Care Quality Commission

Royal Cornwall Hospitals NHS Trust

Royal Cornwall Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Accident and emergency	**Good**
Medical care	**Requires improvement**
Surgery	**Requires improvement**
Intensive/critical care	**Good**
Maternity and family planning	**Good**
Services for children & young people	**Good**
End of life care	**Good**
Outpatients	**Good**

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Overall summary

Royal Cornwall Hospital, Truro (known locally as Treliske Hospital) is a medium-sized general hospital providing care to a population of around 450,000. It offers specialist and general clinical services to the people of Cornwall and the Isles of Scilly, and people who may be visiting in the area. The hospital is registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983; diagnostic and screening procedures; family planning; management of supply of blood and blood-derived products; maternity and midwifery services; surgical procedures; termination of pregnancies; treatment of disease, disorder or injury. There are around 650 beds and the hospital sees around 110,000 patients as inpatients each year. The hospital arranges around 480,000 outpatient appointments each year and around 54,884 people visit the emergency department.

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

The hospital had undergone a number of changes and improvements over the last few years, which had included opening a new accident and emergency (A&E) department at the end of 2013. There had also been a change in leadership of the hospital trust. Many staff told us these changes had been positive and they felt the hospital had improved and they were proud to work there. There was a high degree of respect for the executive team.

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

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

Staffing

The impact of the investment in recruitment and training had made a significant difference to the hospital and had been a factor in the improvements that we saw and that staff and patients described. This work was ongoing and in the meantime some staff felt under particular pressure. We observed that these pressures were felt most keenly in the medical and surgery wards at the hospital. Some nurses we met said they did not have enough time to spend with patients; nurse managers said they were often fulfilling clinical shifts and not their managerial duties; nursing staff said training often had to be postponed if their area was short-staffed. The nursing staff shortages were covered by agency and bank staff.

Cleanliness and infection control

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

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appropriate personal protective equipment when delivering care to patients. We were concerned about the distribution of hand-wash gels, and instructions for people, patients, visitors and staff to ensure that their hands were clean and that they used sanitising gels appropriately. There was not enough provision of hand gel at the entrances to wards and units in all places.

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

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We found the services at the hospital were safe however some improvements were required. Some patient notes were not accurate or complete, which could mean that their care was not well-enough understood to be as effective as it should be.

Staffing levels had increased and while recruitment continued, bank and agency staff were employed to deal with shortages. Despite this, the staff working in A&E, medical and surgical wards at the hospital felt under pressure at times. This had been recognised and the trust was continuing to actively recruit staff.

Maternity and children's services were safe, and staff followed best practice guidance. There were dedicated facilities for children, although no waiting area for only children and families in X-ray, and no arrangements to manage this. Outpatient services were performing well, although not all environments were designed or arranged in the best interests of the patients. This was because some were old and not designed for their current purpose. Patients were protected from abuse.

Learning from incidents was variable across the hospital. Systems designed to avoid harm to patients in surgery had improved, but required continued focus. There were some arrangements for the safety and security in one theatre area which needed addressing.

Are services effective?

Good

Outcomes for patients were good and the hospital performed well when measured against similar organisations. National guidelines and best practice were applied and monitored, and outcomes for patients were good overall. Staff worked in multidisciplinary teams to co-ordinate care around a patient. End of life care was integrated with community services. Staff were supported to be innovative and develop their clinical skills. Most mandatory training and appraisals were on track to be completed annually. New mothers were well supported and children and young people's services were effective.

Are services caring?

Good

During our inspection, we observed that almost all staff were caring and patients confirmed this, saying also that staff were considerate, and treated them with kindness and respect. Patients and carers coming to the maternity and children's services said that staff were caring and kind. A&E staff were praised for their kindness. Staff in the critical care team provided outstanding emotional support. There was an exceptional service provided by staff in the surgical team for people with learning disabilities who might be scared about

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coming to hospital. We found people with learning disabilities were cared for well in other parts of the hospital. Children and their parents were kept involved with decisions and care planning. The care given to people at the end of their life was caring and sensitive.

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

Are services responsive to people's needs?

