of babies on the neonatal unit and children and young people on the children's ward. To gain access to the neonatal unit, parents and visitors needed to identify themselves at the entrance door and reception desk using an intercom / buzzer system. This meant that access to the unit was as secure as reasonably possible. Effective use of CCTV coverage had enhanced safety arrangements. We observed parents being met and providing identification, and the CQC team were asked to provide identification on arrival to the unit.
- The doors to the children's wards were always closed and locked and entry was gained by using the intercom system. The CQC team were asked to provide identification on arrival at the wards. If a parent was concerned about leaving their child, a member of staff would sit with the child until the parent returned.
- The emergency department had a dedicated area for children and young people. Children were met at the main reception, and would then be admitted to the paediatric department. Access was secure and patients and relatives could only be admitted by emergency department staff. There was a secure waiting area for children and parents and the way the reception area was situated gave nursing staff a good view of the waiting area.
- In the most recent CQC children's survey the trust scored about the same as other trusts in a number of questions about the environment. The score was 9.65 out of ten for the question 'Did you feel safe on the hospital ward?'; 9.35 for the question 'Did you feel that your child was safe on the hospital ward?' and 8.65 for the question 'Did the ward where your child stayed have appropriate equipment or adaptions for your child?'
- Acute paediatrics currently had four bedrooms available on the fourth floor of the Tower block for parents to use throughout their stay at hospital. The accommodation also housed bathroom and kitchen facilities along with a sitting room so that parents could spend time away from the ward. A bid application had recently been submitted for charitable funds to upgrade the accommodation and the outcome was awaited. Each bed space also had a pull down bed next to it so that parents could stay on the ward if they preferred to do so. Each ward area also had parents' kitchens or beverage points and seating areas so they could prepare drinks and food during their stay.
- With the opening of the new neonatal unit in May 2017 the parents' facilities were much improved. Reclining chairs were available at each cot side and there were

five rooms and shower and toilet facilities for parents to stay with their babies prior to discharge. There was a water cooler and a kitchen with facilities for storing and making food. A milk expressing room and milk kitchen were also available together with an interview room that was being used as a quiet room. Linen stores with a range of baby clothes were also available.

- Parents were keen to tell us how impressed they were with the new unit. However, the unit was very hot and plans to address the high temperatures were in hand with air conditioning units and fans being used as a temporary measure.
- There was resuscitation equipment available in all areas appropriate for babies, children and young people. The trolleys carrying the equipment and medicines had been checked daily for completeness and full working order and this was documented. Neonatal resus trolleys were secured with core ties that were too tight to easily open. This was highlighted to staff and the executive team on the first day of the inspection and were replaced with the correct ties the next day.
- It was noted that air/oxygen blenders and pulse oximetry in resuscitation at birth were not available on the neonatal unit as recommended in quality standards for cardiopulmonary resuscitation. The international liaison committee on resuscitation in their most recent consensus on science document suggested that for in term infants receiving resuscitation at birth with positive pressure ventilation, it was best to begin with air rather than 100% oxygen.
- We saw a range of equipment was readily available and staff said they had access to the equipment they needed for the care and treatment of babies, children and young people.
- The trust had a dedicated department for clinical equipment maintenance. Faulty equipment was labelled and the fault reported. Maintenance schedules were produced and work was recorded within an equipment management information system. A single label marked clearly with “Do Not Use After” showed when the next service was due, regardless of its nature.
- Filters for humidifiers were changed every three months and breast pump kits were sent for a medical fast clean as required. Freezers were defrosted every month.

Medicines

- There was good medicines’ management in place to keep people safe. Staff had access to the trust medicines management policy which defined the policies and procedures to be followed for the management of medicines and included obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines. Staff were knowledgeable about the policy and told us how medicines were ordered, recorded and stored.
- We looked at the medicines storage audits, incidents and complaints, storage security, medicines records, and supply and waste-disposal processes. Medicines, including those requiring cool storage, were stored appropriately. During our inspection we found all medicines stored securely, and were only accessible to authorised staff. All cupboards were locked and the stocks well organised. Contents of the emergency drug cupboards were recorded.
- Controlled drugs were stored in separate double locked cupboards. They were checked twice daily and the check recorded by two registered children’s nurses. The record book was up-to-date and completed correctly. However, on the neonatal unit the checks stipulated that all stocks were current and did not identify a check for each drug, whereas a separate signature for each drug was recorded in the record book.
- Where medicines needed to be stored in a fridge, the temperature of the fridge was checked consistently.
- Nursing and medical staff had access to pharmacists. All pharmacy services were available seven days a week between 8.30am and 5pm with a late duty to support the evening and on call service doctors could access various online resources to aid prescribing and administration. There was access to the latest information about medicines through the British National Formulary (BNF) online facility, an intravenous (IV) drug database and the neonatal network formulary.
- Triple checks of all chemotherapy prescriptions were made by the pharmacist, the consultant or staff grade doctor. We saw details of these checks following an intrathecal route of drug delivery.
- Pharmacists carried out medicine reconciliation. They also attended regional pharmacy meetings where changes in practice were discussed.
- We saw from electronic records on the neonatal unit that prescriptions were signed and dated. Antibiotics were prescribed in line with National Institute for Health and Care Excellence (NICE) guidelines. As required, the

weight of the baby was recorded. We also saw from records on the children's wards that documentation was complete and legible. It was signed and dated, with children's age, weight and allergies recorded.
- Medication incidents were reported via the trust electronic reporting system. All medication incident investigations had pharmacy input. There had been 16 incidences where medicine errors had occurred as a result of not following protocol. Following investigation, headlines and actions were introduced to adhere to medical administration and reporting to ensure comprehensive prescribing of medication.

Records

- Children and young people's individual care records were written and managed in a way that kept people safe.
- Medical notes for inpatients and outpatients were locked in secure cupboards to ensure confidentiality and security.
- Patient records were well completed and reflected the needs of children and young people. We reviewed five sets of notes on the paediatric wards and four on the neonatal unit. We checked a range of information including the patient being seen by a consultant within 12 hours of admission, the diagnosis and management plan, evidence of daily ward round, observations, a review of antibiotics and input from the multidisciplinary team. Also recorded were discussions with the family, consent and the signature and date with the name and grade of the doctor or nurse reviewing the patient.
- On the neonatal unit information was clear and concise with details of what was happening now, the long term goals, how they would be achieved, and clear review dates. Care plans were reviewed and updated regularly in conjunction with the baby's family. All paediatric early warning scores were completed and accurately recorded to reflect the routine observations undertaken to determine where intervention might be required.
- Information was similarly complete and concise on the children's ward. Care plans were up-to-date and there was evidence of discussions with the child or young person's parents. Consent forms for sharing information and consent for procedures or operations were completed. All paediatric early warning scores were completed and scored.
- Community teams used paper records whereas colleagues in another community trust in the county used electronic records to which they had no access. This presented a barrier to working efficiently in the community and the trust was looking at the best electronic system available and how best to address network connectivity issues in some parts of the county.
- Records were held in most community localities and therapists carried notes in secure orange bags which presented a risk in carrying multiple notes.
- The community teams regularly audited their notes to ensure outcomes and goals and areas for improvement were highlighted with clear actions to address any shortcomings.
- The community team had an electronic system to collect data for each child on a computer shared drive. Details of treatment programmes were stored and regularly updated as required to ensure reports were up-to-date.

Safeguarding

- There were policies, systems and processes for safeguarding children and young people. The policy was consistent with and referenced safeguarding children legislation, national policy, guidance and local multi-agency procedures. The policy clearly described the roles and responsibilities for staff in reporting concerns about children. It covered issues including possible abuse from evidence of bruising to a child, child sexual exploitation, female genital mutilation, human trafficking, fabricated or induced illnesses, and domestic abuse.
- The policy contained guidance for staff where a child did not attend clinic appointments, which were cancelled for no good reason or the patient did not arrive as booked. A safeguarding referral was generated following repeated failure to attend appointments in the outpatient department.
- Staff we spoke with were knowledgeable about the trust's safeguarding children policy and processes, and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of child abuse. They described what actions they would take should they have safeguarding concerns about a child or young person.
- Staff were trained to the appropriate level relevant to their role and responsibilities. These were set out in the

intercollegiate document 'Safeguarding children and young people: Roles and Competencies for Health Care Staff'. They were familiar with government guidance 'Working Together to Safeguard Children'.

- Although there had been an improvement in safeguarding level one and three training compliance since 2016, records up to April 2017 showed that training was below the trust target of 85% (level one: 84% level two: 66% and level three: 83%). Safeguarding training continued to be a priority. The low level of compliance had been recorded on the corporate risk register and was reviewed on a monthly basis as the increased training programme continued. Training levels were also included within the divisional performance assurance frameworks and monitored at monthly divisional performance reviews.
- The named safeguarding nurse had been in discussion with the head of learning and development and the level one safeguarding children leaflet had been sent out to all non-compliant staff on a monthly basis. Level two training formed part of the mandatory training. The named nurse continued to provide additional bespoke level two sessions. It was projected that the compliance level would increase to trust target by the end of 2017.
- Level three training compliance was achieved by attending the annual updates (4 hours every year). This was achieved by 'in house' updates provided by the named nurse. Every third year level three practitioners were required to undertake multi agency training. The safeguarding children training passport/log had been updated to provide alternative opportunities for staff to meet their level three compliance and was available via the safeguarding children webpage, via the intranet. In March 2017 a safeguarding conference was held at the trust including presentations from specialists in domestic abuse, child sexual exploitation and neglect. This met the required level three training criteria and had a focus on the needs of staff within the acute trust.
- Staff were knowledgeable about female genital mutilation (FGM) and aware of their responsibility to report to the police suspicions of FGM in girls up to the age of 18.
- The trust safeguarding department was located in one office and was an integrated department consisting of a children's team and an adult team. Staff reported the effectiveness of a department that worked together with a team approach across the whole trust.
- The trust had named professionals for safeguarding children: the named doctor and the named nurse who maintained monitoring systems to evidence good practice, monitor staff involvement in processes and offer support.
- The safeguarding children's agenda was supported and monitored through the safeguarding children's operational group (SCOG). The group met bi-monthly and was chaired by the chief nurse and safeguarding lead for the trust. Safeguarding activity was reviewed and monitored through quarterly reports to the quality and assurance committee and reported annually to the board.
- The child community health team provided medical support for the safeguarding of vulnerable children and young people. Community paediatricians worked closely alongside social care services and the police to provide timely medical advice, assessment and opinion to help protect the health, wellbeing and safety of children and young people. The trust subscribed to the south west child protection procedures and was a core member of the local children's safeguarding board.
- The medical advice duty doctor for child protection was available to provide advice on safeguarding 365 days a year. There was a dedicated telephone number during week days from 9am to 5pm and contact could be made via the main switchboard at other times.
- The availability and provision of advice, support and supervision for staff continued to increase. Safeguarding supervision was now mandatory for anyone who made a referral with one-to-one peer reviews and de-briefing available. Safeguarding had also been introduced to journal clubs.

Staff confirmed they were offered opportunities for debriefing and learning following difficult safeguarding events. They were encouraged to use reflection to record their learning.

- Staff told us if a child protection issue was suspected the policy and procedures were followed and were dealt with as a matter of urgency. The paediatric registrar and the named nurse for safeguarding children and young people were contacted for ongoing management and advice. The named nurse and / or doctor was informed of all referrals made to social services. The trust cooperated with any request from the local

safeguarding children board to contribute to multi-agency audits, evaluations, investigations and serious case reviews, including the production of individual management reports.
- Children and young people with a learning disability were identified when they were pre-assessed and / or admitted to the hospital. This was then recorded and filed in their medical records and alerted staff to contact the learning disability liaison team who could then provide appropriate support.
- Safeguarding children admission packs were used and provided the clinical teams with easily accessible information and documentation to support and evidence good quality care. An alert sticker was used for children aged 18 and under who presented to the emergency department. This sticker had been developed by the National Institute of Clinical Excellence (NICE) and was used to highlight possible safeguarding concerns.
- An abduction policy was in place and was overseen by the major incident planning meeting. Staff told us they followed the guidelines set out in the policy and the hospital security team and the police were notified.

Mandatory training

- Systems were in place to ensure staff were up to date with mandatory training. However, there was a mixed performance from staff in meeting the trust target for being up-to-date with the latest mandatory training courses.
- The trust provided a programme of mandatory training for staff which included conflict resolution, control of infection, equality, diversity and human rights, health and safety awareness, mental capacity, information governance, manual handling and safeguarding adults and children.
- Mandatory training was available using a range of methods to maximise accessibility, including face-to-face sessions and e-learning.
- Staff told us that mandatory training updates were delivered to meet their needs and that they were able to access training as they needed it. Most staff said they were up-to-date with their mandatory training or had dates booked to attend training in the near future.
- The trust set a target of 95% completion for nearly all mandatory training courses. The only exceptions were medicines management awareness, resuscitation and advanced life support (four years) and incident commander training, for which there were no targets. Data provided by the trust showed the training target of 95% completion was met for registered nursing staff for equality, diversity and human rights (100%) and Mental Capacity Act training (100%). However, the target was not met for infection control training (83.7%) or duty of candour training (91.3%). The trust target was not met for any of these four training modules for medical staff in children's services. In particular only 39.6% of the required staff were up to date with duty of candour training. Only 60.4% were up to date with infection control training. This meant that not all staff remained up-to-date with their skills and knowledge to enable them to care for children and young people appropriately.
- Staff training analysis reports were available to enable attendance to be reviewed, thereby enabling staff to check their compliance with mandatory training. This supported the appraisal discussion and personal development planning. Managers saw which members of their team were in date and were able to plan when team members needed to complete refresher training.
- There was a clear focus on improving compliance for mandatory training. Team leads were supported with guidance on accessing reports via the electronic record and there was a focus on better forecasting of mandatory training completion renewal with managers tasked to providing assurance of achieving 95% rate of completion.

Assessing and responding to patient risk

- Patient risk assessments were completed and evaluated. There were clear processes to deal with children where their medical condition was deteriorating. There were paediatric early warning scores (PEWS) and neonatal early warning scores (NEWS) completed within 15 minutes of arrival. Each chart recorded the necessary clinical observations such as pulse, temperature and respirations. Staff were knowledgeable in responding to any changes in the observations which necessitated the need to escalate the child to be seen by medical staff. There were details of the escalation required, depending on the scores, on each PEWS chart, and details of the actions taken to respond to the risk. Observations were transferred electronically to hand held devices which were carried by junior doctors at all times and a system alert was generated if scores rose.

- Records demonstrated all nursing staff within the unit had been trained in paediatric life support and consultants had also been trained in advanced paediatric life support. Staff were also trained to recognise sepsis and guidelines were available to follow.
- A policy was in place to guide staff in the transfer and discharge of seriously unwell babies, children and young people including patients with complex continuing care needs.
- Surgical services for children and young people were delivered through a dedicated paediatric theatre and recovered in a dedicated paediatric recovery area. Trauma and emergency surgery was performed in dedicated emergency theatres. There was a dedicated pre-operative assessment clinic which saw all elective surgical cases.
- Recovery was overseen by a designated 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. Second stage recovery for children was on the paediatric wards, with a dedicated day case area, called Harlyn ward and inpatients on the two wards, dependant on age.
- Safety checking procedures were in place in theatres to ensure the right child was present. There was a WHO Surgical Safety Checklist for paediatric interventions under general anaesthetic. A monthly audit of the checklist was carried to ensure that all children undergoing a procedure on the paediatric oncology general anaesthetic list had a WHO Surgical Safety Checklist, for paediatric interventions under general anaesthetic, completed and entered in the clinical notes.
- Data collected for 23 procedures during the period from 5 January 2017 to 15 June 2017 showed all checklists were completed with patient details and the completion of the sign in, time out, sign out and confirmation was entered in clinical notes.
- However, the checklists were not always easy to find in the clinical notes and it had been recommended that it should be filed with the procedure consent form so that it could be easily located.

Nursing staffing

- Staffing levels and skill mix were not always at an appropriate level to ensure children and young people received safe care and treatment at all times.
- We were concerned about the appropriate paediatric nursing cover on the paediatric emergency department. There were insufficient numbers of nursing staff in the paediatric emergency department to provide safe care at all times. Royal College of Nursing (RCN) guidance recommends a minimum of two registered children's nurses at all times in all inpatient and day care areas. One senior paediatric nurse was available on the paediatric emergency department and an assistant practitioner was rostered from 10am to 10.30pm**,** however, staff said they were often used elsewhere in the main emergency department during the shift. This situation also posed risks of staff safety from lone working and there was no emergency alarm at the reception area for staff to summon assistance. Nurses who had attained a paediatric module were available in the main paediatric department to cover, if available.
- There were no formal processes in place to ensure appropriate cover was in place during periods of absence. There were occasions when the nurse was away from the department i.e. when they accompanied a child being transferred to the paediatric ward, attending to children and parents' needs, fetching snacks and drinks from the kitchen, taking a break. During these times the reception area was unattended with staff from the main adult emergency department providing cover if available. The nurse would let parents know when they were going off the department and parents could summon help via a call bell on the trolley which was linked to the main emergency department.
- We also saw a record of an incident reported on 26 May 2017 about a delayed admission where a nurse on a paediatric ward had been kept waiting for long periods of time for a child to be transferred from the paediatric emergency department for observations. Both areas had been busy and the comment from the report referred to this putting "pressure on paediatrics emergency department as the paediatric nurse was a lone worker."
- Our concerns were shared with the trust following our inspection. They reviewed our comments and advised that the paediatric emergency department was staffed 24 hours a day, seven days a week with a suitably

trained paediatric nurse. This had been strengthened by the addition of an assistant practitioner from 10am to 10.30pm. During the transfer of a child to a paediatric ward, appropriate cover was provided by a nominated emergency department nurse who had been trained in EPLS and children's safeguarding, hence ensuring the department was safely staffed at all times. However, during our unannounced visit to the department on the evening of 17 July the nurse had to leave the department to get a sandwich for a patient and the reception area was left unattended, albeit for approximately five minutes.

- When there were absences in the paediatric emergency department, nursing staff from the paediatric wards were requested to go to the department. Some staff told us they felt out of their depth when asked to go to the department and were concerned they were the only qualified nurse on duty.
- At the time of the inspection levels of nursing staff and other clinical staff levels in the paediatric and neonatal units were close to the planned establishment. Data from February to May 2017 showed minor variations in the planned registered nursing cover against the actual cover on the paediatric wards. Staffing levels were generally met for both day and night shifts with cover between 89% and 95% for registered nurses. On the neonatal unit data showed planned staffing levels were also generally met with staffing levels between 84% and 98% of establishment. A senior nurse was always present in the units which meant senior nursing advice was always available. We looked at rotas on the children's ward and the neonatal unit from March to June 2017 and saw that most shifts were covered with bank staff filling any gaps. Staffing levels for support staff ranged from between 97% and 160% on the wards and on the neonatal unit from 94% to 100%.
- An acuity safer nursing care tool had been implemented in paediatrics in October 2016. Following a 3-month initial trial period data for the paediatric assessment unit was excluded to gain a better understanding about which way of auditing would produce reliable data for the setting of establishment and providing information on care hours per patient days in the ward areas. This work was ongoing and due for review. The data input was regularly reviewed by the matron against levels of care for consistency. The tool was used alongside the escalation policy to redeploy staff across child health including neonatal and other areas where children were cared for.
- The ratio of nurses to patients on the children's ward met recommended levels. The children's ward staffing levels for children over two years of age were currently one nurse to four patients in the day and one nurse to six patients at night. This was in line with Royal College of Nursing recommended staffing levels. Staffing levels were able to be adjusted based on how many nurses were needed to safely care for the children admitted. This ensured the appropriate level of nursing was achievable within the existing nursing establishment.
- The neonatal unit adhered to the British Association of Perinatal Medicine standards and achieved safe staffing levels. Staffing levels were adjusted accordingly and monitored. The unit aimed to meet the staffing standards which recommended care for intensive care and high dependency babies should be provided by 'qualified in speciality' nurses. This recommendation was calculated based on the intensive care one to one basis, the high dependency one to two basis and special care one to four basis. The recommendation also stipulated a supernumerary team leader should be present on all shifts and this was reflected in the rotas.
- There was a good mix of skilled and experienced nurses and healthcare assistants in both departments. There were senior nursing staff in band eight (matron), seven (senior sisters and senior charge nurses) and six (sisters and charge nurses) supporting band five nurses and band two, three and four healthcare assistants. The band seven nurses were in charge of the day-to-day running of the nursing teams in the departments, with the band six nurses in charge of their own sub-teams in the different areas.
- The nursing workforce was monitored with the director of nursing at the monthly matrons' meeting. Ward managers also met weekly with the matron to discuss staff pressures, moves, safe care and long term sickness and they were always aware of the wider picture across the service and worked together to find creative solutions to staffing issues. Senior staff also looked at staffing levels before they went home to ensure the units were safe and a plan for cover was documented.
- Rostering was completed six weeks in advance and in a fair and equitable fashion. Gaps were generally covered by bank staff and staff with appropriate skills and

experience were pulled from across the wards and the neonatal unit to cover. The practice educator, the oncology outreach team and the matron also covered when necessary. As a result there was no use of agency staff. Patients were also cohorted to the areas where staff were available. In addition ward managers on the paediatric wards had varied their working pattern to provide maximum cover from 7.30am to 6.30pm and ensured they did not take annual leave at the same time. Staff were automatically put on to the bank system and received text messages about shifts to be covered. Some staff said they often felt pressured to cover at short notice.

- Staff also shared their concerns about the reduced staffing levels at night particularly when there were multiple unexpected admissions when the pool of other staff to call on was depleted.
- There was time built into shift changes to allow for nursing handover. We observed good handovers on the ward and the neonatal unit and saw the resulting comprehensive notes. Staff said the handovers were well structured and worked well with opportunities for learning. Issues discussed included a brief high level update, looking at general cover and who was on call and the allocation to individual nurses followed by a detailed individual patient handover. Nursing handovers were attended by nurses and health care assistants.
- There was a mixture of short term and long term sickness absence which was being managed in line with trust policy. There had been an increase in sickness from 4.6% to 5.1% against a trust target of 3.75% with long term absence being the higher proportion of sickness.

There were a variety of sickness interventions across the children's division in conjunction with the human resources (HR) department. Managers ensured workplace assessments were carried out where required, referring to HR and occupational health including the counselling service, providing guidance and support on ill health retirement and maintaining regular contact with individuals. These were designed to support a reduction of sickness absence.

- There was proactive recruitment management and this ensured the efficient and timely recruitment of nursing staff.
- The nursing team were experiencing a churn of staff due to the age demographics of the workforce. A younger workforce was anticipated for the autumn and the team were planning to regroup to adjust to a new less experienced workforce.
- The team were keen to set up a rotational post with the emergency department, the ward area and recovery and were planning to drive through a plan to the executive.

Medical staffing

- Medical staffing levels and skill mix were at an appropriate level so children and young people received safe care and treatment at all times.
- Medical staffing levels and skill mix were complaint with the Royal College of Paediatrics and Child Health and the British Association of Perinatal Medicine standards. The medical staffing skill mix showed 43% consultants, 15% middle grade doctors having at least three years at senior house officer level or higher grade within their chosen specialty. There were 31% specialist registrars in years one to six (which was slightly lower than England average) and 11% trainee doctors at foundation years one and two.
- There were adequate medical staffing levels to safely meet the needs of babies, children and young people with a total of 44 whole time equivalent (WTE).
- During weekdays on the neonatal unit there was one senior house officer (SHO) or advanced neonatal nurse practitioner (ANNP) between 9am and 10pm; one SHO/ANNP between 9am and 5pm; one SHO between 9am and 4pm; one registrar between 9am and 5pm; one consultant between 9am and 5pm; and one SHO/ANNP between 9pm and 9am. At weekends staffing was one SHO/ANNP from 9am to 10pm; one SHO from 9am to 3/4pm (the time was flexible as the SHO would go to general paediatrics later); and one SHO/ANNP from 9pm to 9am.
- On the paediatric wards staffing during the week was three SHOs from 9am to 5pm; one SHO from1pm to 10pm; one SHO from 9am to 10pm; one or two registrars from 9am to 5pm; one consultant from 9am to 5pm; and one SHO from 9pm to 9am. At weekends there was one SHO from 9am to 10pm; one SHO from 3pm to 10pm; and one SHO from 9pm to 9am.
- In addition during weekday evenings there was one registrar from 5pm to 10pm for general paediatrics and neonates; one consultant from 5pm to 9.30pm for paediatrics and one consultant on call from 5pm to 9pm

(occasionally the consultant was on call until 9.30pm). At weekends there was one consultant from 9am to 3pm for paediatrics then from 3pm to 9am was non-resident on call; one consultant from 9am to 12pm on neonates; one registrar from 9am to 10pm and one registrar from 9pm to 9am.