Requires improvement

The hospital supported vulnerable patients well, to ensure care was delivered in their best interests. Discharge arrangements were usually managed well.

Bed occupancy at the hospital was at a level that had an impact on the quality of care, and caused the A&E department to miss waiting-time targets for patients. There was sometimes pressure on maternity services and women giving birth to their babies on the antenatal ward. The critical care unit was not meeting discharge targets, as there were sometimes no beds available into which to move patients who were recovering. Due to this, and other bed pressures, some surgical procedures were cancelled, and responsive care was complicated by medical patients being admitted to surgical wards due to shortages of beds on medical wards. Patients were sometimes also delayed by their discharge into community care not being arranged in good time with and by other providers. The improvements needed to ease the pressure on the hospital required the continuing involvement of partners in the wider community to help manage the impact of the increasing number of people seeking treatment and the delays in people leaving the hospital.

The hospital was cancelling too many operations, and in some circumstances, there were inadequate facilities to consult with patients, which was causing further delays. The arrangements for recovery following surgery were not ideal in some circumstances. This was because of lack of space in some areas. Surgical equipment was sometimes not in the right place. Some patients were dissatisfied with the administration process around appointments. There were some key staff in the hospital for whom there was no succession planning or cover when they were not working.

Are services well-led?

Good

Staff told us they felt the hospital was well-led. They were supported by their peers and managers to deliver good care and to support one another. Staff said they felt proud to work at the hospital and were included and consulted in plans and strategies. The team providing end of life care was well-led and committed to proving compassionate care. The hospital identified areas where improvements could be made, and organised work-groups and experienced staff to address them. Many staff spoke about the executive team with respect and enthusiasm.

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

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What we found about each of the main services in the hospital

Accident and emergency

Good

Patients received safe and effective care. Staff were caring and dedicated to improving standards. Patients and staff spoke highly of the new A&E department, which had improved patients' privacy and dignity. Staff in A&E, and from across the hospital, worked together to ensure they met the needs of patients, and to provide an effective service for patients who had particular needs. At the time of our inspection most patients were being assessed within one hour of admission.

Staff told us that on certain days A&E could be busy, and this was affecting their response to patients. The new A&E department had opened just before Christmas and the staffing levels had yet to be increased to meet the extra service provision. The hospital also reached bed capacity at times, and this resulted in patients discharge onto a ward being delayed. Since April 2013, the department had met the government's four-hour target for 95% of patients to be seen and discharged, in just one month; it was just short of it in three months; and fell below it in four months (December 2013 data was not complete).

Staff within A&E supported each other, and we were informed by many staff that morale was improving and that there was effective team working. The department was well-led; it understood its risks and recognised its achievements. The hospital performed well above the national average in the Friends and Family test in questions relating to their experience of A&E services.

Medical care (including older people's care)

Requires improvement

Staff provided a safe service to patients receiving medical care, but there were concerns when staff were busy, and also about the management of safe record keeping. We saw that medical and nursing staff were busy, and when they were short staffed, they sometimes felt that care was not as effective as it should be. Staffing shortages were being addressed by the trust by recruitment, and with staff from a contingent workforce, including agency staff. Full staffing levels had not yet been achieved. We saw that not all patient records were being fully maintained or accurately completed. This placed patients at risk of not receiving the correct care.

Staff worked effectively and collaboratively to provide a multidisciplinary service for patients who had complex needs. We saw that sometimes, the environment of wards and units were less than suitable for the purpose of supporting patient care, and promoting their health and safety.

Staff were caring. Patients spoke highly about the care they received, and the kindness and helpfulness of the staff. However, we had concerns about delays

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in the 'flow' of patients through the hospital. We saw that patients were often delayed and that staff were put under pressure by this. Whist we are aware of some actions taken to address this problem, this is an area of improvement for the trust.

The service was well-led. We saw at ward level that staff felt supported by the senior staff and, in turn, senior staff told us that they felt supported by the management of the hospital. Medical staff told us that they considered there had been improvements in the leadership of the hospital, with a positive outcome for patients.