- There was currently one registrar vacancy which was covered with agency or bank staff.
- Most doctors said the workload was manageable with consultants covering more in the absence of the registrar.
- There were currently six community paediatric consultants The trust acknowledged that the lack of appropriately trained staff in combination with vacancies in community paediatrics had impacted on compliance with national standards with the potential for significant risk to patients if unresolved and possible increased admission to hospital or pressure on other services. The delivery of key objectives or service had been uncertain due to lack of staff and the loss of key staff. Control measures included the use of existing staff to cover priority areas with extra hours and the employment of a locum to increase capacity within team.
- Community paediatrics had provided safeguarding cover but had not been able to provide a 24 hour cover for safeguarding or sexual abuse with children and young people having to go to Plymouth or Exeter instead.
- Community paediatric staffing was subject to an external review by the Royal College of Paediatrics and Child Health and the recommendation would influence how the service was delivered going forward in terms of the re-design of the service and job planning.
- There was good handover between clinical staff. We observed doctors handover on the ward and the neonatal unit. The sessions were attended by doctors, the nurse in charge, night registrars and consultants. There was an initial safety briefing followed by discussion about staffing, the capacity within the units, deteriorating patients, incidents, safeguarding concerns, risk management and discharges. During the handover sessions there were opportunities for teaching and learning provided by the consultant.
- During morning ward rounds there were clear introductions and conversations with parents with an explanation of treatment and management plans. Parents were given an opportunity to ask questions.

Allied Health Professional staffing

- There was safe provision of physiotherapy and occupational therapy for children and young people. Therapy staff data for the period from February to May 2017 showed a number of vacancies in the workforce. There were occupational therapists and physiotherapists with a planned establishment of between 15.73 whole time equivalent (WTE) in February to 15.69 WTE in May. From the data available, we saw there was an actual WTE of 15.53 in February and 13.7 in May.
- Therapy recruitment to the county remained a challenge and the teams tended to grow their own workforce. Therapy students on placement and medical students completing a rotation with the community paediatricians ensured a high profile was maintained.
- Other professionals supporting the care of children while they were patients on the ward included dieticians and the pharmacist team.

Major incident awareness and training

- There was a trust major incident plan which outlined the decisions and actions to be taken to respond to and recover from a range of consequences caused by a significant disruptive event. The staff we spoke to were aware of the trust major incident plan and how to access this.
- There were local contingency plans for the children's ward and the neonatal unit if there were significant capacity and staffing issues, and problems with equipment. Appropriate actions were described for staff to follow depending on the status of the situation.

Are services for children and young people effective?

Good

We rated effectiveness as good because:

- Children and young people had good outcomes as they received effective care and treatment to meet their needs.
- Treatment by all staff was delivered in accordance with best practice and recognised national guidelines.

- Children and young people were at the centre of the service and the priority for staff. High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for children and young people.
- Staff skills and competence were examined and staff were supported to obtain new skills and share best practice.

However,

- Staff working in the community did not have access to the electronic records system used by another provider of community health care in the county. Staff said it was difficult to coordinate between the two systems and this could hamper delivery of effective care and treatment.

Evidence-based care and treatment

- Policies, care and treatment pathways, and clinical protocols had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them.
- We reviewed a number of guidelines including cerebral function monitoring, management of clef lip and palate, jaundice guidance and found most to be in date apart from BCG neonatal vaccine which expired in November 2016.
- Audits were determined from National Institute of Health and Care Excellence (NICE) guidance to local ideas and trust requirements.
- The departments undertook national audits including the National Paediatric Diabetes Audit (NPDA) for 2015-2016 and the National Neonatal Audit performance. (Results are reported in the Patient outcomes section below). These audits were designed to benchmark current performance and identify areas of improvement.
- Local audits completed in 2016-2017 included: emergency department admission documentation audit, documentation in the emergency department to evidence correct recording and referral, safeguarding awareness in the trust and availability of information in clinical areas. On-going audits included: inter-agency referrals to the Multi-Agency Referral Unit (MARU) by trust staff, availability of safeguarding information in wards and departments, and the paediatric ward safeguarding notes audit and the leave without being seen policy.
- Action plans were in place following participation in audits to address areas requiring improvement. Regular reviews were undertaken to monitor progress. The audit programme and work plan was monitored by the safeguarding children's operational group (SCOG) for children. Audit results were presented at the audit and guidelines group, held bi-monthly by the child health department.
- The paediatric service monitored quality and patient safety via the paediatric dashboard, neonatal dashboard and community paediatric dashboard. This was reviewed at monthly business meetings for each area and subsequently reviewed with governance oversight in the divisional meetings.
- Nursing key quality performance indicators, included infection control auditing for inpatient and outpatient areas**,** an early warning trigger tool for inpatient and outpatient areas highlighting workforce concerns; incidents; appraisals; number of complaints and sepsis audits highlighting areas for concern
- There were clinical pathways for the most frequent reasons where children came to hospital including head injury, abdominal pain and fever. These gave clear and consistent guidance about how to treat these conditions.

Pain relief

- Children, young people and babies had their pain assessed and managed appropriately.
- There was guidance in care plans about pain management for children where it was appropriate, for example, after surgery. Children and young people had their pain assessed and appropriate methods of reducing pain were offered. Nurses assessed children's pain by using age appropriate assessment tools such as smiley faces, indicators from behaviour or responses, and numbers for older children. These assessment tools helped children of all ages and abilities to communicate about any pain. The assessments were included in every child's nursing record we looked at.
- Parents said staff regularly checked with their child asking them if they had any pain and gave pain relief when it was required.

- For babies in the neonatal unit, pain and stress were monitored and registered simultaneously with other physiological parameters such a temperature and blood pressure. This made it possible to continuously evaluate any pain and the need for analgesics or comfort measures. Every baby was assessed on admission to the neonatal unit and before and after potentially painful interventions, and at regular intervals.
- The trust performed about the same as other trusts in the majority of questions relating to effectiveness in the latest CQC children's survey (seven out of eight) including 'Do you think the hospital staff did everything they could to help ease your child's pain?'

Nutrition and hydration

- The assessment and response to children and young people's nutritional and hydration needs were managed effectively. Children and young people were screened to identify those who were malnourished or at risk of becoming malnourished. Snacks, sandwiches and drinks were available for children in addition to the regular breakfast, lunch and tea.
- The neonatal service had applied for stage one of the UNICEF Baby Friendly Awards which championed evidenced based practice to promote and support breastfeeding. This meant that staff were supporting mothers to recognise the importance of breastfeeding, make informed choices and to support them with continuing breastfeeding for as long as they wished.
- Breast feeding support was provided by the team who gave advice on milk supply, initiating lactation, pumping, transition to responsive feeding, and any other feeding issues. A room for expressing was provided on the neonatal unit together with a milk kitchen and milk fridges. Once milk had been expressed a label with the name of the baby, date and time of expression was placed over the lid and down the side of the bottle. Breast milk was stored for 24 hours in the fridges and for 48 hours in the freezers. Temperatures of the fridges and freezers were checked daily and recorded. Breast milk fridges and freezers were situated in the milk kitchen which was not locked and did not ensure the complete security of bottles.
- Following the identification of a risk of giving the wrong breast milk to the wrong baby, a two person check was implemented prior to the giving of expressed milk in line with the positive patient identification policy. Staff encouraged parents to label their own milk or otherwise were second checked. Where milk was decanted from a larger bottle to a syringe or smaller bottle the labels were also double checked.
- Paediatric dietitians provided nutritional support, advice and education to children and parents about diet, supplements and enteral feeding.
- The trust performed about the same as other trusts in the majority of questions relating to effectiveness in the latest CQC children's survey (seven out of eight). The only question they performed better than other trusts was 'Did you like the hospital food?' where they scored 7.82.

Patient outcomes

- A number of regular audits were carried out on the units to monitor performance against national patient outcomes and to maintain standards. Audits were monitored and action plans to address areas of improvement were regularly reviewed.
- Results from the National Paediatric Diabetes Audit (NPDA) for 2015-2016, showed an improving delivery of results. The results had improved year on year to present results. As well as being placed in the top 10% of the 173 paediatric diabetes units in England & Wales, the paediatric diabetes team had been ranked first in the south west for their results looking at adjusted HbA1c readings. HbA1c refers to glycated haemoglobin (A1c) and is a measure of diabetes control. This level of care had been achieved by a number of factors including: close multidisciplinary team working; building respectful relationships with families and young people and empowering families to take ownership of the management of diabetes.
- In addition to auditing the quality of care received by children and young people in England and Wales, the NPDA has developed Patient and Parent Experience Measures (PREMS). These surveys for children and young people with diabetes and their parents provided feedback to their diabetes team about their experience of using the service. The results helped the teams to understand what they were doing well, and to identify what improvements they could make to their service.
- Two separate reports summarised the responses provided by children and young people and by parents and carers. Questionnaires were completed by 63 children and young people, and 43 by parents and carers.

Services for children and young people

- Over 75% of responses from children and parents/carers were positive. However, the answer to the question 'how likely is it that you would recommend this clinic to a friend or another family with a child who has diabetes?'; had decreased slightly from an average of 9 out of 10, to 8.4 from parents/carers, and from children from of 8.2 out of 10, to 7.6. There was also deterioration in the response to some of the other questions, although these generally were small changes.
- The paediatric diabetes team reviewed the results at their team meeting in November 2016 and concluded there were factors that had been likely to have had a negative influence on the responses to some of the questions, for example, the lack of continuous glucose monitoring; the responders might have been rushed as the survey was electronic this time and parents/carers/ patients were given a tablet computer in clinic. Furthermore, the NICE guidelines had been updated and included tighter blood glucose and HbA1c targets which had increased the expectations of patients/ parents; there had also been gaps in the lead dietetic post and the psychologist, who worked part time, had struggled to keep up with referrals and had minimal time for preventative work.
- The team had an improvement plan to address these issues including the return of the lead dietician who had re-written the dietetic educational goals for annual reviews and the psychologist had started to run some group sessions to manage the workload and their plans to increase psychology time; the lack of continuous glucose monitoring had been added to the risk register and this was due to be discussed as part of the 2016-2017 annual operating plan.
- The trust's performance in the National Neonatal Audit performance was above the national average of eligible babies who had their screening performed within the extended screening window. The trust scored 100% against a national average of 98%.The first consultation following admission occurred within 24 hours for 97% of the eligible episodes; this was above the national average, where 88% of eligible episodes had the first consultation within 24 hours of admission.
- There were variable outcomes for multiple readmissions. Data showed that between February 2016 and January 2017 there was a higher percentage of under ones readmitted following an emergency admission compared to the England average in paediatrics. There were 98 readmissions following 1,866 discharges which represented a 5.3% rate compared to the England average of 3.3%. No other specialty reported six or more emergency readmissions following emergency admission in the under one age group during this period.
- Over the same period a higher percentage of patients in the one to 17 age group were readmitted following an emergency admission compared to the England average in paediatrics (3.3% compared to the England average of 2.7%) and general surgery (5.8% compared to 2.1%). No other specialty reported six or more emergency readmissions following emergency admission in the one to 17 age group during this period.
- The trust performed similarly to the England average for the percentages of patients aged one to 17 years old who had multiple readmissions for asthma (17.1% compared to the England average of 16.5%) and diabetes (14.0% compared to the average of 13.3%). The trust performed better than the England average for the percentage of patients in the same age group who had multiple readmissions for epilepsy (18.8% compared to 27.1%).
- There was insufficient data available to compare the percentages of patients under the age of one who had multiple readmissions for asthma, diabetes or epilepsy between March 2016 and February 2017.
- Physiotherapy used a goal attainment scale as a standard to regularly audit outcomes for children and young people by capturing the extent to which individual goals for treatment were achieved.
- The findings of the UK Perinatal Mortality Surveillance for 2015 showed up to a 10% lower rate for the trust than the England average for perinatal mortality.
- Local quality improvement projects included the receipt of all outpatient referrals for investigations via the internal referral system which had reduced the risk of any errors occurring in the referral process when previously referrals had been made by many different routes, including paper letters, emails and telephone calls. A system for clinic room allocation had been rolled out making the process more efficient with a centralised system available for other staff to view availability before making a request. An electronic outcome forms had been introduced to improve process and capture of important data. A second set of measuring facilities was planned to reduce waiting times. Oxygen saturation

monitoring had been implemented with routine observations in all clinics and earlier patient arrival times had been introduced to improve patient flow through outpatients.
- A teaching programme to schools within Cornwall had been rolled out for diabetes care. This had enabled a higher quality of teaching and helped increase the confidence of school staff who supported children with diabetes.
- An electronic whiteboard had been introduced on the paediatric assessment unit and was entering the next phase which allowed data collection for lots of categories including the **number of patients within each triage category (Red, Amber, Green), the number of patients seen by or discussed with a consultant, the number of patients with PEWS score of 3 or more (a sepsis trigger) and the number of patients with safeguarding concerns. Waiting time data included average triage to decision time for each triage category** and s**peciality referral.**
- An audit of missed follow ups from discharge summaries completed had shown no harm and improved processes. This was reported weekly to monitor progress. A text reminder for patients under 13 years of age was awaiting a go live date and this was expected to reduce missed appointments.
- From the child health progress and plans for 2017-2018 we saw the key initiatives and the progress made and needed. Examples included a review of emergency clinic provision, digital dictation and improvement of administration flow, development of the emergency nurse practitioner role, demonstrating clear responses to suspected sepsis, development of a rheumatology service, gaining more patient and family feedback and developing an eating disorder service.

Competent staff

- All staff had specialist knowledge and skills to treat babies, children and young people with their presenting conditions.
- Records showed all nursing staff within the children's wards, the outpatient department the child development centre and the neonatal unit had been trained in paediatric life support and consultants had also been trained in advanced paediatric life support.
- There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and that there was good teamwork. Staff were encouraged to keep up-to-date with their continuing professional development and there were opportunities to attend external training and development in paediatric specific areas.
- The service undertook a range of education and practice development activities aimed at enhancing the knowledge, skills and awareness and development of the staff. There were study days including simulation training on paediatrics and neonates and speciality training.
- Staff said they were encouraged to take responsibility for their own continuing professional development and were able to attend training out of county to attain relevant knowledge and skills.
- There was a trust wide electronic staff record where all training attended was documented. Managers were informed of training completed and alerted to those staff requiring updates for mandatory training through regular discussions with the HR department.
- Most staff we spoke with were positive about the quality and the frequency of clinical supervision they received.
- New nursing staff attended a trust induction and were supernumerary on the unit for the first month to achieve their competencies. During this time they completed a workbook, spent a day with nurse educator and initially worked with an experienced colleague.
- Appraisal completion rates had improved. The figures provided by the trust showed an average compliance rate of 94% between April 2016 and March 2017. Maintenance of this improved position remained a focus for the coming year. All the staff we spoke with said they had received an appraisal during the last year. Staff learning and development was identified through the appraisal process and through supervision meetings.
- Paediatric nurses on the children's ward were complimented by healthcare assistants and play specialists. On the neonatal unit, nurses were also supported by healthcare assistants.
- Surgeons and anaesthetists had appropriate training and competence to handle emergency surgical care of children, and nurses were required to maintain paediatric competency.
- Physiotherapist and occupational therapists were paediatric trained.

Multidisciplinary working

Services for children and young people

- We saw evidence that staff worked professionally and cooperatively across different disciplines and organisations both in the acute hospital and in the community. This was to ensure care was coordinated to meet the needs of children and young people. Therapy was conducted on the children's wards, the outpatient department, and the neonatal unit. Staff reported good multidisciplinary team working with meetings to discuss children and young people's care and treatment.
- During our visit staff told us about the actions of the paediatric emergency response team during the night shift. Staff from the paediatric ward, intensive care and colleagues remotely from another Children's Hospital had managed an emergency in a unified and effective manner during an emergency admission.
- There was access to an integrated community therapy service for children who had physical or sensory difficulties, developmental delay, under-nutrition or excessive weight gain. Community therapy included physiotherapy, occupational therapy and dietetics and was based at the child development centre. A wide range of other professionals, including paediatricians, other therapists and local authority professionals were also based at the centre and worked together to provide coordinated care for children with atypical development and disability. Therapy was carried out at child development centres across the county in Truro, Penzance, Redruth and St Austell and in a variety of other settings such as mainstream and specialist schools; at the child's home; and early year's settings.
- Physiotherapists assessed, treated and managed children and young people with a variety of conditions affecting gross motor function, which are the bigger movements, such as rolling over and sitting, that use the large muscles in the arms, legs, torso and feet. The conditions could be neurological, developmental, orthopaedic, musculoskeletal, and respiratory or as a result of trauma. They also showed parents and carers how to carry out exercises and activities at home to ensure the child practiced them regularly.
- Occupational therapists assessed functional and sensory needs and worked with parents and carers to enable children to become as independent as possible. This was likely to include a course of activities designed to increase range of movement, coordination and sensory awareness.
- Dietetic support was available to children, their families and the professionals who worked with them. Dieticians provided individual dietetic assessment and treatment for children who met the referral criteria and offered self-referral workshops for parents/carers. They also sign-posted parents/carers to information, advice and other services and offered training for professionals.
- Dieticians also worked with young children (six and under) who were significantly overweight as part of the tier 3 multi-disciplinary lifestyles, eating and activity for families programme. They also provided support and training for professionals working with children and families around weight management.
- Community therapists worked closely with community speech and language therapists who were funded by another provider.
- Referrals could be made from the parents/carer, or from any health or education professional who knew the child or young person i.e. paediatricians, GPs, therapists, health visitors, teachers and special educational needs co-ordinators.
- A report was produced summarising the child's needs, and contained a multidisciplinary therapy plan. Where appropriate the child was offered a series of sessions with a therapy support worker who also provided one-to-one support for parents / carers. This aimed to positively support them in the care of their child. Intensive bursts of therapy were provided with the aim of improving the child's skills. Families might also be offered assessment appointments and specialist equipment. Once a child was discharged, there was open access where a referral could be made back to see them again should the situation change.
- Other professionals were called upon to care for babies, children and young people including pharmacists, audiologists, and a consultant ophthalmologist. Radiologists provided clinical imaging including x-rays, computed tomography (CT) scans, magnetic resonance imaging (MRI) scans, imaging and ultrasound.
- Play specialists helped children to understand their condition and medical treatment. They provided preparation and support for potentially stressful experiences such as medical or surgical procedures. The play team visited all ward areas to assess need and to set up play areas with toys and materials. They also provided support to siblings.
- The clinical teams on the children's ward and the neonatal unit were assisted by a dedicated team of ward clerks and reception staff. They provided comprehensive support to consultants, doctors and

nurses with a host of administrative tasks from welcoming children and their parents and checking their details to ensuring notes were available for clinics and answering telephone calls.
- In the latest CQC children's survey the trust scored 8.83 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts.

Transition

- A framework was available for all healthcare professionals to enable them to deliver a well-planned transitional process for young people with long-term health conditions and complex health needs as they moved from child-centred to adult-orientated services.
- The transition policy set out best practice principles to ensure that all young people received a high quality service that was coordinated, uninterrupted, patient-centred, age and developmentally appropriate. The timing of transition depended on the individual patient, but was usually at some time between 16 and 18.
- Most young people transferring to adult services were following a 'Ready Steady Go' transition pathway. Young people and their family were initially introduced to the concept of transition; moving to developing an understanding of their condition and finally feeling confident about leaving the paediatric system. The transition encouraged young people to have a considerable degree of autonomy over their own care.
- Young people and their families were introduced to the pathway through a 'Transition moving into adult care' information leaflet followed by a series of questionnaires at each stage of the pathway and key documents in the form of a transition plan. The plan outlined the timing of key phases, the duration and those to speak to through the process. Visits to the new department and the team were arranged to help the child and their family to get to know the team.
- The process commenced at the age of around 13 years and a young person was introduced to the adult team at least a year prior to transfer. The timing of transfer was tailored to individual need depending on emotional maturity and cognitive and physical development.
- Transition for those with neurological disorders and complex disabilities, with or without a learning disability, presented particular problems. This was because often there was no single equivalent adult service able to take on all of their long-term health care and medical supervision. A lead adult specialty was identified so that care could be coordinated with an emphasis on a holistic approach.
- The specialist nurse for learning disabilities was made aware of those patients with learning disabilities before they were transferred to adult care to assist in planning coordinated care.
- Staff highlighted the achievements in engaging with increasing numbers of adult teams to ensure seamless transition. There was training for staff around the trust and national principals through the transition process. Staff were able to liaise with other agencies which had improved transition across services. Patient experience measures were used to monitor progress.

Seven-day services

- There was 24-hour medical cover seven days a week on the children's ward and the neonatal unit.
- There was access to pharmacy seven days a week between 8.30am and 5pm, with a late duty to support the evening and on call services.
- Access to radiology support at weekends was also available.

Access to information

- Information to deliver effective care was available to relevant staff in a timely and accessible way. There was a range of documentation on the paediatric wards, the outpatient department, the neonatal unit and the community child development centre, and this was easily accessible. Patient paper notes were prepped for elective admissions and clinics and staff confirmed they were available in good time.
- The medical teams said there was good and quick access to test results and diagnostic and screening tests.
- Staff working in the community did not have access to the electronic records system used by another provider of community health care in the county. Staff said it was difficult to coordinate between the two systems and this could hamper delivery of effective care and treatment.
- In the latest CQC children's survey the trust scored 8.98 out of ten for the question 'Did a member of staff agree a plan for your child's care with you?' This was about the same as other trusts.

Consent

Services for children and young people

- Staff said they obtained consent from children, young people and their parents / carers prior to commencing care or treatment. They said children and young people were given choices when they accessed their service. Staff told us about how they dealt with consent issues for young people who did not want to tell their parents. They always tried to sensitively manage the situation while ensuring that the young person received the help they needed.
- Staff were aware of and knowledgeable about the Fraser guidelines and Gillick competency which helped them to balance children's rights and wishes with their responsibility to keep children safe from harm. Fraser guidelines and Gillick competency refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. Since then, they had been more widely used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions.
- Throughout the inspection we saw staff explaining the assessment and consent process to parents / carers and any need to share information with other professionals such as GPs, nursery or school before obtaining written consent. We saw consent forms signed appropriately by parents.
- We heard staff discussing the treatment and care options available to children, young people and their parents.

Are services for children and young people caring?

Good

We rated caring as good because:

- Children and young people were treated as individuals and as part of a family. Feedback from children, young people and parents had been consistently positive. They praised the way the staff really understood the needs of their children, and involved the whole family in their care.
- Parents said staff were caring and compassionate, treated them with dignity and respect, and made their children feel safe. Staff ensured children and young people experienced high quality care.
- Staff were skilled to be able to communicate well with children and young people to reduce their anxieties and keep them informed of what was happening and involved in their care.
- Parents, siblings and grandparents were encouraged to be involved in the care of their children as much as they wanted to be, whilst young people were encouraged to be as independent as possible. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand.
- We observed staff treating patients with kindness and warmth. The neonatal unit and the paediatric wards and the outpatient department were busy and professionally run, but staff always had time to provide individualised care.
- Staff talked about children and young people compassionately with knowledge of their circumstances and those of their families.

Compassionate care

- Throughout our inspection, we observed children and young people being treated with the highest levels of compassion, dignity and respect.
- We observed interactions between staff and children and their families. Staff were open, friendly and approachable but always remained professional. Children, young people and families were often delighted when they saw staff they knew and greeted them as if they were old family friends.
- We observed all staff taking time to talk to children in an age appropriate manner. They involved and encouraged both children and parents as partners in their own care. Parents were aware of the named nurse caring for their baby, child or young person.
- During our inspection we observed excellent interactions between staff, children, young people and their families. We saw these interactions were very caring, respectful and compassionate. The staff were skilled in talking to and caring for children and young people. Parents, siblings and grandparents were encouraged to provide as much care for their children as they felt able to, while young people were encouraged to be as independent as possible.
- The trust performed about the same as the England average for 12 out of 14 questions relating to compassionate care in the latest CQC children's survey. They performed better than other trusts for two

questions; 'Were you given enough privacy when you were receiving care and treatment?', where they scored 9.63, and 'Do you feel that the people looking after you were friendly?' where they scored 10.

- The trust used a number of forums to gather feedback from children and their parents including a pictorial feedback form and the voice of the child. Surveys and audits known as 'Rate my Health' were used to gather feedback from hard to reach groups of patients.
- The trust used the NHS Friends and Family Test to find out if children, young people and their parents would recommend their services to friends and family if they needed similar treatment or care. There was a children and young people's Friends and Family questionnaire where they were asked to rate how much they agreed with the question "I would say this is a good ward/ service/team for my friends and family to be looked after." Options ranged from "I agree a lot" to "I disagree a lot". Children were also asked to draw a picture of when they last visited, what was good about their visit and what could be better. Comments included "the senior manager was very friendly and explained everything."
- Children, young people and their parents we met spoke highly of the service they received. All the feedback we received from the parents was very positive about the care their children received. The comments we received from parents on the children's ward included, "the staff have been fantastic", "I'm very happy with the care", "staff kept my child at the centre of everything". One parent commented that the staff "treated my baby as if he was their own … as if he was as important to them as he is to me."
- Parents on the neonatal unit were also unanimous in their praise and comments included, "the staff are amazing, kind and lovely. I can't fault them. They are very knowledgeable", "I know my baby is in safe and caring hands", and "staff clearly love their work and the babies… they blow me away."
- The children and young people we spoke with said how good the staff had been in looking after them. Comments from children and young people included, "I like the play room", "the doctors are nice and explain things" and "the nurses help me to feel better."
- We observed good attention from all staff to children and young people's privacy and dignity. Curtains were drawn around bed spaces for intimate care or procedures, Voices were lowered to avoid confidential or private information being overheard. All parents said their privacy and dignity was maintained. Children under the age of 12 were supervised at all times by hospital staff when they did not have a parent visiting. One parent told us "I feel very confident in the staff and I'm fine about leaving (my child) overnight in the care of the staff."
- Play specialists supported siblings and other children to help them understand what their brother, sister or friend was experiencing.
- Care from the nursing, medical staff, play specialists and support staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance.

Understanding and involvement of patients and those close to them

- Children, young people and their families were involved with their care and decisions taken. We observed staff explaining things to parents, children and young people in a way they could understand. For example, during a complex explanation, time was allowed for either the child or their parents to ask whatever questions they wanted to. One parent commented that they had been "updated on everything in language I understand."
- Parents were encouraged to be involved in the care of their children as much as they felt able to. We observed that children and young people were also involved in their own care. Children, young people and parents that we spoke with all confirmed this was the case. One parent on the neonatal unit told us how staff had taken time to advise her about developmental care, positioning and turning of her baby, and the parent had gained a good understanding of the reasons why.
- Staff made sure children, young people and parents knew who the staff were and what they did. All healthcare professionals involved with the patient's care introduced themselves and explained their roles and responsibilities.
- Staff recognised when children, young people and their families needed additional support to help them understand and be involved in their care and treatment. They were knowledgeable about the trust framework to support communication with families who were non-English speakers, or for whom English was a second language. Support was also available for families with hearing or visual impairment, or who had learning disabilities.

Services for children and young people

- The trust performed about the same as other trusts for 14 out of 19 questions relating to understanding and involvement of patients and those close to them in the latest CQC children's survey. They performed better than other trusts in the other five indicators including 'Did members of staff treating your child, give you information about their care and treatment in a way that you could understand?' where the trust scored 9.45 out of ten, 'Did hospital staff talk to you about how they were going to care for you in a way that you could understand?' scoring 9.79 and 'If you had any worries, did someone at the hospital talk with you about them?' scoring 9.31.

Emotional support

- We observed staff providing emotional support to children, young people, their parents, siblings and grandparents during their visit to the unit. Children's individual concerns were promptly identified and responded to in a positive and reassuring way. One parent whose child regularly attended the unit said that "nothing was too much trouble for the staff… from the doctors and nurses to the ward clerk … even when they're really busy."
- Children, young people and their families were spoken with in an unhurried manner and staff checked if information was understood. When speaking to parents on the telephone, we overheard staff encouraging them to call back at any time if they continued to have concerns, however minor they perceived them to be.
- Difficult information was discussed in a sensitive manner and a parent told us how supportive the entire team had been "they are always there … I can't thank them enough."
- Staff understood the impact the care, treatment or condition might have on the child or young person's wellbeing and on those close to them both emotionally and socially. There was good support from the hospital multi-faith chaplaincy team who were on call at all times for children and young people, and their family and friends.

Are services for children and young people responsive?

Good

We rated responsive as good because:

- Services were tailored to meet the needs of individual children and young people and were delivered in a flexible way.
- There were good facilities for babies, children, young people and their families.
- The environment for the neonatal service had improved considerably with the opening of the new unit in May 2017. Staff had been involved in the design and planning phase of the development of the unit
- There were no barriers for those making a complaint. Staff actively invited feedback from children and their parents or carers, and were very open to learning and improvement. There were, however, few complaints made to the service and those that had been made were fully investigated and responded to with compassion.
- Children and young people of all ages had timely access to care and treatment

However:

- There were delays in completing discharge summaries and performance required improvement.
- The temperature in the neonatal unit was not always at a suitable level.

Service planning and delivery to meet the needs of local people

- The environment on the children's wards, the outpatient department, the child development centre and the neonatal unit were designed to meet the needs of babies, children and young people and their families. Staff had been involved in the design and planning phase of the development of the neonatal unit. Parents were keen to tell us how impressed they were with the new unit
- Parents were encouraged to stay with their child on the children's ward and there were no restrictions to visiting times. Accommodation was provided for one parent to stay overnight with their child. Each bed space had a pull down bed next to it so that parents could stay on

the ward if they preferred to do so. There were also four bedrooms available on the fourth floor of Tower block for parents to use throughout their stay at hospital. The accommodation also housed bathroom and kitchen facilities along with a sitting room so that parents could spend time away from the ward. A bid application had recently been submitted for charitable funds to upgrade the accommodation and the outcome was awaited. Each ward area also had parents' kitchens or beverage points and seating areas so they could prepare drinks and food during their stay.

- There were five double rooms and showers and toilets directly opposite, within the footprint of the neonatal unit for parents to stay overnight. The rooms were provided for use by parents of babies who were getting ready to go home, or for parents whose baby was extremely unwell. Both parents or a significant other supporting person, like a grandparent, or friend, were welcome to stay. There were, however, no facilities for siblings to stay overnight. Reclining chairs were available beside each cot side to enable parents to rest as they needed. Other facilities included a water cooler, a parent's kitchen where there were facilities for making tea, coffee and cold drinks, and a microwave to heat food. There was a quiet room, a breast milk expressing room, and a play area for siblings. Linen and baby clothes were available for parents to use for their babies. .
- The temperature in the unit was not always at a suitable level. The unit was very hot and plans to address the high temperature were in hand with air conditioning units and fans being used as a temporary measure to control the temperature.
- There were close links with the external provider of community nursing palliative care services. Services were provided for children and young people with life limiting and life threatening conditions. The children's ward liaised with the provider about matters including the criteria for admission and timely discharges, pain management and symptom control. This ensured there was a range of options for children requiring palliative care.
- The outpatient department had transferred all investigation bookings and waiting lists to an electronic system and the waiting times had reduced to 4 weeks in the last 12 months. Extended clinics had also contributed to the reduction: there were Saturday clinics and some clinics ran until 7pm.
- A team of specialist children's nurses looked after patients, both in hospital and out in the community, and worked alongside other health professionals such as therapists, teachers and social workers,
- Community paediatric teams looked after children and young people who had long term, chronic and ongoing conditions, physical disabilities, learning difficulties, social communication difficulties and other long-term disabilities. This care was delivered by a team of paediatricians, including consultants, staff and associate specialists, with junior doctors providing a supporting service. Teams worked in preschools, schools and special schools.
- The development of integrated care involving joint clinical pathways across organisations for patients with long-term and life-limiting conditions within Cornwall was underway to improve outcomes for children. A review of service provision for children was a priority of the local clinical commissioning group.
- The neurodevelopmental team worked with children who were not reaching the expected developmental milestones for their age in areas such as language, mobility, self-care and independent living may. Assessment, diagnosis and ongoing coordination of care were provided alongside professional colleagues in education and social care. The exact care team and care pathway would be tailored to the child's needs.
- Community staff were committed to delivering care as close to home as possible. Children were often seen in a clinic setting or children and young people were visited in their daily lives at home or at schools and nurseries. This minimised disruption for children and their families. Clinics took place across the whole county from the Isles of Scilly to Liskeard, Launceston and Bude.
- Referrals to the community integrated therapy service could be made from anyone who had professional or parental responsibility for a child or young person and had concerns about their development. Referrers included GPs, teachers, educational or clinical psychologists, health visitors, school nurses, children's centre staff, social care teams, parents / carers and young people themselves. A team of therapists considered all referrals and decided whether the referral was appropriate and if so the most appropriate professional(s) to assess the needs of the child or young person.

- Assessment clinics were generally held at the child development centres across the county with any subsequent appointments taking place in the child's school or in their home. A period of intervention with episodes of care followed with a review of the child's progress towards their goal and their continuing needs and discussions with the parents / carers to determine whether further involvement was required. Discharge was agreed if no further intervention was required with a proviso that a referral could be made at any time should the child or young person's needs or circumstances change.
- Therapy staff worked collaboratively with education colleagues providing training for staff in specialist schools to incorporate sensory and posture management in activities and play to develop free function and hand/eye control. Assistants and technicians supported therapists by delivering treatment programmes devised by therapist.

Access and flow

- Children and young people of all ages had timely access to initial assessment, diagnosis, care and treatment.
- Between February 2016 and January 2017 the children and young people's services had a total of 7,465 admissions of which 695 were for ear nose and throat (ENT) and 627 for trauma and orthopaedics. Activity in the paediatric emergency department for the period showed a total of 6,993 episodes.
- Data showed that between May 2015 and April 2017, there was an upward trend in neonatal critical care bed occupancy. The trust's bed occupancy was higher than the overall England occupancy in September 2016 and February, March and April 2017. In both February and April 2017 the occupancy was 100%.
- Primary diagnosis groups recorded on emergency admissions for children under one year of age included acute bronchitis, other perinatal conditions, other upper respiratory infections, viral infection, haemolytic jaundice and perinatal jaundice. For children and young people between the ages of one and 17 the diagnosis ranged from viral infection, other upper respiratory infections, abdominal pain, intestinal infection and acute bronchitis.
- The paediatric assessment unit was situated in the Pollkerris children's ward and provided four side rooms for admission and observation for children and young people who were acutely unwell. Children and young people were assessed and treated in the assessment unit unless otherwise directed by the need for additional infection control measures or a requirement for resuscitation in the emergency department. There was a dedicated hot phone for calls from GPs, midwives and paramedics about accepting admissions of children. From the paediatric assessment unit, children might be admitted to the ward for ongoing treatment, discharged home the same day, or remain in the paediatric assessment unit for a longer observation period. This was to help the team determine if an admission was required.
- Access to Child and Adolescent Mental Health Services (CAMHS) services were managed by the local NHS mental health trust. However, the children's ward had close links with a CAMHS liaison nurse. They contacted the ward every morning, seven days a week. They discussed the children and young people currently on the ward who either had mental health and / or social care conditions or issues.
- The service was effective for those children and young people who did not require a tier 4 inpatient bed. However, there was a risk that young people admitted with mental health issues would not receive appropriate and timely care and treatment. This was caused by a lack of level 4 tier beds locally and could result in a longer length of stay in an acute inpatient ward and a higher incidence of self-harm and potential harm to other patients, families and staff.
- Increasing incidents related to violent and aggressive behaviour from CAMHS patients in paediatrics and increasing lengths of stay had resulted in a meeting between the division and the executive team to take forward this issue and decide as a trust the way forward with partners. CAMHS outreach nurses provided a monthly debrief on the wards to build resilience for staff and to look at new ways of working. Senior staff for paediatrics also attended network and planning meetings to look at service design.
- The division was currently involved in developing an eating disorders pathway to ensure that children and young people received appropriate care in a timely manner and reduced hospital admissions. The matron also attended the CAMHS Transformation Committee which enabled cross working and development of pathways to better suit patient need.

Services for children and young people

- Data from April 2016 to March 2017 showed there were 171 patients admitted into acute paediatric beds with an increased length of stay for those patients seen with eating disorders and awaiting tier 4 beds.
- The outpatient service offered general paediatric clinics and a range of sub-specialist clinics were offered in conjunction with the visiting tertiary specialists from the Bristol Children's Hospital. Clinics requiring a paediatrician included allergy, urology, gastroenterology, endocrinology, respiratory, cardiac, neurology, diabetes and metabolic. There had been 7,374 referrals during the period from April 2016 to March 2017.
- During the period April 2016 to March 2017 most referral to treatment times for non-admitted paediatric referrals reached the 92% trust target. All referrals to paediatric respiratory medicine, metabolic disease, neurodisability, cardiology, general paediatrics and community paediatrics were in target. However, areas not reaching the target were those clinics delivered by visiting consultants from Bristol Children's Hospital. These included paediatric urology, gastroenterology and neurology. The frequency of clinics varied and the trust were engaging with Bristol to find a better way of delivering the clinics.
- Data was also available from the same period showing the number of cancelled clinics within six weeks and over six weeks of the scheduled date. This showed a range of cancellations across the specialty clinics. For those cancelled within six weeks the lowest number was one in medical oncology and the highest was 44 in general paediatrics. For those cancelled over six weeks the lowest was one in metabolic disease and the highest was 244 in general paediatrics. Data for community paediatrics showed there were 41 cancellations within six weeks and 108 over six weeks.
- Clinics were offered in a dedicated paediatric outpatients department and in peripheral hospitals. The children's outpatient clinics were situated on the floor below the paediatric wards. There was a reception area which served the clinics. It was very busy during the time of our visit with general clinics running that afternoon alongside visiting tertiary specialists. The receptionist checked children's details for accuracy and updated and recorded children who did not attend.
- Parents we met told us they were satisfied with the speed of appointments and waiting times were kept to a minimum, and they were always informed if the clinics were running late.
- Surgical services for children and young people were provided by the general surgical and trauma consultant led teams. Elective inpatient and day cases were performed on the same theatre lists. Paediatric general surgical interventions were delivered through a dedicated paediatric theatre (theatre 1 of the Tower) and recovered in a dedicated paediatric recovery area also situated within the Tower. Trauma and emergency surgery was performed in dedicated emergency theatres (in Trelawny) and on these occasions screens/ curtains were used to segregate children from adults to protect their privacy and dignity.
- Second stage recovery for children was on the paediatric wards, with a dedicated day case area, called Harlyn ward and inpatients on the two wards, dependant on age. There was a dedicated pre-operative assessment clinic which saw all elective surgical cases and which worked closely with the surgical teams and the play team to ensure children were assessed and admitted appropriately. Work was ongoing at ward level to ensure the flow of patients into Harlyn ward was monitored and that beds were not overbooked. A draft standard operating process had been produced for the booking of patients.
- Due to the high acuity and activity on the wards and lack of ward clerk cover at night, the timely recording of patient movements remained a challenge. Although there had been an improvement during the day following reminders to all staff of the importance of timely discharge, out of hours remained a focus for improvement.
- Data from March to June 2017 showed the percentage of discharges sent within 24 hours. They ranged from 55% to 72%. Data was also shown for discharges sent after 24 hours and this ranged from 28% to 45%.
- Data showed an electronic discharge backlog of 39 for paediatrics with a maximum delay of four days. Staff said the backlog was normally no more than four to five days. The backlog of discharge summaries was monitored every day and details were incorporated into morning handover. There was an escalation policy in place where staff were pulled from other duties to clear any backlogs. The clinical director and matron reminded ward and medical staff that patients should

not leave the ward without a letter and reminder notices were visible around the wards. During the final day of our inspection there were 32 outstanding discharge summaries to be completed following a busy period the evening before. Timely follow ups for children in community paediatrics were not available as a result of staff sickness and staff vacancy. Control measures were in place which included a review of pending lists and reallocation where possible and additional consultant clinics were provided to see the most at risk patients. Any acute concerns were picked up by acute paediatrics. Alternative methods of contact had been instigated including telephone consultations with a parent (followed up by a letter) or advice by letter. Professional enquiries were passed to clinicians and managed through e-mails and telephone calls.

- There had been an increase in referrals for sensory processing. The community occupational therapists were looking at different models of care and inclusion criteria to meet the demand through pathways and training on the ground.

Meeting people's individual needs

- Children and young people were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs.
- The learning disability and autism specialist team were notified of admissions of children or young people with a learning disability. Children and young people with a learning disability, and their parents or carers, were encouraged to use the hospital passport when they came into hospital. The passport gave hospital staff important information about children and young people and reasonable adjustments that might be required. It outlined the "Things you must know about me; Things that are important to me; my likes and dislikes". This alerted staff to contact the learning disability liaison team who could then provide appropriate support. A risk assessment and care plan was completed on admission and reasonable adjustments were put in place which ranged from open access for carers, chairs for carers to stay and double appointments.
- The trust provided a framework to support communication with patients and carers who were non-English speakers, people for whom English was a second language, people with hearing or visual impairment, or who had learning disabilities. The policy set out clear standards to promote good practice and covered the use of face-to-face interpretation, telephone interpreting, and written translation services. The trust provided three main interpreting services: the Big Word, a 24 hour telephone interpreting and translation including braille for which each department had a unique ID access code; Job line Staffing Services, a face to face interpreting service and Hearing Loss, a– British Sign Language service.
- Outpatient appointments were made via the NHS Choose and Book system or the referral management system and children were referred for specialist clinics or seen for initial assessment in a general paediatric clinic if appropriate.
- The areas we visited in the children's wards, the outpatient department, the children's' development centre and the neonatal unit were accessible to disabled people, and there were appropriate toilet facilities.
- A number of advice leaflets for parents were seen during our visit. These included conditions such as asthma, croup, eczema, nasal surgery, wheeze management, febrile convulsion. There were also leaflets with advice on going home. One parent told us this information was "very reassuring" and helped them "to know what to look out for and what to do." Developmental care booklets were available on the neonatal unit about topics such breast feeding, positive touch and the need for rest.
- There were parent information boards on the children's wards, outpatient department, the community child development centre and the neonatal unit giving details of meal times, infection control, activities and chaplaincy services.
- Patient / visitor concessionary car parking permits were available on application for those attending the hospital on a long-term basis and for those attending hydrotherapy sessions parking permits were available for spaces near the child development centre.
- The hospital's spiritual and pastoral care team provided pastoral support and spiritual care to children, young people and their families. They provided support for all faiths (and none) and maintained close contact with faith leaders in the community. There were chaplains providing a 24-hour emergency on-call service and lay volunteers. Staff said they recognised and respected the importance of individual's religious or spiritual beliefs in their wellbeing. All parents were asked if they would like

the spiritual and pastoral care team to be informed of their admittance and this information recorded and shared. As far as was reasonably practicable, the trust endeavoured to provide suitable facilities to enable people to practice their religions/beliefs within the trust's premises.

- The large play room for the wards was inviting and contained an impressive range of toys and activities. This included a book trolley, a craft table with a host of materials. There were dolls and cars, lorries and ships, jigsaws, a toy cooker, and experienced play specialists assisted with child-led creative sessions. Dolls were used by the team to act out operating theatre procedures with real equipment ahead of anaesthesia. A model of an MRI scanner with model people was used to prepare children awaiting a scan and children could crawl through a plastic tube on their bed to help them prepare for the confined space of the scanner. Staff were very proud that very few children required sedation for procedures.
- Play specialists worked closely with the clinical psychologist and provided an outreach service to other areas in the trust. The play specialists were popular with children, parents and staff and they encouraged children to think about the creative activities they could engage with. Play specialists aimed to see every child or young person once.
- There were photographs of every stage of the child's journey of their procedure, preparation colouring books and an assessment tool with emoji faces and numbers was used to ascertain mood. There was also a range of other equipment intended to help distract and absorb children.
- A well-equipped sensory room for stimulating or calming children was situated next to the play room.
- A range of other services visited the ward regularly such as a music therapist, musicians, entertainers and a storyteller.
- Other areas with play facilities included paediatric outpatients, an area for siblings of babies on the neonatal unit and the paediatric emergency department and the child development centre.
- Children who were well enough and were in hospital for more than five days received schooling from a local education provider. There was a school room adjacent to the outpatient department. Medical staff identified children and young people who met the criteria for educational input. A designated teacher coordinated schoolwork, liaised with the child's school if appropriate, and attended any specific meetings. Children were taught in the schoolroom, at the bedside or on the ward. School operated during term-time. Art projects and sports weeks were also encouraged and arrangements could be made for children to take exams in hospital.

Learning from complaints and concerns

- Parents knew how to make a complaint if they needed to and also felt they could raise concerns with the clinical staff they met. Most parents told us if any issues arose they would talk to the senior nurse available. Information about making complaints was available in all the areas we visited.
- Prior to the inspection the trust provided details of the complaints in the period from April 2016 to March 2017. There had been 15 complaints and we saw details of the outcomes, actions taken and lessons learned. The overwhelming learning from all these complaints was communication, including failure to communicate in a timely fashion and failure to communicate compassionately. Divisional nurse and the governance lead were planning a day on communication skills between patients, disciplines, specialities and divisions using the 'Whose Shoes' methodology.
- Staff encouraged children, young people and their parents or carers to provide feedback about their care and to indicate how likely they were to recommend services to friends and family, and what was good and or could be better about the ward. The test form was available on departure or to complete online if preferred.
- Staff were aware of complaints and any learning that had resulted. The staff we spoke with were all aware of the complaints system within the trust and the service provided by the hospital's patient advice and liaison service (PALS). Staff were able to explain what they would do when concerns were raised by parents. They said they would always try to resolve any concerns as soon as they were raised, but should the family remain unhappy, they would be directed to the clinical manager or the trust complaints' process.
- Divisional staff involved with the management and administration of formal complaints met on a weekly basis. They discussed the current status of any

complaints, identified themes, and agreed any immediate actions that were required. Learning was disseminated back to the teams involved in a complaint.

- The patient experience group worked to deliver the patient and family experience strategy and as part of this remit reviewed the processes and handling of complaints, concerns and compliments, and their themes and trends, and received the quarterly and annual reports prior to submission to the quality assurance committee.
- Complaints and PALS leaflets were displayed widely across the units. The trust website contained information on raising concerns and making complaints. The complaints/PALS officers triaged all concerns and complaints being received into the trust to determine whether they could be de-escalated and resolved informally before registering as a formal complaint; they discussed options with the complainant if they were not sure how they would like their concerns resolved. Staff were encouraged to resolve issues informally and quickly to stop them escalating into complaints.
- An investigating officer was appointed within the relevant division and varied depending on the nature of the issues to be investigated and could be a service lead, a ward manager, a matron or a consultant. The investigations were documented by each divisional governance team. Responses were primarily written from the associate director of the division concerned, and quality checked internally before signing. A final response cover letter was sent from the chief nurse with an invitation to the complainant to come back to the trust with any additional concerns or questions. A complainant satisfaction survey was sent to complainants who had received their responses from January 2017 onwards. Investigation records were held within the division.
- During the last 12 months the trust had implemented more timely targets for responding to complaints. This was 25 working days for a complaint relating to one division and 45 working days for a complaint crossing more than one division, or was more complex, or was a multi-agency complaint.
- Quarterly reports provided detail on learning from complaints, as did the annual report and these were reported and distributed through the patient experience group and quality assurance committee. Examples of learning from complaints were discussed at specialty and divisional level.

Are services for children and young people well-led?

Good

We rated well-led as good because:

- The leadership, governance and culture were used to drive and improve the delivery of high-quality care. The clinical managers were committed to the children and young people in their care, their staff and the unit.
- Frontline staff and managers were passionate about providing a high quality service for children and young people with a continual drive to improve the delivery of care.
- There was a high level of staff satisfaction with staff saying they were proud of the unit as a place to work. They showed commitment to the children and young people, their responsibilities and to one another. All staff were treated with respect and their views and opinions heard and valued.
- Children and young people were able to give their feedback on the services they received; this was recorded and acted upon where necessary.

Vision and strategy for this service

- There was an integrated business plan for the division and this was aligned with the trust strategic objectives of partnership, quality, people and resources and the trust values of care and compassion, inspiration and innovation, working together, pride and achievement, trust and respect.
- Child health spanned health services across acute and community services for children and young people from birth to when they transitioned into adult services. The main area of focus for 2017/2019 would be to integrate services as part of the “One Vision” transformation plan for children across Cornwall and the Isles of Scilly.
- The partnership plan had been drawn from extensive engagement with professionals, partners, children, young people, parents and carers. It set out the vision, principles, drivers for change, priority outcomes,

meaningful measures, actions and enablers that would inform the Children and Young People Transformation Plan 2017-2020. The partner organisations involved in developing this plan included commissioners and providers of education services, community and acute health services, early help and social care services, community safety and policing, work, benefits and housing.

- The vision for child health was that care was delivered to children and their families in a streamlined way avoiding duplication and leading to a better experience and overall healthier population. There were five priority outcomes: strengthening families and communities; promoting and protecting children's physical, emotional and mental health, helping and protecting children from the risk of harm; raising aspiration and achievement towards economic wellbeing and making a positive contribution to the community. Pathways of care were being developed and service models to deliver these internally and with partners externally. Work stream priorities included pathways of care, triage from admission from the emergency department, joint working with the community, IT platforms, lead nurses in the emergency department, training together with the emergency department and surgery.
- Staff had a good understanding of the core values of the service and were committed to providing family-centred care.

Governance, risk management and quality measurement

- There was a clear structure for clinical governance with regular monthly business meetings for acute paediatrics, neonatal and community paediatrics. Minutes from these meetings showed that issues affecting the service were discussed and actions taken. These included a review of incidents reported, risks identified on the risk register and risk management, infection control, safeguarding updates and staffing. The meetings fed into the directorate governance meetings and any actions were tracked to keep them reviewed and updated.
- Regular auditing took place with evidence of improvement or trends. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results.
- There were monthly paediatric mortality review meetings where lead clinicians gave a brief anonymised presentation on each case with learning points and actions. A standard proforma was completed for each mortality.
- There was a clear performance management reporting structure with regular meetings looking at operational performance which fed into the executive performance reviews.
- The units understood, recognised and reported their risks. A risk register was in place and we noted that this had been kept up to date. Risks were identified on the risk register with actions required and taken and a review date. Reference was made to known risks, for example, the risks posed by the lack of access to the electronic notes used by another NHS provider of community children's services, the delays in registering new-born babies' delays in providing numbers for registration and the difficulty in accessing suitable transition for CAMHS patients. A full review of risk was undertaken each month. Risks were shown by specialty and risk level and mitigating actions were recorded.
- Clinical policies and guidelines were available for all staff via the trust intranet system.