Surgery

Requires improvement 

Safety, effectiveness and responsiveness in surgery were good in many areas, but improvements were needed in others. The performance and outcomes for patients from the surgeons and theatre teams were good. The staff teams in theatres used safe systems to ensure that there was no avoidable harm to patients. The compliance with these systems had improved, although this needed to be continued and maintained. Staff spoke highly of one another, and received good peer and management support. The division learned from incidents, and made improvements to practice. Patients were listened to, and the division learned from criticism, comments and complaints.

To improve safety, the security arrangements for one theatre area needed to be addressed. To improve effectiveness and responsiveness, the hospital needed to reduce cancelled operations, and those starting or finishing late. Beds and recovery services needed to be available at the right time, and in the right areas. Patient records needed to be improved, and completed with care and consistency on some wards.

Most staff were caring, considerate and kind, and put their patients first. Most patients felt included and involved in their care. Staff in all areas were said to be mostly open, honest and approachable. We met some exceptionally caring, experienced and dedicated staff. To help the more vulnerable patients in their care, there was an outstanding innovative service for patients with learning disabilities. Patient consent was done well, and best-interest decisions were taken with an inclusive approach for patients who could no longer make the decision for themselves.

To improve care and effectiveness, the hospital needed to address the lack of privacy and dignity for some patients, particularly in theatre recovery. Some patients were remaining on the post-operative recovery wards for too long, as there was no bed available for them. A number of patients told us that administration procedures were a cause for concern, leading to missed or duplicate appointments, and wasted time. The leadership needed to consider and address the risks from patient flow being poor at times, and where it could make changes to reduce subsequent risks for patients.

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Intensive/critical care

Good

Patients received safe and effective care, although staff sickness levels, the amount of training undertaken, and the availability of the outreach service were a concern. Clinical outcomes, including mortality, were good and often above the national average. The caring, consideration and compassion of staff was excellent, and patients we spoke with, and who contacted us, praised the department. The department was well-led.

Due to pressures on bed capacity elsewhere in the hospital, the critical care department was not responsive enough to the needs of patients. A lack of effective patient flow through the hospital meant that most patients were not being discharged when they were ready; too many were being discharged at night; some were not able to access critical care at times; and some were being discharged early when staying longer might have improved their outcomes. Discharge means moving to another ward within the hospital as well as leaving the hospital to go home or to another place to be cared for.

There were high levels of sickness among staff, although the trust had responded by providing bank and agency staff, and permanent staff worked extra hours.

There was a lack of resilience in some areas. The outreach service was understaffed and not able to provide a full service, particularly in the follow-up of patients. The knowledge and skills needed for the computer-based patient record system resided in one member of staff. Business cases had been submitted to the trust for future improvements in the outreach team, but not for increased electronic record system expertise.

Maternity and family planning

Good

The maternity unit at Treliske Hospital provided safe care. The ward-based staff were busy, and on occasions, there had been insufficient staff to meet the needs of individual women in the maternity department. Medical cover was sufficient and included consultant, senior and junior doctors. Staff worked closely with one another across the maternity unit, to provide a multidisciplinary service, for patients who often had complex needs. There were specialist midwives and volunteer staff available to provide additional support to women while they were in the maternity unit.

The maternity unit was clean and hygienic in appearance, with sufficient and appropriately located hand washing facilities and anti-bacterial hand gel. Women and their babies were protected by the training provided to staff and the systems in place, to ensure the environment and equipment was safe for them and the staff to use.

Staff were caring. Women spoke highly about the care they received, and the kindness and empathy shown to them by clinical staff within the maternity unit.

Summary of findings

The service provided to patients in the maternity unit was not always responsive to their individual needs. There were delays at times on each ward, often due to high numbers of women attending the unit, and insufficient beds or staff to support them. This meant that patients were not always cared for in the most appropriate area or ward.

The service was well-led. Staff generally felt supported by the senior staff; although we did hear that, at busy times, clinical managers could make staff feel pressured and were not so supportive. We met with senior managers for the maternity services, who were positive in their comments regarding the recent changes in the hospital management team.