Leadership of service

- The local leadership of the services had the skills, knowledge and integrity to lead the teams. The clinical managers were an experienced and strong team with a commitment to the children, young people and families who used the service, and also to their staff and each other. They were visible and available to staff, and we saw and heard about good support for all members of the team. Staff felt able to openly discuss issues and concerns with senior staff and their managers. They believed they would be listened to, and actions taken when necessary if anything needed to change or be addressed.
- The service was part of the Women, Children's and Sexual Health Division with an associate director who was supported by directorate managers and the clinical team. The team was led by an experienced clinical director. They were supported by a team of knowledgeable and skilled consultant paediatricians, neonatologists and doctors and a community team of community paediatricians and therapists. The nursing

staff were led by experienced senior nurses, a divisional nurse and a matron, and they were supported by staffing teams led by experienced and skilled ward managers.
- The senior management team communicated with staff by email and face-to-face. We received consistently positive feedback from staff who had a high regard and respect for their managers.
- Through the content of governance papers and talking with staff, we saw the leadership of the unit reflected the requirement to deliver safe, effective, caring and responsive and well-led services.
- The leadership, both within medical and nursing staff, clearly understood the challenges to delivering good quality care. They could identify areas where the department needed to improve and what it would take to address these.

Culture within the service

- The staff we spoke with during the inspection said they were proud to work on the units and were passionate about the care they provided. Managers we spoke with said they were proud of the staff they supervised. They said there was a high level of commitment to providing quality services to the children and young people. One member of staff told us, "I feel supported by my colleagues and a valued member of the team… we are like a family and do the best we can." Another member of staff told us, "this is the most welcoming hospital I've worked in."
- Staff were positive about working for the trust, although there had been times when they felt stretched and under pressure because of the volume of their work.
- The culture within children's services encouraged candour, openness and honesty. Staff said they were encouraged to raise concerns. All staff felt comfortable about raising any concerns with their line manager.
- Staff were aware of the trust whistleblowing policy and the arrangements for reporting poor practice without fear of reprisal. They felt confident about using this process if required and that concerns would be taken seriously.
- The staff teams told us that they were always keen to learn and develop the service. Innovation and improvement was encouraged with a positive approach to achieving best practice.
- It was apparent during our inspection that all the staff had the child, young person and their families at the centre of everything they did. They were dedicated to their roles and approached their work with flexibility.

Public engagement

- There were systems to engage with the public to ensure regular feedback on services. This was used for and learning and development. Parents and young people were encouraged to complete a Friends and Family Test form. The response rate was 22.5% and although this was an improvement of 8.5% divisional senior nurses continued to look at innovative methods to increase this further.
- Children, young people and their parents and carers were encouraged to contribute to service development. Various specialist services within paediatrics had support groups and there were parent support groups taking place on the units with information available about other support groups in the area.
- The trust participated in the CQC National Children's Inpatient and Day Case Survey 2014. The survey focused on young patients who were admitted to hospital as inpatients or for treatment as day case patients. It covered every aspect of a child's stay in hospital from interactions with staff, pain management, and facilities for parents and carers. There were 137 acute and specialist NHS trusts across England participating. Feedback was received from nearly 19,000 young patients. The report showed how a trust scored for each evaluative question in the survey, compared with other trusts. An analysis technique was used to determine if the trust performed about the same, better, or worse compared to other trusts. Results were presented for two main groups: children and young people, and their parents or carers.
- Children and young people were asked to answer questions about different aspects of their care and treatment. Based on their responses a score out of ten for each question was allocated and showed most results about the same as other trusts. Questions were divided into issues relating to safety, effectiveness, caring, responsiveness and well led. The trust performed about the same as most other trusts in England in all categories

Staff engagement

- There were effective systems to engage with staff.

- Most staff said they had completed the staff survey for 2016-2017 and would recommend the trust as a place to work. Trust-wide survey results showed 53% responded positively to recommending the trust as a place to work. This was below the national median for acute trusts of 62% and the trust acknowledged there was still much work to do to improve how the staff felt about working at the trust.
- All staff we met said they felt valued and part of the team. They were able to express their opinions and raise concerns through unit and trust-wide forums. Information was provided to staff through regular newsletters sent electronically to staff and displayed on notice boards in ward office areas
- A newsletter was shared with managers across the trust containing information to be shared in team meetings. There were regular staff meetings and publications for patients, staff, volunteers and members called One + all and One + all magazine. A wonderwall had been created in the Trelawney wing where patients and relatives could place messages of thanks for care and staff could thank colleagues. There were message slips and pens available beside the wall.
- Nominations could be made from patients, visitors or staff members for 'We Care Awards' to celebrate outstanding achievements. Individuals and teams working in any part of the trust could be nominated, including volunteers and those employed by external contractors.
- Regular meetings and emails provided opportunities for feedback about governance issues such as incidents, complaints and risk assessments. Performance and continuous improvement was also assessed through discussions about essential training, clinical skills and competencies.
- Clinical managers worked on the wards to be able to engage with staff and see for themselves any issues staff faced. Staff confirmed they were visible and approachable.
- A Freedom to Speak Up Guardian had recently been appointed in the trust. Not all staff were aware of this role or that they could raise concerns about patient care and safety, or any other anxieties they had.
- Access to 'talking therapy' was available for all staff through the trust Employee Assistance Programme. This was a programme based around cognitive behavioural therapy and provided staff with an independent counselling service and advice line.
- Staff said they were proud to work in an inclusive and diverse team where everyone talked to each other and pulled together.
- Staff had access to flexible working and leave policies which included, job sharing, part time working, term time working, compressed working and annualised hours.

Innovation, improvement and sustainability

- Staff were clear that their focus was on improving the quality of care for children, young people and their families. They felt there was scope and a willingness amongst the team to develop services. The team were dedicated with lots of energy and were often one of the first divisions to roll with trust-wide initiatives**.**
- There were a number of examples of projects and programmes undertaken. In May 2016 the hospital was one of six neonatal units nationally to be awarded the prestigious Burdett funding to support work in attaining the Neonatal Baby Friendly Accreditation from UNICEF. Well Child, the national charity for seriously ill children funded a new children's nurse post following a joint bid from the trust and another provider of community services in the county. The post supported children, young people and families living with complex medical conditions in the community, hospitals and other specialist centres to ensure quality care was delivered. Help to reduce the time children had to spend in hospital was also provided by arranging and coordinating the care they needed at home and providing specialist advice as well as emotional and other practical support for the whole family.
- Dieticians had introduced regular exercise clinics which were supported by the Cornwall healthy weight initiative and as part of this the exercise clinics would be trialling activity trackers as part of the project.
- The acute nursing team had been involved in the design and planning of the apprenticeship advanced nurse practitioner role and had been party to discussions held around rotational recruitment between trust and a neighbouring trust to attract and retain staff.
- A Handy app which had been developed by a trust in the south west had been tailored to suit the needs of the county and provided a wealth of information and advice for clinicians.
- There were designated champions for innovation to support any staff who had ideas for change and wanted to take them forward. Innovation club breakfast

meetings were held every six weeks for those wishing to share ideas. A nurse buddying system had been developed by a member of staff and was in place across the children's service.

End of life care

Safe	Requires improvement
Well-led	Inadequate
Overall	Inadequate

Information about the service

End of life care throughout Royal Cornwall Hospital encompasses all treatment and care provided to patients identified as approaching the approximate last 12 months of life, as well as for patients for whom death is imminent. This includes essential nursing care, specialist end of life care, bereavement and chaplaincy support and mortuary services. Care and support is also offered as required to relatives and those people close to patients.

End of life patient care is provided by staff working on any ward or in any clinical setting, for example, outpatient clinics and the emergency department if it is required by patients. In addition, specific expertise is available from the trusts specialist palliative care team to support patients in this stage of their condition. The palliative care team provides trust wide expert clinical advice, support and staff training, particularly for patients with complex care needs

There is a cancer support centre located at the hospital site and accessible to any person affected by cancer. This is staffed by Macmillan cancer support professionals who are employed by the trust. A range of training is also available to staff through the centre.

End of life care at The Royal Cornwall Hospitals Trust is provided in two ways. A specialist palliative care team provides a responsive, bespoke and focused service to patients with complex palliative care needs, via a referral system accessed by nursing and medical staff. This specialist palliative care team comprises two whole time equivalent (WTE) and one part time nurse specialists, one part time administrator and one (WTE) specialist palliative care consultant. An identified link occupational therapist and chaplain work with the team and both attend a weekly specialist palliative care team patient referral and review meeting. General end of life care is provided to all patients by staff working on any ward or clinical setting and is supported by a "link nurse" from each ward. Additionally an "End of Life" care team was in the process of being established by the trust. At the time of our inspection this team comprised of a part time (16 hours per week) clinical nurse specialist on a fixed term one year contract. The remaining roles within this team were vacant at the time of our inspection. The exact role of this team was still in the process of being finalised during our visit. We were told the initial aim of this team is primarily to provide education around end of life care within the trust.

The director of nursing was the trust's executive lead for end of life care, with support from the deputy director of nursing. The medical director was the executive with responsibility for Treatment Escalation Plans.

Between 1st April 2016 and 31st March 2017 the trust reported there had been 1679 deaths in the hospital. During the same period, 836 new referrals had been made to the specialist palliative care team, with an additional 55 patients receiving ongoing care from this team. Of the total patients seen by the specialist palliative care team, 614 (69%) were cancer related and 277 (31%) were non-cancer related.

During this inspection we visited 14 wards and six other specialist departments. These included: the intermediate care and discharge team, the onward care team, the discharge lounge, the cancer centre, the mortuary, chaplaincy service and bereavement office. We spoke with five patients and those close to them. We reviewed 13 sets of patient care records and looked at 13 combined patient treatment escalation plans and Do Not Attempt Cardio Pulmonary Resuscitation **(DNACPR) forms.**

We spoke with 51 staff about end of life care. These included; the specialist palliative care consultant, two of the specialist palliative care nurses, 26 registered nurses, four health care assistants, three chaplains, the end of life trust lead (who was the director of nursing) the interim deputy director of nursing, three administrators, two mortuary assistants plus the mortuary manager, two consultants and 19 junior doctors. We also spoke with a group of 20 volunteers.

End of life care

We observed care being provided to patients and relatives and attended a specialist palliative care team weekly multidisciplinary meeting. Before, during and after our inspection we reviewed the trust's performance information.

End of Life care at Royal Cornwall hospitals trust was previously inspected in January 2017, and was rated as inadequate. End of life care had also been rated as inadequate in January 2016 during a comprehensive inspection. This inspection aimed to follow up on the findings of the most recent inspection; we specifically reviewed the domains of Safe and Well-Led only.

Summary of findings

We rated this service as inadequate because:

- There was no evidence of oversight or scrutiny of incidents that related to end of life care at the trust. Therefore, there was no evidence of learning or changes in practice that had resulted from such incidents.
- Treatment escalation plans were audited and consistently shown not to be completed fully, often missing essential information about whether patients had mental capacity to consent to the plan.
- The specialist palliative care team was too small to meet the demands of the trust as per national guidance. It was only able to provide a five day a week service, and even this stretched the capacity of the team.
- There was not sufficient information or audit for the trust to be assured of the effective use of end of life care documentation. Audits did not address the quality or completeness with which the documentation was completed or understood, and did not contain any follow up action plans to address the issues raised.
- There was no clear incident reporting process for staff to follow in the event of a delayed fast track discharge. There was no evidence of executive oversight of the problem caused by inconsistent reporting.
- There was poor communication at executive level about the future plans for the end of life service at the trust and a lack of consultation on the business plan that lay behind these plans.
- We saw a business plan for the development of end of life care at the trust going forward. However we saw little evidence that there had been any tangible improvements in end of life care with the exception of the increase in use of the end of life care documentation.
- There was a lack of any systematic audit programme relating to end of life care, and few measures that addressed risk and quality.

End of life care

- There was no evidence that the End Of Life Care strategy was being monitored or taken forward since the departure in May 2017 of the end of life facilitator. Key tasks such as training needs analysis within the strategy had not been completed.
- There was no scrutiny or interrogation of, delayed fast track discharges, or the achievement of preferred place of care, for end of life patients and so no learning could be taken from these.
- We saw few mechanisms for capturing feedback from patients, their families and carers, or from staff. There had therefore been no input from these groups into the end of life service.
- We were not assured of sufficient oversight and management of the risk register relating to end of life care.

However:

- Individual reporting of incidents specific to end of life care had improved since our last inspection and the ability of staff to identify such events was good in many of the areas we visited.
- There was an improvement month on month in the number of patients with an end of life care plan based on the five priorities of care.
- Equipment, such as syringe drivers and specialist mattresses was readily available for patients who needed it.
- Areas we visited were proactively managing risks, both in and out of hours to meet the needs of patients who were at the end of life.
- There were effective arrangements in place around the prescription of anticipatory medications to ensure that patients' symptoms could be managed in a timely way.
- Locally, we saw excellent examples of leadership within the specialist palliative care team and the mortuary which meant that staff working within these services benefitted from the support and commitment of their leaders.
- Substantial funding had been agreed which aimed to improve education and provision of end of life care at the trust.
- There had been some improvement in the profile of end of life services since our last inspection.
- The specialist palliative care team were held in extremely high regard across the trust in all areas we visited.

End of life care

Are end of life care services safe?

Requires improvement

We rated safe as requires improvement because:

- There was no evidence of oversight or scrutiny of incidents that related to end of life care at the trust. Therefore, there was no evidence of learning or changes in practice that had resulted from such incidents.
- Treatment escalation plans were audited and consistently shown not to be completed fully, often missing essential information about whether patients had mental capacity to consent to the plan. Incomplete treatment escalation plans were reported on following both the January 2017, and January 2016 inspections.
- The specialist palliative care team was too small to meet the demands of the trust as per national guidance. It was only able to provide a five day a week service, and even this stretched capacity of the team with limited cover arrangements to accommodate annual leave and sickness. This issue was reported upon following both the January 2017 and January 2016 inspections.
- There was not sufficient information or audit for the trust to be assured of the effective use of end of life care documentation. Audits did not address the quality or completeness with which the documentation was completed or understood, and did not contain any follow up action plans to address the issues raised.
- There was not a clear incident reporting process for staff to follow in the event of a delayed fast track discharge. There was also no evidence of executive oversight of the problem caused by inconsistent reporting, and a lack of anyone with clear responsibility for the issue.

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- There was an improvement month on month in the number of patients with an end of life care plan based on the five priorities of care.
- Equipment, such as syringe drivers and specialist mattresses was readily available for patients who needed it.
- Areas we visited were proactively managing risks, both in and out of hours to meet the needs of patients who were at the end of life.
- There were effective arrangements in place around the prescription of anticipatory medications to ensure that patients' symptoms could be managed in a timely way.

Incidents

- Between May 2016 and April 2017, the trust reported no incidents which were classified as never events for end of life care. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. In accordance with the Serious Incident Framework 2015, the trust also reported no serious incidents (SIs) in end of life care that met the reporting criteria set by NHS England between May 2016 and April 2017.
- There was not sufficient oversight of incidents relating to overall end of life care at the trust, or clear mechanisms to facilitate learning from such incidents. We were told that incidents and their learning were discussed in the end of life care group meetings which were planned to occur bi-monthly. We reviewed the minutes of the previous end of life care group meeting and found that incidents had not been discussed at the meeting. This meeting had occurred six months prior to our inspection, and there had not been another since that time. Therefore this meeting did not appear to be an effective process to review incidents.
- Locally, the specialist palliative care consultant had responsibility for the oversight of incidents that related to patients referred to that team. We saw evidence that such incidents were the basis of learning and developing practice for this team, which could include education for all staff providing end of life care. We saw good examples of how learning from incidents had occurred in the hospital mortuary. The mortuary manager took responsibility for the oversight of incidents in that area.
- Learning identified for the incidents we reviewed did not identify specific actions or mitigations that could be taken to avoid repeat events. For example a single word reason of "communication" was written for one incident, this did not clearly identify what action needed

to be taken and by who. None of the staff we spoke with were able to tell us about any changes in practice, or learning that had occurred as a result of end of life reportable incidents.

- Most staff we spoke with had an understanding of their responsibility to report incidents and the types of incidents that should be reported as an end of life concern. For example, if a patient at the end of life was unable to be cared for in a side room, this was recorded as an end of life related incident. Staff spoke confidently about incident reporting where patients did not achieve their preferred place of care and we saw evidence that this was the case. A small number of staff said they were unclear as to the types of incident that may be classified as end of life specific. An end of life incident prompt list was available for staff on the trust intranet.
- When we asked, the specialist palliative care team demonstrated they were aware of the duty of candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 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.

Cleanliness, infection control and hygiene

- Systems were in place to prevent and protect people from healthcare associated infections in most of the areas we visited.
- The mortuary, chaplaincy and bereavement services were co-located in an area of the hospital. This appeared clean and hygienic. Cleaning schedules were in place and were completed daily to demonstrate the areas had been cleaned regularly and consistently. The mortuary technicians were responsible for cleaning rooms and equipment in accordance with a cleaning schedule. Checks were made by the manager to confirm this had taken place.
- On wards and in clinical areas there were plentiful supplies of hand hygiene gels and sinks with soap for hand washing. Posters reminded staff and visitors to ensure their hands were clean whilst in these areas. We saw staff washing their hands and using the hygiene gel regularly, as well as using the personal protective equipment that was available to them.
- On some of the wards we visited, we saw that areas underneath patient beds were unclean, with visible dust which created a hygiene risk. This was escalated with senior ward staff at the time of our inspection

Environment and equipment

- The design, maintenance and use of facilities and premises kept people safe. The trust had an “equipment library” which was used to store all equipment that may be required. If end of life patients required syringe drivers, these could be ordered, collected by porters and brought to the ward – normally within 30 minutes. An audit completed by the medical devices lead showed that the average time for equipment to be delivered to the ward was 27 minutes. Staff told us there were plentiful supplies of these, and they came complete with all of the associated equipment for their use. Syringe drivers are machines which deliver a continuous dose of medicines under the skin of a patient. We looked at the records of patients with syringe drivers and saw that they had been checked regularly in accordance with the trust’s policy.
- The capacity of the mortuary was for 74 adult patients at any one time, plus contingency for a further 24 in the event the main mortuary being full. One viewing room meant there was a high chance that visitors may have to wait to be able to view deceased patients. However, this was mitigated by a booking system used by the bereavement team. Additionally, the mortuary had two waiting rooms that could be used by those close to patients should they need to wait to view deceased patients.
- Entrance to the mortuary was secure via alarmed doors which were monitored by CCTV and required a swipe card to gain entry. Only defined staff were given an entry swipe card which meant that the manager of the mortuary could be assured of its security. Footage from the CCTV was regularly monitored to ensure that the entry system was being used effectively, as well as to enable the manager to be confident the mortuary was being appropriately and safely accessed during out of hours.
- Mortuary equipment was serviced and maintained by trained staff through a combination of external and

internal contracts with companies specialising in the field. We were told that these companies were always responsive and attended to maintain equipment when requested.
- Staff followed a range of guidance, policy and procedures to transfer patients safely in and out of the mortuary.

Medicines

- Arrangements for managing the medicines required by patients at the end of their lives kept people safe. The specialist palliative care team worked closely with other clinical staff to ensure that the appropriate anticipatory medications were prescribed for patients at the end of their life. Anticipatory medicine is a term used to describe a collection of medicines that may be used to treat troublesome symptoms that often affect patients in the time leading up to their death. We saw guidance for prescribing anticipatory medicines for pain and symptom relief that aimed to assist doctors who were not specialists in this area.
- An audit completed in May 2017 into the compliance with the trust's policy on prescribing anticipatory medications showed that in 56% of cases anticipatory medicines were prescribed in line with best practice. 16% were incomplete, meaning that the complete range of anticipatory medications had not been prescribed and 4% were had no anticipatory medications prescribed at all. The remaining 24% of patients who were studied had died unexpectedly and so were not being cared for on an end of life pathway. However this audit was based on a sample of only 25 sets of patient records. The audit also looked at patients who had a syringe driver in place. This found that all of the patients who had one in place were appropriate patients to receive this type of medication. It further identified three patients who did not have a syringe driver in place, could have benefited from one.
- We found that a training and competency assessment for staff to be able to use syringe drivers was rolled out across the trust. Not all staff were trained to use syringe drivers, however ward leaders we spoke with had a clear understanding of which of their staff were trained to do so. The safe use of syringe drivers was further enhanced by the provision of a check sheet which prompted staff to follow a consistent safe process.
- Nurses said they were confident in raising the question of anticipatory medication with medical staff, when they felt patients required it and that they were listened to. In addition, the care planning documentation used for patients at the end of their lives had been updated to ensure that the use of anticipatory medication was considered for all of these patients.
- In all of the wards we visited, we saw that there were plentiful supplies of anticipatory medications available for use by patients. None of the staff we spoke with could recall there being any delays due to a lack of medications being available. This included controlled drugs, which we saw were stored in double locked cupboards inside locked rooms.
- Staff consistently described processes for discharging end of life patients that ensured they, or their families and carers were able to manage their medicines safely whilst at home. There was a supply of information leaflets that could be given to patients to support their understanding of their medication upon discharge.

Records

- People's individual records were not always written in a way that kept them safe and met their specific needs. We looked at 13 sets of patient records of end of life patients. The trust had introduced care plans that related specifically to the needs of this patient group. Based on national guidance around the "Five Priorities of Care" these documents aimed to tailor care for patients at the end of their life and contained both nursing and medical sections in the one document. Of the records we looked at for patients identified as in the last year of life, four did not have specific end of life care plans in place.
- Records that we saw were signed and clearly stamped by those staff responsible for completing them. Nursing assessments were completed which identified the needs of patients in relation to their end of life care.
- Staff had received some training via a "toolbox" facility on the trusts intranet that aimed to support them to learn to use the specific end of life documentation. We were told by staff that they felt the documentation was easy to use and the fact that it was all contained within one document made it a much friendlier document.
- An audit of the completion of the end of life documentation showed that its use had increased in the after its launch in December 2016 from 28% in the first month, to 80% by March 2017. However, this audit did not identify how comprehensively or effectively this document was being used, only whether it was or

wasn't in use. Additionally when we asked how leaders were assured of its effective use in clinical areas, we were told that assurance was sought by asking staff directly how they were finding it. The review was not specific to the numbers of staff asked about the documentation, where they were working and when they were spoken to as this was not recorded.
- We saw that records were organised and stored safely in locked cabinets to ensure the privacy and confidentiality of patient's information.

Safeguarding

- The trust had processes in place to safeguard vulnerable adults and children from abuse. All of the staff we asked were clear about their responsibilities and what actions to take if they needed to make a safeguarding referral. Staff were also able to demonstrate an understanding of the types of concerns that may alert them to a possible safeguarding concern.
- The specialist palliative care team had a 100% completion rate for safeguarding adults and children training at level two.

Mandatory training

- The specialist palliative care team received effective mandatory training in safety systems processes and practices. We were provided with data that told us the level of mandatory training achieved by the specialist palliative care team. This showed that completion of mandatory training for this team ranged between 80% and 90%.
- End of Life training had recently been added to the mandatory training schedule for all staff within the trust. This training was given at induction and then to be repeated annually by staff. At the time of our inspection the training had only been in place for a few months and so those staff who had not yet received their annual mandatory training update, had not yet received the end of life mandatory training. However, the schedule ensured that all staff would have completed this training within 12 months of its introduction. Due to the recent introduction of this training we were not provided with information that demonstrated compliance within the trust.
- Additional training had been designed by the previous end of life facilitator. This was in the form of a "toolbox" training tool for staff to work through. The tool covered the national guidelines of the "five priorities of care" and the associated care planning documents to provide a specific focus on end of life care. Completion of this training was arranged informally on a ward by ward basis. The trust provided us with data showing the number of staff on each ward who had completed this in December 2016. However, the data supplied did not show the compliance rate or the number of staff still to receive this training.

Assessing and responding to patient risk

- Staff identified and responded appropriately to changing risks of patients. The specialist palliative care team met every morning to discuss and review new referrals as well as ongoing cases needing attention. The aim of this daily briefing was to prioritise cases and review changing patient needs. In addition they met weekly for a full multidisciplinary discussion about all patients in the trust who were referred to the team. They were joined at this meeting by the hospital chaplain, an occupational therapist and an administrator. We attended this meeting and saw that comprehensive and detailed discussions were had about all patients, including their pain relief, completion of treatment escalation plans and their preferred place of care.
- Patients receiving end of life care on wards benefitted from daily clinical meetings which allowed for a regular review of their care. Doctors and nurses discussed patient's conditions and amended treatment plans accordingly. This included a review of treatment escalation plans.
- Staff were not always able to respond appropriately to changing risks of people receiving end of life care. We looked at 13 treatment escalation plans (TEPs) during our inspection. A TEP is a document used to define the range and limits of a person's treatment often when it is predicted they are at end of life. Not all of the TEPs that we looked at had been completed fully by doctors. The sections that were left blank included confirmation that an assessment of a patient's capacity to consent had been completed, and whether a discussion had been held with the patient/relatives/ carers about the content of the TEP. When we spoke with junior doctors, they told us they often found it difficult to get support from their senior colleagues when completing a TEP. It was felt by some that some senior doctors believed that doctors should make decisions at the time of treatment and so were reluctant to sign off a TEP.

End of life care

- An audit published in June 2017, completed by the trust lead for TEPs had looked at a sample of 388 patients. The audit showed that of the 235 patients (60%) that did not have a completed TEP, 72 (31%) of these should have had one in place. Trust policy defines clearly the circumstances under which a TEP should be considered. This meant that the trust could not be assured that all patients at the end of life were being treated appropriately if their condition deteriorated.
- Risk assessments were carried out for patients receiving end of life care and management plans developed that were in line with national guidance. We saw that risk assessments were completed in relation to pressure areas, and embolisms, as well as nutrition and falls in all of the records that we looked at. These assessments also included action plans to address the risks presented to patients, for example the prescription of medication to minimise the risk of embolisms in patients who were not mobile.
- Some nursing staff were able to identify and respond appropriately to changing needs of patients receiving end of life care. We saw evidence in the areas that we visited that nursing staff felt confident to have discussions and challenge medical staff about whether patients were or were not entering the final stages of life. We saw that where appropriate, patients were commenced on the "end of life pathway". This pathway aimed to ensure that the specific needs of end of life patients were taken into account in the planning of their care and treatment. We also saw evidence that staff were not afraid to take patients off of this pathway, where their condition improved and amend their care and treatment accordingly.
- Patients for whom it was determined a discharge into their preferred place of care was the desired course of action, were referred to the onward care team. This team was responsible for arranging funding and onward care for this patient group following their discharge. At the time of our visit, three end of life patients were awaiting discharge and had funding in place to provide the necessary packages of care. One of these patients had had this funding in place for seven days but had been unable to be discharged due the absence of suitable care in the community. Another patient had been waiting for two days post funding agreement. We were told by ward staff that patients sometimes had to wait weeks and as a consequence did not all achieve their preferred place of care.
- Staff on Lowen ward, providing care to patients with cancer, also provided a 24 hour advice and triage phone service to patients at home. Using the United Kingdom Oncology Nursing Society (UKONS) triage tool, registered nurses assessed patients who contacted the ward to establish whether or not their symptoms suggested they needed to be admitted to hospital. This system worked effectively to identify patients at home who were deteriorating and meant they could be admitted to hospital directly from home. In addition we saw that staff on Lowen had numerous risk assessment tools that enabled them to identify at the earliest opportunity, patients whose condition may be deteriorating quickly.
- On the Headland unit, providing chemotherapy to outpatients, a radiographer had become the first radiographer in the trust to become qualified as a non-medical prescriber. This meant that whereas previously staff and patients would have to wait for a doctor to prescribe medication which could delay patients, this was no longer the case. In addition, this radiographer was working with the hospital pharmacy team to address ongoing pharmaceutical arrangement for the unit to further streamline and improve the service.

Nursing staffing

- The allocated specialist palliative care team was insufficient in size to provide a seven day a week service to patients and support other trust staff. The nursing establishment of this team comprised 2.7 whole time equivalent nurses made up of a band 7 clinical nurse specialist, a band six nurse and a band five nurse who was part time. All of these posts had been recruited to. We were told that these nurses regularly arrived early for work and stayed later in order to provide a service to patients in need.
- We heard from numerous nursing staff across all areas that they would benefit from a greater presence of the specialist palliative care team and the bespoke support it could offer. However, we did not see any evidence that the additional funding secured prior to our visit would be used to increase the presence of the specialist palliative care team to a seven day service. We were told the funding would be used for an additional end of life team.
- There were no cover arrangements in place for the specialist nurses in the event of any absence. During our

visit, a full time specialist nurse was on annual leave, meaning that for two days of that week, there was just one specialist palliative care nurse available to cover the needs of the entire hospital. We were told that this was often managed by providing phone support to nursing staff, rather than visiting all patients referred to the team, with visits being reserved for the most complex patients.

- Clinical leadership was provided to the specialist nurses by the trust's lead cancer nurse specialist.
- In addition to the specialist palliative care team, in the days prior to our visit, the trust had appointed two part time (1.4 whole time equivalent) band seven nurses on a one year fixed term contract. This followed the successful submission of a business case which aimed to extend the end of life service at the trust, with a second end of life team. It was not clear how the two teams would work together at the time of our visit, but we were told the primary initial role of the newly appointed nurses would be around education of clinical staff who were not specialist end of life staff but who provided end of life care.
- Each ward at the trust had an end of life link nurse with responsibility for disseminating key messages to the rest of the ward teams.

Medical staffing

- Medical staffing levels for end of life care did not meet with national guidance. Guidance from NHS England (Specialist Level Palliative Care: Information for Commissioners, 2016) states there should be sufficient medical and nursing cover to allow assessment, advice and patient management seven days a week. Furthermore, the guidance states there should be provision for 24 hour telephone advice. At the time of our inspection, there was one whole time equivalent specialist palliative care consultant. This was not sufficient to provide specialist medical services at all times.
- There was a limited amount of cover for the specialist consultant when they were not at work. Consultants working at the local hospices could provide cover for up to two days per week during annual leave, or other absences. Additional cover was provided by the trusts on call medical consultant who was not a specialist in palliative care. Staff spoke positively of the support they received from the local hospices out of hours – both the advice line and the support provided by hospice staff.

Major incident awareness and training

- There was a major incident plan in place for the mortuary department which was linked to local authority contingency plans and reviewed every year.
- We saw there were other business and management plans to support any unexpected or extended use of the mortuary service. This included the ability to increase capacity with the use of mobile storage and/or through access to community facilities.

Are end of life care services well-led?

Inadequate

We rated well-led as inadequate because:

- There was poor communication at executive level about the future plans for the end of life service at the trust and a lack of consultation on the business plan that lay behind these plans.
- We saw a business plan for the development of end of life care at the trust going forward. However we saw little evidence that there had been any tangible improvements in end of life care with the exception of the increase in use of the end of life care documentation.
- There was a lack of any systematic audit programme relating to end of life care, and few measures that addressed risk and quality. This issue had been reported following the inspection in January 2017.
- There was no evidence that the End of Life Care strategy was being monitored or taken forward since the departure in May 2017 of the end of life facilitator. Key tasks such as training needs analysis within the strategy had not been completed.
- There was no scrutiny or interrogation of, delayed fast track discharges, or the achievement of preferred place of care, for end of life patients and so no learning could be taken from these.
- We saw few mechanisms for capturing feedback from patients, their families and carers, or from staff. There had therefore been no input from these groups into the end of life service. This issue had been reported following both the January 2017 and January 2016 inspections.

- We were not assured of sufficient oversight and management of the risk register relating to end of life care.

However:

- Locally, we saw excellent examples of leadership within the specialist palliative care team and the mortuary which meant that staff working within these services benefitted from the support and commitment of their leaders.
- Substantial funding had been agreed which aimed to improve education and provision of end of life care at the trust.
- There had been some improvement in the profile of end of life services since our last inspection.
- The specialist palliative care team were held in extremely high regard across the trust in all areas we visited.

Leadership of service

- Leaders had the skills, knowledge, experience and integrity needed to carry out their roles at a local level. There was clear clinical leadership from the specialist palliative care consultant and specialist nurses in respect of meeting the clinical needs of patients and supporting generic staff. We saw that daily meetings within the specialist palliative care team were well structured and had clear direction. Likewise, the weekly multidisciplinary meeting lead by the specialist palliative care consultant used an effective and thorough format to ensure comprehensive delivery of specialist palliative care to all patients identified within the trust.
- In the mortuary service we saw that the skills of the manager ensured that staff were supported and skilled to carry out their responsibilities. On wards and in clinical areas we saw examples of where leadership was having a positive effect on patient care at end of life. For example newly qualified nurses were learning from their senior colleagues about providing end of life care in line with national guidance.
- Leaders did not always have the capacity to lead over and above their daily clinical duties due to the size of their workload. The specialist palliative care team was led by the palliative care consultant but this individual was unable to lead on other aspects of end of life care in the hospital due to a lack of capacity.
- Above local level there was a lack of stable, coordinated leadership for end of life care at the trust. We were not assured that leadership of the end of life service at executive level was effectively meeting the needs of the service at the time of our visit. There had been a number of recent changes in executive leadership and at the time of the inspection the newly appointed director of nursing was the executive lead for end of life care. A recent business case for the development of end of life care at the trust had been put together by the director of nursing, however no consultation had taken place with the existing members of the specialist palliative care team, or the end of life care group about what this plan should look like. We were therefore not assured the business case and plans for the service was based on a true reflection of the challenges facing end of life care at the trust.
- At the time of our inspection we were given differing and inconsistent feedback between managers and staff when we asked them about involvement in, or consultation regarding the future plans for end of life care at the trust. Executive leads for end of life care told us that they had discussed the business plan with clinicians in the weeks leading to our inspection. Clinicians told us they had been made aware of the business plan after it was submitted and in preparation for our inspection.
- There was no trust wide steering group or committee for end of life care. This meant that there was not a formal system within the trust to be consulted with about the direction of end of life care.
- We looked at the board meeting minutes dating back to September 2016. There was no discussion of end of life care minuted for any of these meetings suggesting that end of life care was not seen as a priority for discussion at these meetings. The effectiveness of overall trust leadership to drive improvements in end of life care was limited by the restricted functioning of the of the End of Life Care group. The group had not met for the six months prior to our inspection, which meant that key tasks that may be undertaken by this group, such as the reviewing of incidents and complaints, and the monitoring of the strategy had not been undertaken effectively.

- The deputy director of nursing also had the oversight of end of life care supporting the director of nursing in an interim capacity for two days per week at the time of our inspection. This person had been in post for around six weeks.
- We did not see any evidence of embedded leadership of the end of life service which resulted in the working relationship between the executive and trust leads and the front line end of life service not being fully collaborative. This was evidenced by the lack of discussion of end of life care at board meetings, and the lack of meetings being held by the end of life care group. This had the potential to impact on the effectiveness and provision of the service. However, there were plans for the development of the leadership team for the end of life service to be developed in the months following our inspection.
- There had been a gap in oversight and independent scrutiny at board level because of an absence of a non-executive director for end of life care. However, the recently appointed trust chair had been assigned responsibility for this on their appointment.

Vision and strategy for this service

- There was a vision for end of life care with quality and safety the top priority. End of life care at the trust had its own strategy based on the national "5 Priorities of Care." Five priorities of care is national guidance, created by the "Leadership Alliance for the Care of Dying People" and provides guidance for caring for someone at the end of their life. The approach recognises that in many cases, enabling the individual to plan for death should start well before a person reaches the end of their life.
- Launched and disseminated in December 2016, the strategy was the work of an end of life facilitator, with input from the end of life care group. The facilitator post was not filled at the time of our visit, having become vacant in May 2017. The end of life care group had not met since January 2017. There was no effective approach to monitoring, reviewing or providing evidence of progress against the delivery of the strategy in the absence of the facilitator and this included the actions that were contained within it. For example, the strategy talked of a training needs analysis to assess and plan the training needs of clinical staff across the trust. At the time of our inspection this had not occurred. The previous training needs analysis being completed in October 2016 by the previous facilitator. We were not assured therefore that end of life care within the trust was being driven forward in accordance with the strategy and identified priorities at the time of our inspection.
- The executive lead for end of life care at the trust, had submitted and had approved a business plan for funding to extend the scope of the end of life care team. We were told the priority for this team was to increase the size of a dedicated team providing end of life care at the trust. It was not clear whether this was to be a separate function to the specialist palliative care team, or whether it would incorporate the specialist palliative care team. . We were told a primary focus of this expansion would be education, including learning based on the five priorities of care, from which the new care plan documentation was based. This work had not begun at the time of our visit, but we were told that the trust aimed to have a fully functioning end of life team by October 2017.
- On the wards we visited, staff demonstrated a mixed understanding of the end of life strategy. At the end of 2016, the end of life team had identified seven "priority" wards which had higher numbers of deaths, and focused the development of resources on these wards. These wards had benefited from a launch of the strategy by the then end of life care facilitator. Consequently staff on these wards were able to confidently discuss the strategy. However, in other clinical areas, staff did not demonstrate that they understood how their role would contribute to achieving the strategy. A band six ward sister told inspectors they had found the strategy accidentally whilst searching for another document.

Governance, risk management and quality measurement

- We were not assured that there was an effective governance framework in place to support the delivery of the strategy and good quality care. Executive leads were recently in post and were not clear about how they got assurance of the quality of end of life care being provided at the trust. We heard of plans from the executive leads about how end of life care was to be developed within the trust, with a target date for completion of October 2017. However, staff we spoke with felt they had not had an opportunity to contribute ideas to the business plan that was to underpin development of end of life care had been minimal at the

time of our inspection, and front line staff we spoke with did not feel that they had contributed at all to the business plan underpinning the proposed development.

- There was a lack of robust audit to fully evidence quality and risk management issues for end of life patients. We were told of informal arrangements whereby leaders with a responsibility for end of life care visited wards and talked to staff about how they felt end of life care was delivered. However, this was not formally recorded or analysed. The only formal audit that had taken place related to a very specific group of patients, in the last few days of life, receiving care on one of seven "target" wards and focussed on the use of the end of life documentation. The trust had not participated in the National Care of the Dying Audit. We were not assured of the presence of any overarching end of life systematic program of clinical or internal audit, or the availability of any personnel to complete these pieces of work at the time of our inspection.
- We also did not see any evidence of audit of the total number of end of life patients achieving their preferred place of care. However, the specialist palliative care team had audited this outcome of preferred place of discharge for patients referred to them only. This showed that 63% of patients referred to the specialist palliative care team, achieved their preferred place of discharge. This audit presented findings only, with no information about the obstacles to patients achieving their preferred place of discharge.
- We did not see any evidence that delayed fast track discharges were being effectively audited by the trust. Teams were unclear as to what constituted a delay that should be reported, and so we were not assured that the correct information would be available for analysis of this issue. We asked the executive lead about monitoring of delayed fast track discharges but were not provided with information or evidence that this was being monitored effectively. We were shown a draft policy which sought to address this issue, but this was not completed or in use at the time of our visit.
- We saw that there was a continuing healthcare (CHC)/Fast Track process improvement meeting which was occurring every two weeks at the time of our visit. This was attended by representatives from the trust as well as the CHC board to look at ways of improving this process. We reviewed the minutes of this meeting, but it did not discuss the rates of delayed discharges or causes of specific delays. It did appear to be a productive forum for addressing the issue however, although we did not see any evidence of this being monitored.
- Locally, within the specialist palliative care team, staff were clear about their roles and had a clear understanding of their responsibilities. However, they also recognised that due to the size of their workload and the small team they worked within, it was not possible for them to formally evaluate the service they provided or carry out any tasks that were not clinically related. This was a source of frustration for the team as they were keen to develop what they could offer within the trust. We were told by the executive lead for end of life care that the plans for changes to end of life care would include the integration of this team with any new team providing end of life care services and so grow its ability to work more widely.
- We were not assured that there was sufficient oversight of complaints that related to end of life care. The newness of the end of life governance team meant that there was an apparent lack of clarity around who had oversight, and took responsibility for the communication of learning from complaints. The most recent overview of complaints was in January 2017 and was completed by the previous end of life lead for the trust.
- The end of life risk register was written in June 2017, and the responsibility for these risks lay with the deputy director of nursing who had some governance of end of life care. This was an interim measure until the new end of life team were in post, at which point the matron within that team, would take on responsibility for the risk register. There was one risk on the end of life risk register which related to the identified concerns of the previous CQC inspection in January 2017. Actions had been identified which aimed to mitigate the risks caused by these issues, however we were not assured that there was sufficient oversight or management of the risks identified on the end of life risk register at the time of our inspection.
- As there were no strategy meetings that focused on end of life care, we did not see any evidence of a process that would review progress against the identified risks. When we asked the executive lead for end of life care how they were assured the risk register was being overseen effectively, we were told the responsibility for this lay with the deputy director of nursing.

End of life care

Culture within the service

- Staff felt respected and valued within the teams they worked. At local level, staff spoke passionately about ensuring patients at the end of life received care which reflected their needs. The specialist palliative care team provided a service in a mutually respectful and supportive way, both internal to the team and externally to the wider trust.
- The weekly multi-disciplinary meeting began with a check that all staff were feeling well, and managing sufficiently. Throughout the trust the commitment and dedication of the specialist palliative care team was held in consistently high regard. The competence they demonstrated and support they offered was felt to be invaluable, and provided readily and with compassion.
- Staff we spoke with who provided end of life care told us they enjoyed their jobs and felt that they made a difference to patients and their families and carers at a crucial time and they felt supported by the colleagues and teams they worked with.
- However, we did not see that there was a strong emphasis on promoting the safety and wellbeing of staff providing end of life care. Demand was being met, by clinical staff working over their allotted hours on a daily basis, and was the result of demand outstripping supply of specialist palliative care.
- Evidence suggested that end of life care had only recently been given priority within the trust. We saw evidence that plans were being considered to increase and improve end of life care provision. However we did not see that any changes had yet been embedded that raised the profile of end of life care at the trust at the time of our inspection. End of life care did not appear as a topic in any of the board meeting minutes we looked at, which dated back to September 2016.

Public engagement

- We saw little evidence of engagement with the public, patients or relatives to gain feedback into the service. No surveys had been undertaken that asked the question about whether the end of life service had met the needs of patients, and so it was not possible to see how any involvement had helped to shape the service delivered.
- The bereavement office provided comment cards for families to record their thoughts, but we saw little evidence that these were being evaluated.
- The specialist palliative care team were waiting on the delivery of some patient surveys at the time of our visit with a view to handing these to patients and their families and carers.

Staff engagement

- We did not see any evidence of staff involvement in the shaping of end of life care at the trust. None of the staff we spoke with in clinical areas had been asked to give any feedback on the services that end of life patients received.
- In the weeks prior to our inspection the end of life representative at executive level had commissioned the completion of a business plan to extend the provision of dedicated end of life care at the trust. At the time of our inspection, this funding, in excess of £200,000 had been agreed. Staff we spoke with felt they had not had an opportunity to contribute ideas to the new business plan and their views about what could enrich end of life care at the trust had not been sought. The same staff demonstrated some innovative ideas about the way in which provision could be improved but were frustrated they had not been asked.
- All of the wards we visited had an end of life link nurse. The role of this nurse was to attend regular meetings and feedback key information about end of life care to their colleagues.
- In the week before our inspection, the trust had organised a one day conference for registered nurses, and another for healthcare assistants. This conference aimed to enhance understanding of end of life care for staff working within these roles.

Innovation, improvement and sustainability

- The trust was working with Macmillan cancer care to offer opportunities for clinical, ward based staff to join the specialist palliative care team for a three month secondment. However, this role had not been filled since May 2016, although we were told that two staff had been appointed to start in the coming months. The idea of this role was to skill staff working in general ward areas to provide end of life care in line with best practice, and based on real life on-the-job experience. The reason given for these roles not being filled was the inability of their posts to be backfilled, leaving wards short staffed.
- Data provided to us showed that the rate of referrals to the specialist palliative care team were increasing year

on year, whilst the size of the team had remained the same. Total patient numbers had increased from 697 in the year ending 2012, to 891 in the year ending April 2017. This represented a 22% increase in demand during this time. The team were meeting patient needs by consistently working over and above their contracted hours to ensure they could provide an effective service. Whilst this was recognised as showing dedication, it was felt not be sustainable without any increase in resources or support for this team. Staff in all areas told us they wanted to see a larger specialist palliative care team that could deliver a seven day a week service. The business case that had been submitted by the executive lead did not identify any extension to this specialist palliative care team as part of the end of life service going forward. We were told that there were discussions planned with the specialist palliative care team to talk about the future of end of life care and how it would look at the trust.

- When we met with the specialist palliative care team, we were told that a separate business plan had been submitted by the lead to increase the hours worked by one team member from part time to full time, and also to raise the banding for this role to enable that person to widen the scope of the service that could be offered. This had been submitted in November 2016. At the time of our inspection, the team had not received any feedback about this business plan. We raised this with the executive lead for end of life care and they did not have any knowledge of this business plan.
- There was little succession planning in place for any long term absences for any of the specialist palliative care team. Current arrangements for cover stood with local hospices but this was for short term absences.
- The manager of the mortuary told us of plans for a “live screen” IT facility to be installed. This screen would be similar to those used on wards, and would provide the mortuary staff with the ability to pre-empt demand and deliver a more responsive service. The manager had written and followed through a business plan to secure funding for this technology, which was to be installed later in 2017.

Outpatients and diagnostic imaging

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

Information about the service

Royal Cornwall Hospitals NHS Trust had both generic and dedicated specialist clinical areas for outpatients. Royal Cornwall Hospital had dedicated facilities for paediatrics, cardiology, rheumatology, ear, nose and throat, oral surgery, dermatology, maternity and gynaecology. These areas were staffed with nurses with specialist interests and supported by specialist diagnostics, for example ultrasound in gynaecology, dental X-ray in the oral surgery clinic, dedicated equipment for ophthalmology and minor operating facilities in dermatology.

Outpatient services were delivered from three trust sites, Royal Cornwall Hospital, St Michaels, and West Cornwall Hospital, and at several community hospitals run by another local provider. One stop clinics such as dermatology were provided at Royal Cornwall Hospital. Virtual clinics were provided in several specialties such as trauma and orthopaedics and ophthalmology.

Diagnostic imaging services consisted of X-ray, computed tomography (CT) scans, magnetic resonance imaging (MRI) scans, ultrasound scans, and nuclear medicine. These were provided across all three trust sites.

Acute, general and trauma imaging services were delivered 365 days a year, 24 hours a day on the Royal Cornwall Hospital site. There was a 24 hours a day, seven days a 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.

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

There was a central outpatient booking team which supported the majority of specialties.

There were three main outpatient departments within Royal Cornwall Hospital accommodating a number of outpatient services and a number of further departments or areas 'owned' by individual specialties.

The trust delivered 334,000 examinations in 2016/17. It had had three magnetic resonance imaging (MRI) and four computed tomography (CT) scanners (one of which was at West Cornwall Hospital), three gamma cameras, 39+ ultrasound machines, dental equipment, dual energy X-ray absorptiometry (DEXA), mobile X-rays and image intensification fluoroscopy supported by radiographers and nurses. Breast screening and symptomatic breast imaging services were delivered as an integral element of the breast care pathway with between eight and nine dedicated one stop clinics per week. Patients seen throughout the day were based on clinical prioritisation and urgency.

Outpatients and diagnostic imaging

Dedicated inpatient slots were available in CT, MRI and ultrasound on all weekdays. Weekend and bank holiday imaging was available for CT, MRI and ultrasound. There was no on-call MRI service between 8pm and 8am.

In addition, trust diagnostic services were provided by audiology, cardiology (including echocardiography, electrophysiology and angiography), urology (cystoscopy and urodynamics), neurophysiology, respiratory physiology, gynaecology (colposcopy) and endoscopy.

During this inspection we spoke with 16 patients and 67 members of staff, including ward clerks, booking clerks and administration staff, consultants, medical and nursing staff, heads of departments and speciality leads.

The average weekly activity for the top 15 diagnostics were:

Non-obstetric ultrasound - 1,020

CT - 743

MRI - 533

Echocardiography – 232

Audiology – 197

Gastroscopy – 84

Colonoscopy - 63

DEXA – 41

Flexi sigmoidoscopy – 30

Neurophysiology – 24

Cystoscopy - 18

Urodynamics – 17

Respiratory physiology - 13

Electrophysiology - 1

Summary of findings

We rated this service as inadequate because:

- Incidents were not always reported promptly. This impacted investigation timeliness and delayed potential learning opportunities.
- The approach to declaring and serious incident was slow and investigations took too long.
- Ophthalmology and Cardiology follow up appointment waiting lists are too long and patients are coming to harm through delays in treatment.
- The fracture clinic remains a risk to patients due its design, unregulated clinic temperature and poorly maintained furnishings.
- Records in cardiology of 24 hr cardiac record tapes and echocardiograms were not stored securely and were found stored in a letter tray.
- The 24 hr cardiac record tapes and echocardiograms were not being managed in a timely way and were dated back as far as March 2017. These and were yet to be interpreted by specialists.
- There was a lack of Wet Age Related Macular degeneration or glaucoma clinics causing significant delays in treatment for patients.
- Managers and staff told us there were capacity and demand issues in some clinics that meant there were an insufficient number of clinics running to deal with demand.
- Patients had unacceptably long waits for follow up treatment in ophthalmology & cardiology.
- The fracture clinic remained not fit for purpose and issues identified from the January 2016 inspection remain.
- A programme of rolling improvements in the outpatient service which was led by the outpatient improvement board had made some progress but significant challenges remained.
- An unusually high number of staff at all levels in outpatients felt the culture within the trust was one of intimidation, bullying and discrimination and several staff had left or been signed off with stress.
- Accountability for decision making was unclear in several speciality clinics.
- Visibility of CEO and board staff was minimal.

Outpatients and diagnostic imaging

- Governance procedures to monitor waiting lists, waiting times, frequency of cancelled clinics, and RTT timelines for patients were not robust enough which meant the impact on patients was not fully known.
- In ophthalmology demand continued to outgrow capacity at a predicted rate of 4,000 clinic slots by the end of 2017.
- There remained significant challenges around access to appointments and the high volume of clinic cancellations.
- We spoke with 12 patients and they were not made aware of the friends and family test.

However:

- Staff teams were up to date and competent with the trust safeguarding training and procedures.
- The imaging service had good examples of learning from incidents and measure in place to prevent a reoccurrence.
- Imaging worked closely with medical physics to ensure minimal dosage of radiation was given to patients.
- The trust has commenced a major project to implement a radio frequency identification (RFID) tagging system for medical devices.
- There were strong innovative practices across the outpatients department.
- In imaging we found the leadership to be visible and supportive.
- There had been significant investment into the trust's imaging services.