Services for children & young people

Good

Children received safe and effective care throughout the hospital. The staff were aware of best practice guidance, and followed this when delivering care and treatment. Children and young people's health was monitored using a recognised assessment tool. Parents told us that the staff were kind and caring to both their child and to themselves. We found the children and young people's services in the hospital were well-led.

The service was not always responsive to the needs of children and young people. We found that the service provided to young people without additional needs stopped at 16, with no formal care pathway for young people aged between 16 and 18. Parents found that there were excessive waiting times to see a doctor, when attending the assessment unit. While there were no paediatric trained staff in outpatients clinics that saw children in the general outpatient setting, the staff were able to get support from paediatric trained staff or the play therapist, where appropriate.

End of life care

Good

Patients received safe and effective end of life care. Their care needs were being met and the service worked effectively with community services throughout Cornwall when patients were transferred into their care. The care team worked Monday to Friday. Out-of-hours support was provided to hospital staff by the local community hospice. This enabled clinicians across the hospital to access expert palliative advice and support 24 hours a day.

Most patients and their families were positive about the care and support they received, and said they were treated with dignity and respect by all staff they encountered. Staff had appropriate training, and supported patients to be fully involved in their care and decisions. The end of life team was well-led, and staff were dedicated to improving standards of end of life care across the hospital as a core service, rather than a 'specialty service'.

Outpatients

Good

Patients received safe and effective care, and staff were caring. Staff demonstrated a robust understanding of child and vulnerable adults safeguarding.

Summary of findings

Patients were seen within two weeks for urgent appointments. Some clinics we visited, such as the fracture clinic, were very busy, and patients waited a long time to be seen, with no information about how long they might have to wait. All the outpatient clinics were managed differently by departments, and information on quality and safety was fed into individual divisions, such as the surgical division or medical division.

Patients told us that the mammography clinic and dermatology service were outstanding. The services were well managed at a clinical and service level. The hospital was committed to reducing waiting lists where issues had been identified. It had brought in extra resources to ensure patients were seen within national targets. The hospital had introduced a 'text reminder service' to try to reduce the number of non-attenders.

Hand-wash gel and hand-washing advice for people visiting the main outpatients department in the Trelawney building were not prominent enough.

Many patients mentioned difficulty with the car parking being expensive and too far away from the clinics. However car parking prices were similar to other hospitals in the peninsula and to the centre of Truro. Drop off and collection points for patients were available at the main entrances.

Summary of findings

What people who use the hospital say

The hospital trust was rated about the same as other trusts in the 2012 Adult Inpatient Survey, while falling below other trusts in its performance around privacy and dignity in the emergency department, and the availability of hand-washing materials. It performed just below the national average in the inpatient Friends and Family test, but well above the national average for the A&E department. The trust was ranked better than other trusts in 29 out of 69 questions in the 2012/13 Cancer Patient Experience Survey, and only worse than other trusts in two of the questions.

Areas for improvement

Action the hospital MUST take to improve

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

Action the hospital SHOULD take to improve

- The recruitment of additional staff and the planned use of bank and agency staff had been successful to date. This needed to continue to address the pressures that staff were feeling in the A&E, medical and surgical wards. The hospital needs to ensure it has suitable numbers of qualified, skilled and experienced staff to safely meet people's needs at all times.
- Some wards were not as clear in their development as others. Staffing and support were needed for the stroke and elderly care wards.
- Identified shortcomings with hand hygiene were being addressed, but needed further work to be effective.
- There were issues with the management of processes related breaches of the four hour waiting time target in A&E and the percentage of patients being termed as "clinical exceptions", which was significantly higher than the national average.
- Departments needed to ensure they had sufficient equipment at all times. Both A&E and theatre reported equipment being moved or used elsewhere in the hospital, and this causing risks and delays.
- Staff reporting of incidents was improving, but response to reporting, and the culture around it being used as a threat by staff, needed addressing.
- The use of the World Health Organisation (WHO) surgical safety checklist had improved, but required more attention until it was being used with full compliance.
- There were at times, difficulties, due to the availability of either beds or midwives, in transferring women from the antenatal ward to the delivery suite. This had resulted in some women labouring and delivering their baby on the antenatal ward. This had implications for the levels of staff support provided to them and not meeting women's choices regarding their birth plan. For example, a woman could not have an epidural on the antenatal ward.
- Care for young people stopped at the age of 16 in the designated unit, and new patients aged between 16 and 18 were cared for by adult services.
- The lack of succession planning for key members of the critical care team, or sufficient effective cover for when they were not working, meant that the Outreach service did not fulfil its potential.
- There was a risk to the IT systems in critical care from only having one experienced member of staff to provide back-up support and expertise.
- Privacy, dignity and confidentiality were not always being achieved for some patients.

Action the hospital COULD take to improve

- More work could be done to improve the care for people with dementia.
- Administration needed to be reviewed to understand why patients were dissatisfied with the service they received in relation to appointments.

Summary of findings

Good practice

Our inspection team highlighted the following areas of good practice:

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

Requires improvement

Royal Cornwall Hospital

Detailed findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

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

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

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

Background to Royal Cornwall Hospital

The Royal Cornwall Hospital, Treliske, is the principal provider of acute services for the county of Cornwall. It is a medium-sized teaching district general hospital providing acute, specialist and community healthcare to the people of Cornwall and the Isles of Scilly. The hospital has a 24-hour emergency department and maternity service. It serves a population of around 450,000 people, which often doubles when the area is visited by holiday-makers and tourists in the summer months. There are around 650 beds and the hospital sees around 110,000 patients as inpatients each year. The hospital arranges around 500,000 outpatient appointments each year and around 54,884 people visit the emergency department.

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

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

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

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

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

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

Good

Accident and emergency

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

Information about the service

The accident and emergency (A&E) department is open 24 hours a day, seven days a week to provide an emergency service to the people of Cornwall and visitors to the area. This is the only A&E department in the county of Cornwall, although there is an urgent care department in the West Cornwall Hospital in Penzance. The new department was officially opened on 24 December 2013 and has increased the number of treatment areas for major illness from nine to 22. About 55,000 patients (adults and children) are expected to attend this department each year. The hospital triages patients as they are admitted, to ensure they reach the correct department. The department has a clinical decision unit used for patients who need ongoing observation or assessment before they are admitted to hospital, transferred or discharged.

During our three separate visits to A&E we talked with over 30 patients. We also spoke with staff, including nurses, doctors, consultants, managers, therapists, support staff and ambulance staff. We also received information from our listening events and from people who contacted us to tell us about their experiences. We also collected comment cards from a designated box set up for our visit. Before our inspection we reviewed performance information from, and about the trust.

Summary of findings

Patients received safe and effective care. Staff were caring and dedicated to improving standards. Patients and staff spoke highly of the new A&E department, which had improved patients' privacy and dignity. Staff in A&E, and from across the hospital, worked together to ensure they met the needs of patients, and to provide an effective service for patients who had particular needs. At the time of our inspection most patients were being assessed within one hour of admission.

Staff told us that on certain days A&E could be busy, and this was affecting their response to patients. The new A&E department had opened just before Christmas and there had been an investment in staffing. A further consultation was currently being undertaken to review the numbers of nursing staff in A&E. The hospital also reached bed capacity at times, and this resulted in patients discharge onto a ward being delayed. Since April 2013, the department had met the government's four-hour target for 95% of patients to be seen and discharged, in just one month; it was just short of it in three months; and fell below it in four months (December 2013 data was not complete).

Staff within the A&E supported each other and we were informed by many staff that morale was improving and that there was effective team working. The department was well-led; it understood its risks and recognised its achievements. The hospital performed well above the national average in the Friends and Family test in questions relating to their experience of A&E services.

Good

Accident and emergency

Are accident and emergency services safe?

Good

Safety and performance

Most of the patients we spoke with during our inspection said they felt safe, were well cared for, and received excellent care. We spent time observing the care and treatment that people received in A&E. We saw some excellent practice, care and treatment of patients. At the time of our visits most patients were being assessed within one hour of their arrival.

The data supplied by the hospital trust showed an increase of 2,500 patients attending A&E from the previous year. One senior staff member said the new layout of the A&E department had resulted in improved monitoring of patients. There was now much less, if any, moving around of patients to bring more seriously ill patients closer to the observation area. This improved patient safety management, with the increased number of cubicles around the staff base. There was information about the performance of the department on display in the treatment area of A&E, for staff to monitor their performance and targets.