Are outpatient and diagnostic imaging services safe?

Inadequate

We rated safe as Inadequate because:

- Ophthalmology and cardiology follow up appointment waiting lists were too long and patients were coming to harm through delays in treatment. The process for risk assessment was not sufficient to adequately protect patients from harm and there were no clear action plans to manage and reduce the backlogs.
- Incidents were not always reported promptly. This impacted investigation timeliness and delayed potential learning opportunities.
- The fracture clinic was a risk to patients due its design, unregulated clinic temperature and poorly maintained furnishings.
- Paper based patient records were not stored securely.

However:

- Safeguarding policies and procedures were available to staff who knew how to access and follow these.
- Cleanliness and infection control were found to be well audited and compliant. Staff adhered to infection control procedures.
- We found the time taken for diagnostic images to be reported was maintained by increasing staffing levels to meet demand.

Incidents

- Staff understood their responsibilities to raise concerns, including how to record safety incidents and near misses, and then report them. However, we were concerned that staff did not always recognise what events should be recorded as concerns, incidents or near misses. We found that staff dealing with a current incident at the time of our inspection were unclear of the best course of action to take, and were undecided whether to report it onto the trust incident reporting system before speaking with other staff.
- Incidents were not always reported in a timely manner. Three staff spoke of delays of more than 24 hours before

reporting an incident. We found significant delays before some incidents were reported. We reviewed 200 incidents, of which 41 (20%) were not report within 48 hours.

- Not all incidents were reported. During our inspection a patient had arrived to have their implantable cardioverter defibrillator checked and it was found the battery was so low on power it could not power itself up for diagnostics. This also meant it would not have had enough power to shock the patient during a cardiac event and potentially prevent death. This was not reported as an incident. We brought this to the attention of the trust but were told they did not consider it required reporting, or that it was appropriate to record as an incident. However, this event had not been experienced before and therefore any learning opportunities were potentially missed. The trust's incident reporting policy stated: "6.5.1 the trust recognises its responsibility to report, record, investigate and learn from all incidents. Research has shown that the more incidents are reported, the more information is available about what is going wrong, and the more action can be taken to improve safety in healthcare".
- There had been no never events in the outpatients department in the twelve months preceding our inspection. A never event is a serious patient safety incident that has the potential to cause serious patient harm or death and should not happen if healthcare providers follow national guidance on how to prevent them.
- Some incidents were used as opportunities to learn and make improvements. There were some examples of incidents where lessons were shared to ensure action was taken to improve safety. For example, when an incident occurred in the MRI machine an action plan was developed and actions completed included the installation of new safety barriers, personnel safety checks prior to entering a restricted space and the re-education of staff. However, we were not provided with suitable assurance that this was always the case because investigation reports were not routinely shared with us and were not provide during the inspection.
- In the first six months of 2017 ophthalmology had four patients who lost whole or partial sight due to long waits for follow-up appointments. These were investigated by the trust and it was found that harm to these patients would have been reduced if they had been seen more promptly. Prior to the fourth incident in May 2017 the trust had taken limited action to learn from these incidents and reduce the risks.
- In cardiology a patient died after waiting 21 weeks for a dual chamber ICD (implantable cardioverter defibrillator). The trust's 72 hour report stated, "While it was likely this death was due to a delay in offering a date for elective admission, it was not certain this was the cause of death". As a result of the investigation, the trust placed the cardiology department into internal special measures to review the patients who had delayed appointments, follow ups and delayed elective appointments.
- The imaging service reported radiation incidents into the risk management process. The imaging service also ensured that exposures that were 'much greater than intended' were notified to the Care Quality Commission under the Ionising Radiation (Medical Exposure) Regulations or to the Health and Safety Executive under the Ionising Radiation Regulations 1999.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of and demonstrated good understanding of, their responsibilities under this legislation. Serious incident initial summary reports showed that this requirement had been considered. However, we cannot be assured the trust was meeting the regulation in full because we did not see any documentation to confirm all the required actions had been taken.
- Staff we spoke with 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's guidance and how to access this. More senior level staff, for example ward sisters and matrons, were clear about the trust's responsibilities and how they were involved in the duty of candour.

Cleanliness, infection control and hygiene

- In the majority of clinics hand hygiene was promoted for visitors and patients. However, in the ophthalmology

clinic the hand gel dispenser was not clearly visible and over a period of ten minutes none of the seven newly arriving patients used the gel on entering or leaving the waiting area.

- Staff followed trust policy on hand hygiene. Staff cleaned their hands between patients using either hand gel or soap and water.
- Outpatient hand hygiene results were compliant across the clinics with most clinics scoring in the region of 98%-100%. The lowest two scoring clinics were the cardiac catheter lab at 88% and urology at 89%. The trust target for compliance was 85% and above.
- Some staff we spoke with were aware of their clinic's performance with regards to hand hygiene. Hand hygiene audits were displayed in some waiting areas but not all.
- The environment in the fracture clinic did not promote cleanliness, infection control and hygiene. Fabric armchairs were used in patient waiting areas, some of which contained rips and had exposed fillings. This presented an increased risk to bacterial contamination. Wooden furnishings along the walls were deeply chipped and unsealed; the porous nature of this surface further increased the risk of bacterial harbourage. The floor was deeply ingrained with passing foot traffic and in need of replacing. There were issues with air flow and high temperatures. A fault in the ventilation system within the clinic made the environment extremely hot and staff had deployed fans to move the air around the clinic to improve the environment for patients and staff. However, this increased the risk of airborne pathogens being carried through the clinic. We were told at our last inspection in January 2016 that this was a temporary location for the clinic, however the clinic had not been relocated and works to improve the environment had not been undertaken. All these concerns were raised following our inspection in 2016, but had not been addressed.
- We found regular environmental hygiene audits for outpatients and diagnostics were undertaken. Audit results indicated that standards were between 90% and 100% for most areas. The trust's target for compliance was 85%. The lowest score for compliance was in audiology at 80%. We could see that the auditor had given recommendations to staff on how to improve areas that were not compliant from the audit.
- Staff we spoke with were able to describe the process for ensuring hygiene was adhered to. We saw evidence of regular daily cleaning schedules in most of the clinics we visited.
- In cardiology we did not see any cleaning checklists. When we asked staff about this we were told the rooms were cleaned but this was not recorded. We could therefore not be assured regular cleaning was taking place.
- Within imaging and X-ray we found good precautions were taken if a patient posed a risk of infection. They were seen at the end of the day and then a deep clean was undertaken of the room and equipment used.

Environment and equipment

- The environment and equipment in the fracture clinic did not always keep patients safe. Staff within the fracture clinic told us the environment was not fit for purpose and they felt patients were being put at risk. Patients who had to keep a leg elevated due to the nature of their fracture were at risk of having their leg knocked into because there was no provision to protect them. Chairs were not movable and in a busy clinic there were lots of people passing by who could accidentally knock into the raised leg. Additionally, no dedicated children's waiting area was available and this meant children were not separated from adults. These issues were highlighted in our January 2016 inspection report, but no action had been taken to improve the situation.
- The reception staff were unable to see much of the waiting room due to the layout of the clinic, which meant if a patient deteriorated while in the waiting room they may not be identified by staff. This issue was highlighted in our January 2016 inspection report, but no action had been taken to improve the situation.
- Medical devices and equipment was in date with servicing and well maintained. A rolling schedule of planned preventative maintenance was in place.
- The trust had commenced a major project to implement a Radio Frequency Identification (RFID) tagging system for medical devices. The system is designed to provide the real-time location of tagged devices across the hospital and to enhance future planned maintenance scheduling across the trust.
- Emergency equipment was well maintained. We found the resuscitation trolleys were all sealed with tamper-evident seals and all dates were correct and

inspected regularly by clinic staff. The only trolley of concern was in ophthalmology where the resuscitation trolley was in a locked room and no signs indicated where it was located in the event of an emergency. This was highlighted in our January 2016 inspection report, but still remained an issue.

- We found personal protective equipment was available for all staff in all clinics we visited. This came in differing forms, such as aprons, gloves and eye protection.
- Hazardous waste and by-products were safely managed. We observed staff maintaining safe storage and management of clinical waste and sharps, such as hypodermic needles.
- The general outpatients' clinic was bright and airy and the patients we spoke with thought the clinic had a clean and welcoming appearance.
- Equipment we looked at was visibly clean and stored appropriately. The trust used "I am clean" stickers to identify clean equipment. We observed stickers on equipment in different outpatient areas that identified they were clean.
- A rolling electrical safety programme was in place. We observed all electronic equipment had been safety tested to ensure they were compliant with portable appliance testing (PAT) electrical safety regulations, and we saw this taking place.
- Radiographers showed us the equipment available to them to help minimise their exposure to radiation. Lead coats were available for all staff to use, and were in good condition and stored correctly.
- Imaging had effective systems in place to keep people safe. We found the imaging service ensured that ionising radiation premises had safe systems in place to control the area and restrict access. We saw 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.
- The trust had two MRI scanners that were located in a clinically inappropriate location. The area was aging and poorly maintained and the corridor was used to store beds and trolley cages. The area was not consistently cleaned and staff said bringing ventilated intensive care or special care babies down through dirty areas was not clinically appropriate. The corridors were cluttered which meant beds with large equipment attached, such as monitors or drips attached have access difficulties.
- There were systems in place to minimise the potential risk of harm for radiation exposure incidents. 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.
- The imaging department had radiation dose optimisation groups working in line with department of health requirements. This ensured incidents related to radiation were as low as possible.

Medicines

- The management of medicines kept patients safe from harm.
- Medicines training was provided by the trust and competency frameworks were in place to ensure staff were compliant with trust policy. We were told staff had completed these however, due to the trust's reporting systems we could not be assured all staff had completed these.
- Emergency medicines were available on resuscitation trolleys. These were recorded as being checked daily. Emergency medicines were checked and in date.
- The outpatient and imaging departments we visited did not administer controlled drugs.
- Patients' allergies information was checked and recorded as part of the trust's policy to use a contrast media for a procedure.
- We found that prescription pads were stored securely. In the main outpatient department, the FP10 prescription pad was stored in a lockable cabinet.
- The radiology department used patient group directions (PGD) for contrast media and bowel preparation for pneumocolon (virtual CT examinations of the large bowel).

Records

- Care records were not stored securely in the outpatient service. In several of the clinics we visited we found notes were stored insecurely and were not always observed by staff. This meant unauthorised people could access these confidential records. In the cardiology outpatient's clinic, we saw that approximately 150 patient identifiable records of 24 hour cardiac tapes were stored in a letter tray in an unlocked staff room within a publicly accessible area.

- In the same clinic we saw open records trolleys with records accessible behind reception and on one occasion reception was left unattended.
- Care records were accurate, complete, legible and up to date. We inspected 18 records from a selection of different outpatient clinics. All of the notes we read contained a copy of the referral, a treatment plan, and a discharge summary, which had been shared with the patients GP. Alert stickers highlighting allergies were visible on records and details contained within the inside cover.
- There were systems in place for managing records. These systems were monitored and expansions planned. Space and storage of paper notes remained a significant pressure for the trust. The medical records staff told us the current date for moving completely to electronic records for the trust was March 2018. This would have all patient records electronically scanned and archived meaning improved data management, security and retrieval for files and notes.
- The availability of patient notes was audited one week in every four. These audits showed that during June 2016 to May 2017, an average of 97% of notes were available at the start of outpatient clinics, and an average of 99% of notes were available at the end of clinic. The worst performing audit week was in May 2017 when only 94% of notes were available at the start of clinic, and 95% of notes were available at the end of clinic. This was due to courier availability over a bank holiday.
- Electronic records were available when paper patient notes were not. Staff were able to demonstrate the practice of creating a temporary folder when paper files were not available in clinics by obtaining the relevant information from the electronic copy. This could mean appointments would take place with all the relevant information that might be important for their care or treatment.
- As the trust moved to a fully electronic record base they ensured all external agencies contracted to scan current paper records had attained the ISO 27001 standard. This provided recognition and assurance that information would be handled safely and correctly.
- We found radiology had an image archive service that contained all historical and current patient images and was available to authorised staff across the trust. This helped ensure returning patients' images could be recalled swiftly and improved patient clinic times and reduced the need for further imaging for the patient.
- The World Health Organisation Five Steps to Safer Surgery was used as a checklist when carrying out non-surgical interventional radiology. A monthly audit of compliance to adhering to the checklist showed that radiology consistently met 100%.

Safeguarding

- Safeguarding processes kept people safe. There were trust policies and procedures in place to ensure that adults and children were appropriately safeguarded. These followed current legislation and national guidelines. We found polices for safeguarding women and children with, or at risk of, female genital mutilation and people at risk of domestic violence.
- A safeguarding flow chart was apparent in various outpatient clinics that gave simple, clear steps to follow if staff had safeguarding concerns.
- Information about how to report any safeguarding concerns and safeguarding adults' information was displayed in outpatient clinics.
- The safeguarding lead and team was well known to staff on the clinics and staff felt confident they could approach them for advice or concerns at any time.
- We found robust procedures were in place for paediatric imaging and safeguarding with strong radiologist input.
- Safeguarding training information was not available so we were not assured of the level of competence of staff.

Mandatory training

- Staff all had a package of mandatory training in health and safety, major incident awareness, accident reporting and minor incident investigation and basic life support. The trust was unable to provide specific data on how many staff were up to date with their mandatory training in such areas as manual handling and safeguarding. We were provided with departmental figures that showed most departments were at 95% and above for completion of mandatory training, the trust target being 95%.
- Outpatient departments that were below 95% were gynaecology outpatients at 88.7%, neurology clinic 88.9% and haematology/ oncology 94.8%.

- Staff reported that mandatory training was provided in a range of formats including e-learning and face-to-face sessions. Staff preferred face to face sessions and felt the e-learning packages did not meet their learning needs.

Assessing and responding to patient risk

- Processes to asses and respond to patient risk did not ensure patients were kept safe. Long waiting lists and backlogs were not being risk assessed and managed adequately to ensure patient safety.
- In cardiology we found a back log of approximately 150, 24 hour cardiac recording tapes reaching back to March 2017. When we asked staff how many tapes they thought were backlogged they were unable to tell us. This was of particular risk because if any cardiac anomalies were present in the tapes, the patient would remain unaware of this. Without the records being checked frequently, the lifestyle or medical condition of that patient could be placing them at an increased risk if left untreated. Staff informed us that they had initially worked extra hours on weekends earlier in the year to reduce the back log but were told to stop because the trust used an external analytic company for the work. Since then the backlog had been growing and it had left the staff frustrated and concerned.
- In cardiology, from December 2016 to June 2017, 554 patients had been delayed past their agreed date for follow up appointment. A backlog had developed due to a change in model that removed an outpatient consultant. Cardiology had yet to appoint a speciality lead and therefore the Consultant Cardiologist had to multirole. We were informed of two patients who had died of cardiac related causes while delayed on the waiting list. While it is not possible to say the deaths were directly linked to the delay, the trust reported it was highly likely.
- Although risks associated with delays were being assessed, we were not assured this process was sufficient or that there was an effective plan in place to reduce the backlog. In cardiology we found delayed follow up appointments were 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. This did not take account of the patient's current condition and was therefore not sufficiently managing the risk.
- In ophthalmology there were 6,503 patients who had breached the time for a follow up clinic. We also found an increase in demand for the Wet Age Related Macular degeneration (WARM) clinic had not been met. This meant patients were not being reviewed within a safe timeframe. At the time of our inspection there were 1,200 patients waiting for WARM treatments. This delay to treatment had caused harm to at least four patients between July 2016 and May 2017 who had suffered partial loss of vision or complete blindness as a result. A plan had been submitted to train more associated health professionals and machine trained staff to manage waiting lists.
- Staff reported that they could seek assistance from the hospital wide patient at risk team by dialling 2222 should an emergency situation arise.
- In diagnostic imaging, radiographers were trained in adult life support which enabled them to manage patients who may react adversely to any contrast media.
- 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 and standards maintained.

Nursing and support staffing

- Staffing levels kept patients safe. One matron was assigned to oversee the management of the entire outpatient's service across all of the registered locations. On each hospital site the matron was supported by a team of sisters/charge nurses.
- Nursing staff working in the outpatients department considered there were sufficient numbers of staff to support the clinics. Specialities such as diabetes, ear nose and throat and dermatology supplied their own clinical nurse specialists to support clinics.
- However. There were not enough staff for Wet Age Related Macular degeneration injections. Adverts to fill vacancies had been placed but there had been little response.
- Data provided by the trust showed day and night shift fill for registered nursing staff was below 100% since July 2016. In April 2017 at its lowest point it went to 92%. Gaps in staffing were filled using agency and bank staff. Although overall the reliance on agency staff had been reduced.
- In outpatients and diagnostic imaging a recognised acuity tool for staffing numbers was not being used.

Outpatients and diagnostic imaging

- Staff turnover in the records department was high. This was due to staff worried that the advent of electronic-records would threaten jobs. However, operationally the department continued to maintain a safe service as reflected in its audit results.

Medical staffing

- There was sufficient medical staffing to keep patients safe. Individual medical and surgical specialities were responsible for arranging clinical support for their clinics. Due to the nature of how services were configured, medical and surgical staff were required to work across a range of sites in order to facilitate outpatient clinics. While some medical staff raised concerns that this had led to increased travelling times, the majority of clinical staff were accepting of this arrangement as they believed in delivering services to the local population which was convenient to patients.
- The trust's diagnostic imaging department had 25 consultant radiologists. The department was fully operational Monday to Friday between 8.30am and 5pm. Consultants job planned for programmed activities that were scheduled across the working week. There were 10 radiology specialty registrars on clinical placement from the Peninsula Radiology Academy; these were allocated Monday to Friday 9am to 5pm.
- There were 11 consultant radiologists on the general on-call rota which ensured there was sufficient consultant support available at all times.
- There was radiology registrar and a consultant radiologist available either on call or onsite 24 hours a day seven days a week.

Major incident awareness and training

- There was a major incident plan in place which included the outpatient departments. There was a mixed understanding among nursing and medical staff with regards to their roles and responsibilities during a major incident. This meant that in the event of a major incident that patient evacuation and management could be placed at risk as staff were not clear what to do in the event of an emergency.
- Staff were able to signpost us to the trust wide policy which was located on the trust intranet.
- Electronic records were stored on two separate servers in two separate locations and backed up every hour. This ensured if one site was compromised the other location would remain operational with current files still being available.
- Radiology had strategy and contingency plans. In the case of catastrophic equipment failure which included the provision of a static mobile scanner for two years, and partnership working with a third party provider.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

- We could see evidence from audits that the results triggered change.
- We saw strong relationships between multi-disciplinary teams.
- A new rib fracture pathway had been created to manage pain with a holistic approach. This improved patient pain relief and their outcomes.

However:

- We found outcome data muddled between the outpatients specialities. Clinic staff found this frustrating as they were unable to see how their clinic was performing.

Evidence-based care and treatment

- Outpatients clinics used evidenced based care and treatments. There was access to specialist investigations such as magnetic resonance imaging (MRI) or a computerised tomography (CT) scan. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. A CT scan uses X-rays and a computer to create detailed images of the inside of the body.
- National Institute for Health and Care Excellence (NICE) guidance was followed in both the outpatients and diagnostic imaging departments. The diagnostic imaging department ensured it followed NICE guidelines for acting on radiologist reports, such as NICE quality standard 17 for suspected lung cancer.

- Staff described how they flagged urgent reports to GPs, and followed this up to ensure the report and its recommendations had been followed up. We saw the department had a standard operating procedure in place to deal with unexpected findings. Staff were aware of this and competent in its use.
- We observed posters around the department sign-posting patients who thought they may be pregnant to let a member of staff know. All women of child bearing age having examinations involving ionising radiation of the abdominal or pelvic areas were checked for their last menstrual period. We were told that if a patient was pregnant but a radiological examination was clinically indicated, then the examination would take place with lead protection being used to protect the foetus.
- Radiological investigations on women who were pregnant required discussion between a senior radiologist and/or the referring clinician to consider the risks versus benefits. This ensured both mother and child had the fewest exposures to radiation.
- Clinical teams within cardiology, dermatology and the fracture clinic were all seen to have access to, and utilised a range of guidance from, the National Institute of Health and Care Excellence, Royal Colleges and other national best practice sources.
- Protocols were in place for radiology examinations such as cervical spine and orthopaedic X-rays.

Pain relief

- Pain relief was managed and reviewed in the outpatient clinics we visited. Pain relief could be prescribed within the outpatients' department and then dispensed by the pharmacy department.
- There were chronic pain and pain intervention clinics at the hospital. Patients could be referred to the pain management clinic if assessed as needing this by their consultant.
- Staff were able to demonstrate methods available to them for management of patients' pain, and how to escalate complex pain management issues.
- Pain services collected outcomes related to the clinical effectiveness of pain management techniques. This information was used to make changes where required. For example, the pain clinic had developed a new rib fracture pathway which used multidisciplinary intervention from nursing staff, consultants and anaesthetists. This managed pain from rib fractures encompassing a holistic approach to the patient's pain.
- Pain could be managed at the pain clinic with various procedures such as injection of pain relief, nerve blocks carried out by consultants and with Capsaicin (the main medicinally active component of chilli peppers and used in gels and patches).

Patient outcomes

- Outcome data was muddled between the outpatients specialities. For example, in general outpatients it was hard for staff to demonstrate how a given clinic's outcome data reflected how well the clinic was performing. Staff felt this was due to many clinics being under the surgical specialties management rather than outpatient specific clinics.
- We saw audit information that demonstrated the radiology department regularly audited diagnostic reference levels in radiology and diagnostic services. These audits showed the correct amount of radiation was being used to image a particular part of the body.
- We found that outpatient clinics and associated diagnostic services participated in both local and national audits, benchmarking, accreditation, and peer review. From these, actions were put in place to improve outcomes. For example, more effective ways to inform patients of their appointments to try and reduce the number of patients that did not attend.
- During the inspection the imaging department was due to be assessed for the imaging services accreditation scheme (ISAS). ISAS is a patient-focussed assessment and accreditation programme that is designed to help diagnostic imaging services ensure their patients consistently receive high quality services, delivered by competent staff working in safe environments.
- Patients we spoke with who were waiting for clinics said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.

Competent staff

- Staff were competent within their roles. We spoke with staff across several outpatient clinics who told us they had participated in the annual trust appraisal. Outpatients were at 97.8% completion for annual appraisals.

Outpatients and diagnostic imaging

- Nine staff we spoke with said their appraisals were up to date but felt they were very procedural and not very beneficial to the individual.
- The radiology manager told us all radiology staff had had an appraisal. We could see from supplied data that radiology staff were at 97% complete for appraisal, the last few were due to absence or illness and to be completed on staff return.
- Staff in radiology and diagnostics told us all staff had a comprehensive induction. This included mandatory training, including infection control and manual handling.
- Staff were supported in the revalidation process. Staff we spoke with reported they were given the time to attend continuing professional development training and time was also given for them to complete the revalidation process. The revalidation process is where all nurses and midwives in the UK maintain their registration with the Nursing and Midwifery Council.
- Staff told us the trust encouraged staff training; however it was mostly done online using e-learning packages. Many staff said they did not feel this was effective for all courses, for example mental capacity act training. Several staff felt face-to-face training was better as they could ask questions at the time.
- Staff administering radiation were appropriately trained to do so. Those staff that were not formally trained in radiation administration were always adequately supervised in accordance with legislation set out under the Ionising Radiation (Medical Exposure) Regulations.

Multidisciplinary working

- Staff worked together in a multidisciplinary environment to meet patients' needs. All necessary staff, teams and services were involved in assessing, planning and delivering patient care and treatment. We were told relationships between the outpatient departments were good and learning was shared.
- The Ionising Radiation (Medical Exposures) Regulations 2006 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 ensure patients receive no more than the required exposure for the desired benefit, within technological limits. The diagnostic imaging service worked closely with medical physics to ensure the dose of radiation each patient was exposed to was the lowest possible to obtain a good image.
- Radiologists attended a range of multi-disciplinary meetings to provide clinical support to treating physicians and surgical teams.
- All staff we spoke with told us that medical and surgical teams worked well with the outpatients clinics.
- Cardiology held multi-disciplinary team meetings each Wednesday morning where they were developing a more structured approach with peer review input to improve patient treatments.

Seven-day services

- Not all outpatient services were available seven days per week. There was, however, provision for additional clinics to be provided on Saturdays to assist with outpatient backlogs.
- Main outpatient clinics ran from 8am until 8pm Monday to Friday, with further clinics on Saturdays and Sundays to meet demand as required.
- The interventional radiology service was available on call 24 hours a day and staffed by five consultants.
- The ophthalmology service provided day clinics on Saturday to help manage demand.
- The oncology outpatient service did not provide weekend or evening clinics but there was an out of hours oncologist available 24 hours per day, seven days a week.
- Emergency radiotherapy was available throughout the weekend.

Access to information

- Staff were able to access the information they required to do their job. Staff demonstrated to us they could access policies and procedures via the intranet. We saw staff accessing trust policies and procedures, medicines databases and their own personal service record.
- Information on sexual health services, screening and contraception were on the trust website to allow staff to inform patients of further treatment and support if required.
- When patients moved between teams and services or hospitals the information needed for their ongoing care

was shared appropriately and in a timely way. Staff were able to clearly tell us the different ways images were shared securely depending on the receiving organisation's computer system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff were aware of consent and decision making requirements of legislation and guidance. This included the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act and deprivation of liberty safeguards training was incorporated into safeguarding training.
- We found patients adequately supported to make decisions. We observed a patient consultation where the clinician gave clear explanations. The nurse helped ensure the patient understood the information.
- Consent was gained from patients prior to procedures going ahead. A patient in the fracture clinic told us that nursing staff had plainly explained the consent procedure and described the treatment options available to them.
- Radiographers followed the trust policy on consent to ensure patient consent was gained for each scan or procedure. We observed staff following this policy as they gained consent from patients. This was in line with the Society and College of Radiographers' recommendations.
- Staff told us that doctors discussed treatment options during the consultation. Where written consent was required, this would often be obtained in the outpatient clinic. Patients told us they had been asked for consent before their procedures.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- Staff adopted the "hello my name is" by way of introduction to all patients.
- We found people were supported, treated with dignity and respect and were involved as partners in their care.
- We observed receptionists talking to patients in a respectful way.
- Patients told us nursing staff and doctors explained clearly what options were available to them.
- Patients were empowered and supported to manage their own health, care and wellbeing.

However:

- The fracture clinic cubicles were small and close together. Private and confidential conversations in adjoining cubicles could be overheard.

Compassionate care

- Most patients were treated with dignity and respect. Staff were polite and helpful during conversations. Staff ensured patient confidentiality.
- Most outpatients departments had suitable rooms for private consultations. However, we observed that privacy was compromised in the fracture clinic because patients' personal information could be overheard by other patients. This was because the cubicles were very small and close to each other and simply curtained off.
- We spoke with twelve patients who had received care and treatment at the clinics. All spoke positively about their experiences. Comments of note were: "always a professional and friendly manner" and "I was respected each time I attended".
- We observed a good rapport between patients, reception and nursing staff. We observed volunteers directing patients to the various outpatient and radiology departments within the hospital.
- We observed staff stopping to speak with patients they knew. It was apparent that patients who attended clinics often had built professional relationships with the nursing staff.

Understanding and involvement of patients and those close to them

- Patients spoke of having a full discussion with the doctor regarding their treatment options available to them. They said this made them feel listened to and part of the whole process.
- All healthcare professionals involved with the patient's care introduced themselves and explained their roles and responsibilities.
- Patients said how approachable and reassuring the nursing staff had been during their treatment.

Outpatients and diagnostic imaging

- We saw staff interacting with patients and their families to ensure they understood the treatment process. If required, this included how the family member or carer could assist with the care of the patient once they returned home.
- Patients we spoke with told us they felt informed about their care and treatment. Patients understood when they would need to attend the hospital for repeat investigations or when to expect a repeat outpatient appointment.
- Where some patients had presented with complex conditions, they told us that nursing staff were available to explain in further detail and in a manner which they could understand, any changes to their treatment or care.

Emotional support

- We found patients' emotional needs were supported. There was a policy and procedure on chaperoning in place, which was available to staff and patients on the trust website. Information on the chaperone service was displayed in waiting areas.
- We observed staff providing emotional support to patients and relatives during their visit to the department. Patients' concerns were promptly identified and responded to in a positive and reassuring way.
- We saw staff providing reassurance for patients who were anxious. This included a nurse spending time with a patient, explaining what the patient should experience and how staff would help.
- Patients were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. For example, staff discussed treatment options with patients and encouraged them to be part of the decision making process. We observed physiotherapists exercising with a patient and family member ensuring they knew what mobility exercises to practice at home.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because:

- There were capacity and demand issues in ophthalmology and cardiology. These demands had led to increased waiting times and unacceptably long waits for follow up treatment.
- Action plans put in place to had failed to reduce the number of people waiting for follow up appointments in cardiology and ophthalmology.
- The fracture clinic did not meet patients' needs and issues identified following our January 2016 inspection continued.
- Patient's told us that directional and information signage for moving through the hospital were challenging.
- The outpatients' transformation programme had not managed to improve patent flow through the outpatient clinics.
- There were a high number of cancelled appointments for avoidable reasons.
- Not all clinics had been designed to be dementia-friendly.

However:

- A new wide bore scanner was soon to be available to meet the needs of larger patients.
- We found the time taken for diagnostic images to be reported was adaptable and managed demand.
- Imaging was performing well and managing many of its key waiting times.

Service planning and delivery to meet the needs of local people

- Cardiology and ophthalmology were not meeting the needs of the local people. We found there were capacity and demand issues in clinics that meant there were an insufficient number of clinics running to deal with demand. Managers and clinical staff also voiced their concerns at the number of patients requiring both services.
- Information about the needs of the local population was used to inform how services were planned and delivered. For example, demand for the ophthalmology service had increased and the service had tried various strategies to adapt and manage to meet both capacity and demand. However, the need for glaucoma and wet age related macular degeneration clinics continued to place significant pressure on the service. The trust was placing people at risk by not managing the pressures on the service.

Outpatients and diagnostic imaging

- We observed that waiting times varied across the imaging departments. Most patients we spoke with were tolerant and understood if they were not seen at their scheduled appointment times. We found the longest wait for treatment was for magnetic resonance imaging scans, with an average wait of 54 minutes. The shortest waits were for X-ray with an average wait of 17 minutes.
- Virtual clinics were provided by some outpatient clinics to assist with flexibility, choice and continuity of care. Available clinics were trauma and orthopaedics, the fracture clinics and ophthalmology. Consultants would investigate X-rays and records and then decide if a patient was required to come to the hospital. A virtual clinic provides a direct contact to named consultants by email or telephone and reduces the need for patients to visit the hospital.
- The outpatients' bookings team had optimised their telephone booking service so they were able to monitor key performance indicators, such as the time spent on the call. Attempts to contact a patient and other information specific to that patient, for example if they were hard of hearing or had a language barrier, were also available.
- Provision of suitable children's waiting areas was available in most clinics. However, the fracture clinic offered a very small area for children. This area was out of sight of reception staff and children were found to be waiting alongside adult patients. Staff described this as inadequate for their needs. This issue was noted in our last inspection in January 2016 but no action had been taken to address the concern.
- Patients told us the current signage and directions for moving through the hospital were challenging. One patient we spoke with told us "it was difficult to find your way, more so around the tower block area of the hospital".
- Diagnostic imaging was in the last phase of commissioning a new wide bore MRI scanner to accommodate larger patients. Prior to this being in place patients would have to travel out of the county to receive a scan.
- The demand for mobile magnetic resonance imaging (MRI) was being met. The trust outsourced to an MRI imaging service four times a week to help manage demand and reduce waiting times.
- Imaging had a plan to ensure continued provision of service to protect aging machinery. A capital replacement plan was in place with a five and ten year strategy. This included replacement of all high value and close to end of life machines.

Access and flow

- There were consistently long delays for patients requiring follow up treatment in ophthalmology. At the time of our inspection, there were 1,200 patients who had experienced the longest delays for follow up for Wet Age Related Macular Degeneration injections. While initial gains had been made to reduce the number from 2,000, the continued growth in demand for the service meant this number continued to grow beyond the capacity of the trust.
- In cardiology, from December 2016 to June 2017, 554 patients had been delayed past their agreed date for a follow up appointment. A backlog had developed due to a change in model that removed an outpatient consultant, and cardiology had yet to appoint a speciality lead. Therefore the consultant cardiologist had to cover multiple roles, reducing their capacity.
- In ophthalmology 6,503 people had breached the time for follow up appointments from December 2016 to June 2017. Extra clinics had been opened and staff trained to enable further accessibility to patients, but demand continued to place pressure on the service.
- Action plans to improve services to reduce patients waiting for cardiology and ophthalmology had been developed but progress had been slow. Some key milestone dates for each service had not been completed. Several actions had extensions in an attempt to achieve these targets but had not reduced the number of patients on the waiting lists.
- There was an emergency eye service. This was staffed by trained nurses and medical staff for emergency referrals. A daily booked clinic ran between the hours of 9am and 5pm. This service was designed to manage the flow of emergency eye patients through ophthalmology and not block other ophthalmology clinics. Staff had noticed an improvement in patient flow since the service had begun.
- The trust provided two week wait services via electronic referrals and provided advice and guidance services in renal, cardiology, haematology, neurology and

dermatology. The advice and guidance services allowed GPs to access rapid advice and/or treatment without the patient necessarily needing to be seen in an outpatient setting.

- Rapid access chest pain clinics (RAPAC) were also provided via electronic referrals. Patients were vetted to go direct to CT, MRI or into general RAPAC clinics.
- A rapid access neurology service was available for emergency department and ambulatory care patients, or patients discharged from a ward.
- An accelerated access clinic for primary joint replacement surgery was run by trauma and orthopaedics. This clinic ensured patients that required this service were moved promptly and freed up clinic slots for waiting patients.
- The ear, nose and throat service held an emergency clinic in general outpatients. This helped reduce the number of patients presenting in the emergency department.
- Gastroenterology and hepatology both ran "hot" clinics for patients identified with cancer. Hot clinics were consultant or associate specialist run and used to evaluate GP referrals.
- For breast cancer patients the Mermaid Centre ran symptomatic multi-disciplinary clinics to better manage patient demand.
- There were two areas in speech and language therapy (SLT) outpatients: head and neck specialist SLT service and specialist palliative SLT service. The head and neck specialist SLT responded to urgent swallow, voice and laryngectomy valve issues and could be as rapid as the same day if critical to the patient's wellbeing.
- The palliative SLT service responded within a week for urgent swallow issues that related to palliative care or end of life.
- The Cove, a purpose-built Macmillan Cancer Support Centre, opened in November 2016. This service had been developed to help patients find information and support, including information about specific types of cancer, treatments and how best to live with it. There was also support with finances and benefits, diet, exercise, and someone to talk things through with.
- The trust had established an outpatients' transformation programme to help positively impact on patient flow. However, the programmed had failed to reach any of its intended goals from April 2016 to July 2017. This meant patient flow through the clinics was not as fluid as hoped and patients continued to be faced with cancellations beyond their control.
- The outpatient transformation programme had attempted to reduce waiting lists and cancelled clinics. The 2016/17 target to reduce the "did not attend" (DNA) rate to 5.7% had not been met, with rates remaining above 6% in most months, peaking at 7.4% in December 2016. The DNA rate was at its lowest at 6.14% in April 2016. The inability to reduce the cancellation rate meant that patients were waiting longer for clinics slots to be available.
- A target had been set by the outpatient transformation programme to reduce the 'new to follow up' ratio. New to follow-up ratios are performance measures that look at the numbers of new appointments against how many then require follow up appointments. Reducing unnecessary follow-up is part of improving patient experience of the health service. The aim was to reduce the number of follow up appointments to 1.9. However, this remained above target peaking at 2.28 in April 2016 and the lowest achieved ratio was 2.05 in April 2017. This meant more patients were returning for follow-up appointments and slowing the flow through outpatient clinics.
- The outpatient transformation programme had set a target to reduce the number of clinics cancelled with less than six weeks' notice for avoidable reasons. The target was 26%. However, the trust peaked at 83.90% in June 2016 and its best performing month was 54.50%. The programme had not achieved its goal and clinics continued to be cancelled. This left patients having to be re-booked for an appointment.
- There were also a high number of avoidable cancelled appointments with more than six weeks' notice. In the four months leading up to our inspection figures ranged between 10.22% in February 2017 and 17.4%. In April 2017. The trust reported that the main reason for cancellations over six weeks from the appointment date was annual leave. Of those cancelled within six weeks, the top reasons were annual leave followed by sickness.
- The outpatients bookings team had set an ambitious target for answering calls within 22 seconds. In March 2017 the service received over 10,000 calls and the average time taken to answer was 50 seconds. Between December 2016 and May 2017, 68% of calls were answered within 22 seconds.

Outpatients and diagnostic imaging

- The percentage of patients seen by cancer specialists within two weeks was good. For all cancers 98% of patients were seen in the two week time frame in the period October 2016 to December 2016.
- Imaging was performing well and managing many of its key waiting times. For example, in January 2017 the imaging department had 7,205 patients waiting for imaging procedures. None of those patients waited more than eight weeks, significantly better than the department of health guidelines which set a maximum wait time of 18 weeks.
- Imaging consistently performed well in keeping waiting times low. Between January 2017 and May 2017 imaging maintained waiting times below eight weeks. Only in April did two patients wait longer than ten weeks.
- We found the time taken for diagnostic images to be reported was adaptable. For example, when lists became too long the imaging department responded by outsourcing the reporting function and reducing delays. The average wait for reports was between six to nine days.
- To increase sonography (medical ultrasound) capacity the training of an additional sonographer had begun. The additional sonographer was hoped to improve waiting times for this service.
- To manage imaging waiting list numbers the use of an internal radiologist consortium was used before using third party providers. This was of benefit to the trust as its reduced costs and for patients it provided continuity of care.

Meeting people's individual needs

- Services were planned, delivered and coordinated to take account of people's individual needs. There was a patient identifying system that showed patients living with conditions such as dementia or learning disability. This meant staff were able to plan additional support requirements for these patients. This included the provision of chaperones, interpreters or the trust's learning disabilities team.
- The trust's learning disabilities team would be ready to assist staff in the clinics prior to a patient with learning disabilities arriving. The team would also go outside to meet the patients on arrival at the hospital.
- Not all clinics were suitable for wheelchair users. We found waiting rooms to be small and limited the mobility of wheelchairs. The patient would have to wait in an area where movement of the chair was unhindered but not necessarily within the waiting area.
- The religious needs of patients were met and respected. The chaplaincy provided spiritual, religious and pastoral care to patients, relatives and carers; people of all faiths and those of none. The chaplaincy also provided a confidential listening ear for staff and could help with ethical questions and de-briefing after difficult and traumatic incidents.
- Staff we spoke with were aware of the counties' evolving cultural, social and religious needs and did their best to accommodate patient's wishes.
- There was written information available for patients. Some of these leaflets had been produced by the trust and other items had been provided by external agencies and translation services.
- A translation service was available to enable staff to communicate with patients where English was not their first language. We saw written information was available in several languages and large print.
- Bookings staff told us that if a patient required a translation or interpretation service this could be arranged and be in place when the patient arrived.
- We found provision for those with hearing impairment. Hearing loops were available and identifiable in all the outpatient clinics we visited.
- Not all clinics had been designed to be dementia-friendly. Easy read clocks and toilet signs were apparent in some, but not all, clinics. Each clinic had access to dementia champions who could assist with patients with complex or advanced dementia.
- In both the outpatient department and diagnostic imaging extra time would be allowed for an appointment if staff were made aware that a patient had learning difficulties and may require extra time.
- Bariatric patients' needs were met. We found hoists, chairs and wheelchairs available.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. The outpatient manager dealt with initial complaints that had not been resolved by individual managers in each clinic department. If they were unable to deal with a patient's concerns satisfactorily they would be directed to the patient advice and liaison service (PALS).

Outpatients and diagnostic imaging

- The trust had received 12 complaints relating to outpatients between June 2016 and May 2017. Of those complaints six were upheld and three were partially upheld. One was complaint had been withdrawn.
- The trust's complaints policy stated that the trust would aim to respond to complaints within 25 working days. For cases graded as high, complex cases and cases involving other organisations, this could be extended to 60 working days.
- Five of the complaints received took over 60 days to close. Complaints were commonly about clinical treatment, behaviours of staff and poor communication.
- The trust regularly shared information about complaints with staff. Quarterly reports provided details on learning from complaints which were distributed through the Patient Experience Group and Quality Assurance Committee.

Are outpatient and diagnostic imaging services well-led?

Inadequate

We rated well-led as inadequate because:

- A significantly high number of outpatients staff at all levels felt the culture within the trust was one of intimidation, bullying and discrimination and several staff had left or been signed off with stress.
- Governance procedures to monitor waiting lists, waiting times, frequency of cancelled clinics, and referral to treatment timelines for patients were not robust enough which meant the impact on patients was not fully known.
- A programme of rolling improvements in the outpatient service was not delivering sufficient results in a timely manner and significant challenges remained.
- Accountability for decision making was unclear in several speciality clinics.
- Leaders, including the board and divisional management, were not visible within the outpatients department.
- Staff and public engagement was not given sufficient priority.

However:

- In imaging we found the leadership to be visible and supportive. The culture in imaging was open and staff felt able to raise concerns.

Vision and strategy for this service

- The vision and strategy for the service was not clear to staff. There did not appear to be a robust trust level strategy to bring clinicians across all the specialities for the outpatients' service to improve performance. Senior staff told us that the current structure was unworkable and too large.
- Most staff we spoke with knew about the trust's values. Two staff explained what that meant for them in their role.
- Accountability for decision making was unclear. This meant getting a cohesive strategy and plan in place with a clear direction for the whole service had not yet been achieved. Cardiology and ophthalmology had no clear course to steer to improve the backlog of follow up appointments. When we spoke with the speciality leads for those departments they were unable to definitively state the actions being taken to improve the services.
- There remained significant challenges around access to appointments and the high volume of clinic cancellations. Managers told us that future projects were pencilled in but were awaiting sign off. The original cancellations database had not been successful at reducing the number of cancelled clinics. There was no clear strategy to improve this.
- Staff we spoke with were aware of improvement plans for the outpatient's clinics and departments but we were told many had stalled due to costs.

Governance, risk management and quality measurement

- Governance procedures to monitor waiting lists, waiting times, frequency of cancelled clinics, and RTT timelines for patients were not robust enough. For example, clinical leads did not have an up to date knowledge of the waiting lists for their specialties or delays for follow up appointments. This meant the impact on patients' safety was not fully known.
- The outpatient transformation project continued to meet monthly in an effort to meet the challenges presented. We saw evidence of this in the meeting minutes for this group where issues such as waiting times, the appointment booking system were discussed.

The outcome of these meetings was shared with the department managers with information being further disseminated in team meetings. Since its inception the group had yet to meet any of its targets.

- Decisions to put on additional clinics to manage the waiting lists were dependent on clinicians having the time available for additional clinics, clinic space and nursing capacity available to run clinics. In one instance we heard of an ophthalmology consultant attending a clinic in his own time to try to manage the number of follow up appointments.
- Risks were recorded and managed with mitigating actions in most cases. Risks were identified on the divisional risk register for outpatients. These comprised of risks such as: Failure to address sufficient follow up capacity in ophthalmology. While risks were recorded we could not be assured these were being managed effectively.
- We were provided with action plans for both cardiology and ophthalmology but we found many of the actions were not fulfilled by the proposed completion dates by several months. For example, in cardiology the eradication of a backlog of echo cardiograms was due to be completed by 30th May 2017 but remain un-fulfilled. The trust has since updated this action plan with a completion date of August 2017.
- Action had been taken to address the shortfall in follow up capacity in ophthalmology. This included using locums, collaborative working with local GP surgeries and service improvements within the wet age-related macular degeneration clinics. However it had been identified that demand continued to outgrow capacity and 4,000 additional clinic slots would be needed by the end of 2017. There was no clear plan for how this would be achieved.
- 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 delivered data to these 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.
- There were procedures in place to maintain clinical governance and risk management. For example, a monthly outpatient services dashboard detailed performance information tracking. This tracked various performance systems including statutory and mandatory training, appraisal rates, complaints and response times, medical records performance with twice daily audits and quality and safety meetings.
- Leaders within the diagnostic imaging service demonstrated a good rounded understanding of performance, which took into account safety, quality, activity and financial information. Managers were realistic in the business cases they made for equipment and staff.

Leadership of service

- Staff did not always feel supported by the leadership team. The majority of the staff we spoke with felt the executive management team were not visible and they had not seen the Chief Executive or other executives on the clinic floor unless the Chief Executive was doing media rounds. This left the staff with a feeling of detachment with board members.
- Most staff said they did not see senior managers very often. We were told that the structure of outpatients meant senior managers often had responsibility for other services as well as outpatients as they were also involved with the surgical specialities.
- Clinicians were troubled about the time it took to get concerns discussed and actions taken when they highlighted issues that impacted on patients and staff. For example, in outpatients most staff did not know who had overall responsibility for monitoring waiting lists across outpatients and ensuring patients were seen within the 18 week referral to treatment (RTT) target. Several staff told us management were not effective in managing issues and this meant “things never get sorted as too many people were involved in making a decision”.
- Cardiology did not use the central booking system. Cardiology had their own system and booking practices. This meant that leaders were out of touch with what was happening on this speciality’s booking management and we were told that cardiology was failing to manage the 500 plus backlog of RTT bookings. There was a lack of clarity about authority to make decisions and how individuals were held to account.
- In imaging we found the leadership to be visible and known to staff. Staff spoke of a supportive lead that encouraged personal and role development with clear career pathways structures.

Outpatients and diagnostic imaging

Culture within the service

- The culture within the outpatient service was unhealthy. However in diagnostic imaging the culture was open and supportive.
- The trust had policies in place to ensure people were not discriminated against. Staff we spoke with were aware of these and gave us examples of how they followed this guidance when delivering care and treatment for patients. However some staff in outpatients claimed they were discriminated against by management because of their grade or disabilities.
- Prior to this inspection some staff from outpatients had approached us because they felt that they were intimidated or bullied by the managers and felt that they had exhausted all avenues available to them in order to resolve the issue. During the inspection we were approached by other staff that raised similar issues. Concerns were raised about human resource processes that were not felt to be independent or followed proper procedures. Staff told us of two members of staff that had resigned as they felt “no one is listening”.
- During this inspection we received written and verbal concerns about the culture at the trust. Staff in outpatients raised concerns about bullying and harassment. One told us they had reported their concern to a senior manager but did not feel they had been listened to and the situation had not been resolved. Instead they felt they had been punished for reporting it. Another member of staff told us they had raised concerns but did not feel they could go above their line manager and their concern had not been taken seriously. Their situation had not been resolved. It was unclear whether the trust understood these issues or had developed a robust action to address them. Staff we spoke with were not aware that any plan was in place.
- We observed that the outpatients staff were patient focused and strived to provide a better service for their patients. Staff we spoke with said they aimed to provide a good experience for patients who visited their department but often felt limited by the time they had to spend with patients as many clinics were very busy.
- Staff told us they were aware of the trust’s whistleblowing policy but some staff were reluctant to speak out because they "feared being singled out". They spoke of not feeling very confident in its ability to protect individuals’ rights or to ensure impartiality if they were a whistle blower.
- There was concern in one focus group that spoke of a lack of accountability of the consultants in outpatients. Clinic times were not well monitored and they said that consultants could open a clinic late or close early with relative impunity.
- By contrast in diagnostic imagining staff spoke of an open and supportive culture where they could raise concerns and feel safe doing so.

Public engagement

- Patient Advice and Liaison Service (PALS) information was available on notice boards in waiting areas. These informed patients of the PALS service and invited patients to provide feedback and comments.
- No information was provided for outpatient clinics by the trust about current findings from the Friends and Family Test. The Friends and Family Test is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses.
- We spoke with 12 patients waiting in three clinics, none of which had heard of the friends and family test or were made aware of it during their clinic treatments.
- We found outpatient surveys were used in the pain clinic. Patients were given a feedback form to complete regarding the quality of service. These were reviewed once a month by the nurse in charge.

Staff engagement

- Throughout the inspection, most staff were welcoming and willing to speak with us. Some staff said they could see improvements were taking place and the trust were better at keeping them informed of changes that were happening that affected them.
- Staff working in the outpatient department told us that whilst they were engaged in making decisions which impacted on local matters which were in keeping with the day-to-day management of the department, they did not feel fully engaged in the wider context in determining how the department was run or how services were provided to the wider population.

Outpatients and diagnostic imaging

- A staff survey in September 2016 was sent to all 5,000 staff but only had a response from 1,200. The trust executive team therefore felt it was not representative. The general sense gained from this survey was one of an unhappy workforce. The findings from this showed that priority issues were communication, staff engagement, raising concerns, harassment, bullying and aggression. An action plan was developed from this to improve the issues that were of concern to staff.

Innovation, improvement and sustainability

- In radiotherapy the successful transition from ISO 9001:2008 Quality Management System (QMS) to ISO 9001:2015 (April 2017) had been completed. Companies use this standard to demonstrate the ability to consistently provide products and services that meet customer and regulatory requirements.
- The Clinical Oncology & Radiotherapy Physics QMS had been successfully merged.
- The implementation of Sonographer-Led Injection service had improved clinic facilities for patients.
- A quality radiographer had been accepted into Q community. The Q community is a national initiative to recruit 5,000 Safety Fellows following a recommendation of the widely respected 2013 Berwick report. This will improve on patient safety.
- A new positron emission tomography (PET) CT scanner had been introduced. This meant patients no longer had to travel to Devon.
- A nurse led paracentesis (a procedure to take out fluid that has collected in the belly) service commenced in January 2017 with a team of five nurses trained to increase capacity.
- An improved treatment option for the rapid removal of blood clots from veins and arteries had been introduced following the purchase of new equipment. In some instances this prevented patients having emergency surgery and reduced length of stay.
- The service had introduced chemoembolisation for hepatocellular carcinoma. This provided targeted treatment of liver tumours. Previously patients would have to have travelled to Plymouth for this treatment.
- The development and implementation of “RADAR” by Royal Cornwall Hospitals NHS Trust improved monitoring of referral to treatment, delays and clinic cancelations. It had won several national awards for innovation.
- The implementation of an electronic patient record tailored for ophthalmology included audit and reporting functionality.