We observed excellent pathways of care, in particular for stroke patients. In one example, the specialist stroke nurse was called to A&E when the ambulance crew advised they had a patient with a suspected stroke. Records showed that this patient had been scanned to establish if they had suffered a stroke within nine minutes of their arrival. We were informed that over 70% of stroke patients at the hospital were scanned within 30 minutes of arrival. The Stroke Association stated that patients should have a brain scan within 24 hours of having a suspected stroke. This showed that the trust performed exceptionally in this area of care. This excellent care for patients with a suspected stoke was also achieved with one stroke nurse being based in the department, and cover provided from the stroke ward when they were not on duty. The data collected by the hospital showed that stroke patients were then admitted onward to the stroke ward in a timely manner.

Many A&E staff told us that the newly expanded department did not have sufficient staff to maintain patient safety when they were at full capacity. All the nursing and medical staff we spoke with (35 in total) felt the increase in treatment areas for major injuries or illnesses (from nine to 22) had not been matched by increased staffing to meet the new demand. The matron said there had been an increase in senior staff after a consultation paper looked at restructuring of these roles. A further consultation was currently being undertaken to review the numbers of nursing staff in A&E.

Consultants at the hospital worked longer shifts to assist the department. Staff said this worked well. However, there was some concern as to whether this would be sustainable in the long term, particularly as the number of consultants had not increased to meet the increase in capacity. The information received from the hospital, which was for staff numbers prior to the expansion of the unit, showed that the hospital employed 8.6 whole time equivalent consultants, with no vacancies, 10 specialty doctors (these are senior posts) with 1.6 vacancies, and one registrar with one vacancy. The number of consultants was in line with the recommendations from the College of Emergency Medicine.

Consultant cover was good, with provision seven days a week. An additional consultant was appointed in November 2013. Consultants worked to cover the period from 08.00 hours to 22.00 hours. Overnight, the hospital had a registrar doctor or speciality doctor on duty, who was available by bleep, and junior doctors working to cover the A&E department. One junior doctor, when asked about seeking advice, stated they had “never had trouble getting hold of a consultant to speak to”. Another junior doctor said: “sometimes things can get a bit hairy but the new A&E allows us to get to events soon and respond faster”.

Learning and improvement

There had been criticism of hand-washing facilities in the most recent NHS Staff Survey for the hospital. The department was taking effective steps to control the spread of infection. We spoke to the lead nurse for infection control, who said that the A&E department was currently exceeding the national hand-washing targets, with a current rating of 98% of staff doing this procedure correctly. The data about this was on display, for staff to monitor their targets and results. This ensured the risks to patients from the spread of infection were reduced.

Good

Accident and emergency

Systems, processes and practices

Significant incidents were reviewed, and information about them communicated to the hospital executive board, and to staff working in the department.

The A&E department had an effective computer system that was said to be efficient and well utilised by staff. The system allowed the on-call consultant to access patient records and to provide support to other minor injury units in rural areas. This advice also included directing patients to the correct department or hospital for treatment.

Staff were clear about what to do in particular situations, with readily accessible policies. The pathways of care, including for stroke and myocardial infarction (heart attack), were well supported and worked well. There was a clear communication strategy between different levels of staff.

Monitoring safety and responding to risk

The A&E department had a daily safety briefing as part of the handover between shifts. The hospital co-ordinator, who monitored the availability of beds, had clear information on the bed capacity around the hospital. They were able to monitor the flow of patients due for admission and discharge, and plan a strategy in advance to make beds available if possible.

The week before the inspection, 'escalation beds' were open for two days. Escalation beds were temporary beds available when the bed capacity of the hospital was reached, and further short-term beds were needed. Part of the escalation process involved consultants from other specialities attending A&E, to review their patients, and avoid admission if possible. The urgent care team, or acute team, would attend A&E to support patients to release other staff in A&E. This happened, for example, if a patient needed more staff support. The other teams would provide these staff, and not use A&E staff.