Outstanding practice and areas for improvement

Outstanding practice

- The critical care unit had arranged for an external provider to provide shiatzu massage to patients on the ward to help with muscular pain. The service was also available to staff.
- The unit was using a local private ambulance to enable patients to go on day trips to local destinations. Nurses and doctors from the critical care unit would accompany them on these visits following a thorough risk assessment process.The patients suggested the destination and the unit endeavoured to grant their wish. Payment for the use of their services comes from the Charitable Fund.
- Emotional support and information was provided to those close to patients. Following the participation in the Provision of Psychological Support to People in Intensive Care (POPPI), three nurses from the unit had undertaken training to enable them to deliver psychological support to improve outcomes for patients being discharged from the unit. The nurses in question were delivering this support to patients during our inspection. The nurses were also able to provide support to colleagues when required.
- A member of the nursing team had recently returned from a secondment with the end of life team. Following their return, the nurse shared what they had learnt with the rest of the nursing staff. An initiative was also put forward to deliver additional support to bereaved children. We saw many tools to help children to cope with their loss. For example, the unit had invested in story books surrounding death. There were also puppets, colouring books and toys which could be used to distract and comfort children.
- If appropriate, deceased patients were moved to one of the isolation rooms so relatives could spend time with them in private. Staff also accompanied bereaved relatives to their cars or waited with them if using public transport so they were not alone.
- There was excellent local leadership of the children's service. Senior clinical managers were strong and committed to the children, young people and families who used the service, and also to their staff and each other.
- The trust had direct access to electronic information held by community maternity services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- There was an outstanding commitment from frontline staff including clinicians, administrative and cleaning staff to provide a high quality service for children and young people with a continual drive to improve the delivery of care. Staff were passionate about doing the best they could for the children in their care.
- The outpatient department had introduced an improved treatment option for the rapid removal of blood clots from veins and arteries following the purchase of new equipment. In some instances this prevented patients having emergency surgery and reduced length of stay.
- The imaging department's ability to maintain waiting lists at eight weeks and below.
- The development and implementation of "RADAR" by Royal Cornwall Hospitals NHS Trust improved monitoring of referral to treatment, delays and clinic cancelations. It had won several national awards for innovation.

Areas for improvement

Action the hospital MUST take to improve

- Improve the approach to identifying, reviewing and investigating incidents and never events.
- Adopt a positive incident reporting culture where learning from surgical incidents is shared with staff and embedded to improve safe care and treatment of patients.

Outstanding practice and areas for improvement

- Ensure there is an effective system in place to monitor and scrutinise incidents relating specifically to end of life care ensuring subsequent learning can be implemented.
- Take immediate steps to improve incident reporting timeliness, consistency, investigation, learning and sharing of learning processes.
- Review and implement the systems and processes to ensure staff follow the principles of duty of candour.
- Review the security of the antenatal ward to ensure the privacy and security of women who were inpatients.
- Take immediate steps to address the fracture clinic environmental issues that have been present since the January 2016 inspection, including adequate safeguarding systems for children.
- Ensure safety checks on surgical equipment are carried out by the planned dates.
- Provide surgical patients with sepsis with timely access to intravenous antibiotics.
- Securely and confidentially manage all patient information.
- Ensure that patient records are stored securely across the trust. Patient confidentiality must be maintained in accordance with the Data Protection Act.
- Ensure that the causes of incomplete treatment escalation plans are addressed and compliance is improved in critical care.
- Ensure patients are risk assessed and operated on in the correct theatre with the correct equipment and staff available.
- Ensure emergency resuscitation teams have immediate access at all times to a member of staff who is able to deal with difficult airway intubation.
- Ensure full compliance with the Five Step to Safer Surgery World Health Organisation (WHO) checklist to prevent or avoid serious patient harm.
- Meet expected levels of medical and nurse staffing levels on surgical wards to keep patients safe.
- Ensure there are sufficient numbers of midwives and nurses, with the right skill mix on duty at all times to deliver safe care.
- Ensure inductions of labour are safe in relation to capacity, activity and staffing on the delivery suite.
- Ensure there are sufficient numbers of suitably qualified nursing staff in the paediatric emergency department and formal processes in place to ensure appropriate cover was provided at all times.
- Improve compliance with the use of surgical patient care bundles.
- Ensure better quality data about processes and outcomes within the maternity services is available for analysis and to support improvement.
- Ensure the maternity dashboard includes sufficient information to provide a comprehensive overview of maternity performance. Proactively benchmark processes and outcomes in the maternity service against comparable trusts in rural areas.
- Ensure all surgical staff receive annual appraisals, mandatory training, appropriate supervision and professional development.
- Ensure all midwives update their training to a level where they all have the skills needed for their roles, and set targets for completion of training in line with trust targets of 95%.
- Ensure there are clearly articulated and understood processes in place for identifying and managing deteriorating women and that the processes are monitored.
- Review the risks and contingency plans for opening and staffing the second theatre and ensure there is a robust process in place that is well communicated and practiced.
- Identify, analyse and manage all risks of harm to women in maternity services, ensuring local risk registers are maintained in all discrete units and feed into the divisional and corporate risk register.
- Review and improve the high dependency processes and facilities for managing high dependency care in maternity services ensuring there are adequately skilled and trained staff on duty at all times.
- Take immediate steps to ensure the privacy and dignity of patients using the fracture clinic cubicles
- Improve the incomplete referral to treatment pathway compliance for surgical patients.
- Review the arrangements on the antenatal ward to ensure one-to-one care and women's privacy and dignity when giving labouring and giving birth there in the absence of additional capacity on the delivery suite
- Ensure all patients have their operations at the right time, whether in an emergency or for a planned procedure.
- Ensure surgical facilities are appropriate to meet patients' needs.

Outstanding practice and areas for improvement

- Improve bed management, and discharge arrangements to ensure a more effective flow of patients across the hospital to improve cancellations of patient's operations.
- Ensure access and flow into the critical care unit is improved to ensure delayed admissions, delayed discharges and discharges out of hours are reduced so patients receive the right care at the right time and in the right place.
- Take immediate steps to ensure that the backlog of patients awaiting cardiology procedures is eradicated.
- Take immediate steps to ensure that the backlog of 24 hour cardiac recordings and echocardiograms are reviewed.
- Take immediate steps to ensure that the backlog of patients awaiting WARM ophthalmology procedures and glaucoma service is eradicated.
- Improve the response times for patients' complaints.
- Ensure governance processes are embedded in practice to provide assurance that surgical services are safe and effective and provide quality care to patients.
- Ensure that systems are in place so that governance arrangements, risk management, and quality measures in maternity are effective. Ensure audits are aligned to incidents and identified risks.
- Ensure governance systems and processes are established and operated effectively to ensure the trust can assess, monitor and improve the quality and safety of the services provided to patients receiving end of life care.
- Ensure action is taken to address behaviours and performance which are inconsistent with the vision and values of the hospital, regardless of seniority.

Action the hospital SHOULD take to improve

- Review the trigger list for incident reporting to consider whether the thresholds are correct.
- Develop Local Safety Standards for Invasive Procedures.
- Ensure all of the learning points and actions identified during monthly mortality and morbidity meetings in critical care are recorded and followed-up.
- Continue to ensure safeguarding training compliance is brought up-to-date in the children and young people's service and sustained at trust target levels.
- Ensure medical staff mandatory training completion rates in critical care improve to comply with trust targets.
- Continue to ensure staff in the children and young people's service have their mandatory training brought up-to-date and sustained at trust target levels
- Improve compliance of patient screening for MRSA.
- Promote the use of hand gel for visitors and patients in the ophthalmology department.
- Ensure cleaning checklists in the cardiology outpatients department are used.
- Ensure there is access to patient toilet facilities within the surgical assessment unit and theatre recovery area.
- Repair the toilet facilities on Pendennis ward, to ensure they do not overfill and lead to closure of a bay.
- Ensure all areas of non-compliance with the Department of Health guidelines for critical care facilities (Health Building Note 04-02) are included on the local risk register.
- Ensure the environmental problems in the postnatal ward are resolved as quickly as possible
- Reposition the high dependency unit on Polkerris ward to ensure observation of children at all times.
- Improve the environment around the MRI scanners to allow better access for beds and patients.
- Consider improving directional signage around the tower block area of the hospital.
- Improve access facilities within outpatient waiting areas for wheelchair users when clinics are busy.
- Ensure all checks carried out on the difficult airway trolley are permanently recorded to ensure all equipment and medicines are available in the event of an emergency.
- Ensure all resuscitation trolleys in use on the critical care unit are in tamper-evident containers.
- Consider the use of air/oxygen blenders and pulse oximetry on the neonatal unit as recommended in quality standards for cardiopulmonary resuscitation.
- Improve the secure storage of breast milk stored in the fridges and freezers in the milk kitchen on the neonatal unit.
- Improve the processes to identify and dispose out of date medicines in surgery.
- Ensure all controlled drug register checks are carried out and recorded every day, in both the north and south sides of the critical care unit.
- Ensure the issues around the electronic drug charts in use, on the critical care unit and throughout the hospital, are rectified.

Outstanding practice and areas for improvement

- Review the method for checking controlled drugs on the neonatal unit to ensure that stock checks and signatures are recorded for each individual drug.
- Continue to consider an electronic record system for the community paediatric teams and in the meantime to ensure there are systems in place for the secure carrying of multiple paper records.
- Ensure there are regular nurse meetings on the critical care unit.
- Ensure there are sufficient gynaecology nurses to run clinics at times that suit women.
- Review the back-fill arrangements when midwives working on call have to work at night to ensure they are fit to work their shift next day.
- Examine whether the provision of specialist palliative care can be expanded to provide a seven day a week service as per national guidelines, to meet the needs of the trust.
- Review the provision of physiotherapy resource on the critical care unit to improve compliance with NICE Guidance 83 (Rehabilitation after critical illness in adults).
- Review the benefits of multidisciplinary handovers in the delivery suite.
- Develop clear written guidance for midwives about MEOWS, managing community obstetric and neonatal emergencies, baby weight loss and feeding concerns.
- Ensure staff in the outpatient departments are aware of their roles and responsibilities during a major incident.
- Develop policies and guidelines in maternity with more involvement of a range of relevant staff, particularly those who will need to implement the policy or are affected by it
- Ensure there are effective means of communicating changes to guidelines and audit compliance in maternity.
- Proactively promote smoking cessation to reduce smoking in pregnancy to national levels.
- In line with national guidance, routinely audit and evidence if patients are achieving their preferred place to receive their end of life care.
- Expand the scope of audit of end of life care documentation to assess the competency and understanding with which it is used.
- Improve the clarity of outpatient clinics outcome data to allow staff to have ownership and value to the work they do.
- Ensure the use of diaries is offered to patients on the critical care unit to help them, or their loved ones, document the events during their admission.
- Ensure patients, parents/carers are aware of the Friends and Family test and promote good use of this tool.
- Ensure all nursing staff are competent in using specialist equipment on the critical care unit.
- Ensure that there are mechanisms in place which effectively capture feedback from staff, patients and those close to them that can contribute to the design of end of life services.
- Ensure that governance processes and systems can provide assurance that delays with fast track discharges for end of life patients are being monitored and managed in accordance with national guidance relating to end of life care.
- Ensure there is a clear incident reporting process to follow in the event of delayed fast track discharges.
- Continue to improve the discharge paperwork provided to ward staff in critical care to improve compliance with NICE Guidance 50 (Acutely ill adults in hospital: recognising and responding to deterioration).
- Continue to improve the completion rate of discharge summaries in children and young people's services.
- Improve start times in operating theatres.
- Consider using the second theatre for elective caesarean sections so women did not have to wait in the event of emergencies in the main theatre.
- Review the number of scanning slots available to the day assessment unit so women do not have to travel more than once to the hospital.
- Reduce waiting lists for women awaiting non-cancer gynaecology treatment
- Fix the problem with post inpatient follow up appointments.
- Take further action to reduce the number of outpatient clinics that are cancelled for avoidable reasons.
- Improve the procedures used to monitor waiting lists, waiting times and the frequency of cancelled clinics for avoidable reasons.
- Give ownership management of the cardiology waiting referral to treatment lists to the bookings team.
- Improve systems and processes to show how complaints have been scrutinised for themes and level of impact in end of life care and what subsequent actions have been taken.

Outstanding practice and areas for improvement

- Ensure surgical leaders have the time to lead effectively.
- Improve communication between executive level staff and local end of life care teams about the development of the end of life service at the trust.
- Ensure there is a process in place which monitors the delivery of the end of life strategy and the actions held within it.
- Review the effectiveness of the outpatient transformation team.
- Clarify individual accountability for decision making within specialty outpatient clinics.
- Ensure the risk register in use within the critical care unit includes all risks identified by the unit. This includes ensuring that continuing risks are not closed and remain open until the risk is mitigated.
- Ensure there is an effective system at governance level to review, mitigate and improve services in relation to quality, safety and risk for end of life care at the trust.
- Develop a vision for the maternity and gynaecology services, including the community midwifery services and the birth centres and share this with staff.
- Take steps to improve the culture within the outpatient departments where bullying and harassment are present.
- Improve the engagement of both staff and the public in outpatients.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care (1)The care and treatment of service users must— (a) be appropriate, (b) meet their needs, and (c) reflect their preferences. (3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user; (b) designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met; The provider had not taken adequate steps to provide appropriate care and treatment in critical care to meet patient needs. Not all level two patients were able to receive critical care following their surgery due to a lack of beds in that service. Patients were not always discharged from critical care onto wards from the service in a timely way when medical fit for to do so. The number of patients discharged at night was higher than the national average and the occupancy on the critical care unit frequently exceeded recommended levels.

This section is primarily information for the provider

Requirement notices

Staff were not always able to respond appropriately to changing risks of people receiving end of life care.

Not all of the treatment escalation plans that we looked at had been completed fully by doctors. The sections that were left blank included confirmation that an assessment of a patient's capacity to consent had been completed, and whether a discussion had been held with the patient/relatives/ carers about the content of the treatment escalation plan.

This meant that the trust could not be assured that all patients at the end of life were being treated appropriately if their condition deteriorated.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect (1) Service users must be treated with dignity and respect. (2) Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular — (a) ensuring the privacy of the service user; The cubicles within the fracture clinic were very small and close to the neighbouring cubicle. Patients' personal information could be overheard when clinicians were discussing treatment options and other confidential details.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users.

This section is primarily information for the provider

Requirement notices

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

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

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

(g) the proper and safe management of medicines;

The hospital did not ensure that confidentiality was maintained at all times. Pregnancy test results with patient identifiable information were found in two sluice rooms.

Systems to assess monitor and mitigate risks relating to the health, safety and welfare of service users receiving care were not operating effectively, including protecting service users from avoidable harm.

Patients were not always risk assessed prior to their operations and equipment and staff were not in place, or operated on in the correct theatre with appropriate facilities. WHO checklists were not robustly undertaken or audited. Incidents were not identified, reviewed and investigated in a timely manner.

Surgery services were not meeting the incomplete pathway referral to treatment times for all of the surgical specialties.

Patients requiring emergency surgery were sometime delayed unnecessarily.

Patients with cancer had operations cancelled on the day of planned surgery.

Bed management, medical patients in surgical beds, and delayed discharges of care impacted on the flow of patients in surgery

Incidents were not identified, reviewed and investigated in a timely manner. Learning from incidents and never events was not shared with staff and others to promote learning.

This section is primarily information for the provider

Requirement notices

The hospital was poorly compliant with care bundles to effect improvement in a particular disease area, treatment or aspect of care.

Patients with severe sepsis were not given intravenous antibiotics within one hour.

Care and treatment was not provided in a safe way for all maternity service users, and not all risks were identified and mitigated effectively. Some staff did not have the skills to care for women and babies safely.

Women were labouring in the antenatal ward and the day assessment unit, because there was not enough capacity on the delivery suite. These women did not receive one-to-one care which is proven to support good outcomes

The processes for identifying deteriorating women using the maternity early warning score were not routinely used.

The progress of women's labour was not routinely recorded on the partogram recommended in trust guidelines

There was no process to ensure a safe skill mix including high dependency skills on the delivery suite

More women sometimes had their labour induced than the unit could safely manage in a day and decisions to induce labour did not take account of capacity, activity and staffing on the delivery suite.

Some midwives in the community were not confident in cannulation and potentially not able provide basic life support in the face of ambulance delays to remote communities/birthing centres.

This section is primarily information for the provider

Requirement notices

There was a lack of scrutiny and subsequent learning from incidents relating to end of life care at the trust. There was not an effective process in place at the time of our visit which had responsibility for the oversight of incidents.

Incidents that affected the health, safety and welfare of people using outpatient services were not consistently reported internally and to relevant external authorities/ bodies. Incidents that included the potential for harm were not always reported. Adequate steps to ensure learning was identified and shared with staff were not in place.

The trust was not safely managing the backlog of cardiac 24 hour recording tapes.

The trust was not safely managing patients on WARM injection follow up lists and glaucoma lists coming to harm.

Out of date medicines were stored on wards, and on a resuscitation trolley, and had been administered to a patient. On the trauma unit we found a batch of lorazepam which had expired in April 2017. We also noted an incident had occurred on the trauma unit during the inspection period when a patient was administered an out of date controlled drug. However, the report stated there was 'no apparent injury or minor injury not requiring first aid'. On the surgical admissions unit we found two bags of intravenous energy feed which had expired in November 2016.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

(1) All premises and equipment used by the service provider must be —

(a) clean

(b)secure

(c) suitable for the purpose for which they are being used

(e) properly maintained

Premises where care and treatment were being delivered were not always clean, secure, suitable for the intended purpose or well-maintained:

There were not adequate toileting and shower facilities on Theatre Direct and surgical assessment unit. There were two showering facilities on the unit – one for male and one for female patients. However, these were situated inside the toilets in two of the three available toilets.

Safety checks on equipment were not carried out by planned dates. A maintenance record of medical devices report dated June 2017 showed planned preventative maintenance had not been carried out by the expected date on three out of 18 anaesthetic machines (17%); and 11 out of 110 (10%) anaesthetic syringe pumps.

On the trauma unit we found a bladder scanner which was due a safety test in January 2017. In Theatres Direct we found a manual blood pressure cuff which was due a safety check in January 2014.

On the surgical admissions lounge we found an oxygen saturation monitor and an electrocardiogram monitor which were due to be safety checked in June and July 2016 respectively.

This section is primarily information for the provider

Requirement notices

The antenatal ward was not secure as it had open access to members of the public during the day as the entrance was shared with the day assessment unit and nurse consulting rooms.

The delivery suite did not have a facility for women needing higher levels of care.

The second theatre on the delivery suite was not kept ready for immediate use and not used as a second theatre for elective lists

The capacity of the delivery suite was too small for the number of women delivering so some delivered on the antenatal ward

The postnatal ward was too hot and large freestanding fans used to cool the corridors had trailing wires causing a risk of falls

Emergency drugs were stored outside the postnatal ward due to high temperatures which meant staff did not have ready access to emergency medicines

The fracture clinic was not fit for purpose. A number of issues reported following our previous inspection in January 2016 were still present during this inspection. The trust had previously advised us this was only a temporary location but the clinic had been relocated and we did not receive adequate assurance that this was still the case.

Issues included:

- The seating area being worn and torn increasing the risk of bacterial harbourage.
- The seating area being hidden from the receptionists' view.
- Children were not adequately safeguarded because there was no dedicated waiting area for children.

This section is primarily information for the provider

Requirement notices

- Deeply chipped wood work throughout the clinic increased the risk of bacterial harbourage.
- The paintwork around the reception desk was black with what appeared to be body grease, increasing the infection risk.
- Insufficient waiting areas for patients with fractures that need elevation.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints (2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Complaints were not dealt with within 25 working days in line with the hospital policy. From June 2016 2016 to May 2017 the service consistently missed the target of closing complaints within 25 days. The target was for 90% to meet this deadline. The average working days for complaints to be closed was 69 days.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to –

This section is primarily information for the provider

Requirement notices

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

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

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

(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

Systems and processes were not effective enough to identify, monitor or mitigate risks to the health, welfare and safety of people who use the service, or the quality of the service.

Governance processes were not embedded in practice to provide a robust and systematic approach to improving the quality of surgical services.

Risks, issues and poor performance were not always dealt with appropriately or in a timely way. Managers lacked time and support to lead effectively.

Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the maternity services provided because;

The quality and accuracy of performance data was not adequate and some data was poor quality and not used to identify trends or areas for improvement.

This section is primarily information for the provider

Requirement notices

The information management system for the maternity service did not hold the information needed to run an efficient service.

Maternity guidelines were not properly aligned and made different recommendations about the same issue.

The service had not identified all risks such as the number and skill mix of staff or provided adequate mitigation for some of the risks identified.

There was limited audit activity to review for the quality of processes in maternity and for improvement or benchmarking.

There was little evidence that anybody at a governance level was taking overall responsibility to review, mitigate or improve services in relation to quality, safety and risk for End of Life Care at the trust.

There was no oversight or governance processes that gave assurance that issues with fast track discharges for end of life patients was being monitored or managed. This is against national guidance relating to end of life care.

There were no mechanisms in place which effectively captured feedback from either staff or patients and those close to them that allowed any input into the design of end of life services.

The systems in place for monitoring at risk patients on waiting lists were not effective in preventing patients coming to harm in both ophthalmology and cardiology.

Despite having actions in place to monitor and reduce waiting lists, the number of patients waiting for treatments had grown.

This section is primarily information for the provider

Requirement notices

Patient records were not stored securely in cardiology. Patients' medical records and other patient identifiable data were left unattended behind reception and in a room accessible by the public.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. (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 (c) where such persons are healthcare professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practice or a requirement of their role. There were not sufficient nursing staff on duty on all surgical wards (with the exception of Wheal Coates) to ensure the safety of patients at all times to monitor and provide care and treatment to patients. The surgical assessment unit and Theatre Direct which only had 82% of planned nurses during the day in April, 85% in May and 88% in June. This was of particular concern as the numbers of healthcare assistants also fell short of planned levels during the day in these two areas where there were 81% of planned numbers in April, 75% in May and 75% in June.

This section is primarily information for the provider

Requirement notices

There were high vacancy rates in medical staffing. In March 2017, there was a vacancy rate of 14.2% (relating to 44 WTE vacancies). Senior managers confirmed recruitment was a significant challenge. For example, there were eight anaesthetic vacancies at the time of the inspection. This was managed on a daily basis. The highest vacancy rates were in the trauma and orthopaedics specialty, where there were 39.1% middle grade vacancies and 25.6% junior doctor vacancies.

There were not sufficient numbers of suitably qualified, competent, skilled and experienced midwives in the maternity services because

There were risks to women because there were not enough staff to cover workload in the delivery suite

The escalation policy to ensure safe staffing was not working effectively

There were insufficient numbers of suitably qualified nursing staff in the paediatric emergency department to provide safe care at all times.

RCN guidance recommends a minimum of two registered children's nurses at all times in all inpatient and day care areas. However only one suitably qualified nurse was available in the department.

There were no formal processes in place to ensure appropriate cover was in place during periods of absence.

There were occasions when the nurse was away from the department i.e. when they accompanied a child being transferred to the paediatric ward, attending to children and parents' needs, fetching snacks and drinks from the kitchen or taking a break. During these times staff from the adjacent main adult emergency department, who had completed a paediatric module, provided cover if available. However, there were occasions when the reception area was left unattended.

This section is primarily information for the provider

Requirement notices

Compliance with mandatory training and appraisals for surgical staff were below target. Only 57.8% of the required staff were up to date with duty of candour training. Only 70.1% were up to date with infection control training.

Compliance with mandatory training was significantly below the trust target of 95%

Not enough staff on the delivery suite were trained to manage high dependency patients so women were sometimes cared for by staff without appropriate training.

Not all midwives were skilled in cannulation, epidural knowledge and suturing.

On call community midwives were not trained in STAN monitoring or hospital computer systems but were sometimes required to work on the delivery suite

Only 55% of midwives were up to date with new born life support training updates.

Not enough midwives were trained in new-born checks even though the maternity service had assumed responsibility for this in April 2017.

Action was not always taken to address behaviours and performance in surgery which was consistent with the vision and values, regardless of seniority.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour (1) Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. (2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—

This section is primarily information for the provider

Requirement notices

(a) notify the relevant person that the incident has occurred in accordance with paragraph (3), and

(b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

(3)The notification to be given under paragraph (2)(a) must—

(b) provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,

(c) advise the relevant person what further enquiries into the incident the registered person believes are appropriate,

(d) include an apology, and

(e) be recorded in a written record which is kept securely by the registered person.

(4) The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—

(a) the information provided under paragraph (3)(b),

(b) details of any enquiries to be undertaken in accordance with paragraph (3)(c),

(c) the results of any further enquiries into the incident, and

(d) an apology.

(6) The registered provider must keep a copy of all correspondence with the relevant person under paragraph (4).

We saw that the trust's duty of candour 'being open policy' was not used in all situations where duty of candour applied in surgery.

This section is primarily information for the provider

Requirement notices

We saw that discussions may be had with patients/ relatives but a written apology did not always occur. One person was responsible for producing duty of candour letters and there were no provisions for cover in case of absence.