There was a hospital bed meeting at 1pm each day, and if admissions through A&E increased, the hospital opened escalation beds. The escalation plan was put into place when the A&E department was at maximum capacity.

The pressures on the department from the shortages of beds, as they arose, were monitored by the hospital bed co-ordination team, and responded to by an escalation process.

Anticipation and planning

The department used national guidelines, and past statistics on attendance and why patients came to the department, to plan for the future. The bed-planning meetings were given data to factor into the calculations about expected admissions based on experience, the time of the day or night, and whether it was the week or weekend. This would be adapted to accommodate the significant rise in the population on a temporary basis in, usually, the summer months, when visitors and holiday-makers arrived.

Are accident and emergency services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

The A&E department drew upon the specialisms available in the hospital to support people with specific emergency care needs. The use of staff skills in this way promoted a strong clinical management of the department.

Two people who were admitted via the ambulance service, and their relatives, said they had been seen "very quickly". One said they had been "helped with their pain" and the second person said: "my pain is under control". We also observed a nurse asking a recent admission if they would like any pain relief.

All the patients admitted via the ambulance service we spoke with confirmed they had been seen by the doctor quickly, with some being diagnosed or forwarded to X-ray as needed. Serious injuries were prioritised for emergency treatment.

Performance, monitoring and improvement of outcomes

The department used the monitoring of performance to improve outcomes for patients. The operational lead for A&E, clinical matron and A&E consultant, told us about weekly specialty meetings with multidisciplinary involvement. This included consultants, the clinical matron and band 7 nurses (sisters). The team looked at complaints, risk registers and waiting times. If there were any performance issues or emerging risks they were

escalated to the divisional management team, and on to the trust board, if necessary. Monthly governance meetings were also held, and included the staff who attended the weekly meeting as well as junior doctors.

Information from the hospital showed that the operational leads had reviewed serious incidents and taken actions to implement improvements in A&E. These actions covered a variety of areas: Property bags are now being issued for patients within A&E, as a result of a risk highlighted with regard to lost patient property. All radiology reports, on patients who have had clinical imaging carried out, are reviewed retrospectively. Appropriate actions are taken in order to prevent patients with fractures 'slipping through the net'; this action is as a result of missed radiological results not being reviewed. Mobile screens are no longer used following an incident when they contributed to a patient falling; the design of the new department significantly improved privacy and dignity for patients, and mobile screens are now not required.

Further work in progress included documentation audits following concerns that there was a lack of written evidence when carrying out investigations into incidents and complaints.

Staff, equipment and facilities

The A&E department was well laid out, clean and appropriately equipped. The resuscitation room was well equipped. Equipment sometimes left the department with the patient when they were admitted to the wards. There was a system for replacing that equipment from the central equipment library. However, some senior staff stated that, at times, equipment was not always in the right place and this created some risks.

Multidisciplinary working and support

We observed A&E staff liaising with other professionals to meet the needs of the person admitted. This included a psychiatric consultation, arranged quickly for someone who needed assistance. We also observed the work of the stroke nurse, including the process from admission of a patient to the patient being ready to be discharged to the ward. There was an excellent pathway and outcome for this patient.

Staff and patients said the A&E department had excellent relationships with other departments within the hospital.

We saw a mental-health specialist come to assist someone who had taken a suspected overdose, and a care of the elderly nurse come to assess and support an older patient.

Are accident and emergency services caring?

Good

Compassion, dignity and empathy

Patients said staff were kind and caring, and they felt they had been treated with dignity and respect. We observed some good examples of care. For example, a patient who already had a diagnosis of a serious illness came into A&E feeling unwell. They said they had been seen quickly and given treatment quickly, with the doctor taking time to listen to their worries about their illness and the effect it had on their life. Another patient came into A&E concerned about contacting their family. This person said A&E staff had reassured them and contacted their family which "put my mind at rest".

The development and opening of the new A&E department had delivered improvements, including the protection of the privacy and dignity of patients. For example, there had been an increase in the number of cubicles available, so people could be seen or wait in a private space. However, we observed some instances where confidentiality was compromised, such as in the waiting area of A&E. On one occasion, for example, we, other patients and members of the public, overheard a doctor planning a follow-up appointment for a patient. The data from the Adult Inpatient Survey 2012 showed that the hospital trust performed worse than other trusts (in the worst 20% nationally) when people were asked if they were given enough privacy when being examined or treated in the A&E department.

The nursing staff said that the department had a good level of understanding of frail elderly dementia patients. The new Frailty Assessment Unit had helped to move patients who needed this service more quickly from A&E. During our visit an elderly care nurse came to A&E to review a patient, to ensure they met the criteria to be admitted to the frailty ward. This helped to ensure they received the appropriate treatment, and were admitted quickly to the right place to care for them.

Good

Accident and emergency

All the patients we met spoke highly of nursing and medical staff. These included comments such as: "staff have been really wonderful", "great staff here", "pain under control quickly" and "waiting to go up to the ward, all staff very kind, helped with pain, nothing could be better".

Involvement in care and decision-making

The data from the Adult Inpatient Survey 2012 showed that the hospital performed about the same as other trusts when people were asked how much information about their condition or treatment was given to them. Comments from patients showed that they were involved in taking decisions about what happened to them and nothing was done without their consent.

We spoke to an elderly patient who had two relatives with them. This patient had arrived by ambulance. They and their relatives agreed the care given had been excellent. They said staff had asked the patient if they were happy with the treatment planned for them; this included asking permission to take blood. They said they had been met at the A&E department by a team of doctors and nurses. They had offered the patient breakfast and drinks, as they had been admitted during the early hours of the night. Clear explanations had been given to them on the treatment plan and what was happening and when.

Trust and communication

We asked reception staff about patients whose first language was not English. They stated that they had information to pass to people, but that this had been lost during the move to the new A&E department. However, before we left the hospital, this information had been replaced and staff were collecting information leaflets to give to people. If a translator was needed, they could be contacted via telephone to help people understand the treatment planned for them.

Emotional support

We met one patient who had been admitted with a head injury. They had been worried about who would contact their family and did not know what to do. We went back to visit this person later, and they said the staff had been "brilliant". Staff had contacted their relatives; they had a cup of tea, and were "very comfortable".

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The hospital understood the needs of the community it served. There were co-ordinated pathways of care to meet people's needs. The new department had been designed to meet people's needs, including improving privacy and dignity, and enabling the hospital (the only A&E department in the county of Cornwall) to treat more people. There were escalation arrangements to increase the level of consultant cover for the department in busy times. The hospital knew from experience how the pressure on the department could increase significantly when tourists and holiday-makers came to the area. The consultant cover could be doubled during these times and other times of pressure, to meet the needs of patients.

Access to services

The pressure on bed space meant waiting times in A&E were often not meeting targets, and this impacted upon patient care. There was also some uncertainly with clinicians and managers, as to the exact point in time where decisions relating to patients were taken. This meant some reports on waiting times were not consistent. There was an understandable focus on targets and waiting times, but also evidence of the data not being entirely accurate.

The government target for patients attending A&E was for them to be seen within four hours of arriving. The reasons for the target not being met most of the time were predominantly a result of bed space in the hospital reaching capacity (71%), and the performance in the department (17%). We observed during our visits, when people were nearing the four-hour wait, they were moved to the clinical decisions unit (CDU) attached to the department for observation or test results. On the first day we visited the A&E department, records showed seven people had their ongoing plans for care and treatment in place. These people were then moved to the CDU. We observed, however, that some patients nearing the four-hour target were being moved to the CDU. These people were then recorded as being seen, so they did not breach the four-hour waiting time target. This raised

Good

Accident and emergency

some questions for us about the way patients were being managed, especially at times of pressure on the department. We have raised these questions with the hospital trust and they were investigating this further. These questions did not, however, relate to the care and appropriate treatment of patients.

Along with the breaches of the four-hour target in A&E, the level of patients considered as 'clinical exceptions' was high. 'Clinical exceptions' were patients who were assessed as potentially benefiting from more than four hours of care by A&E staff, and therefore could be excluded from the four-hour target. This included patients who were at the end of their life and it was seen as inappropriate to move them to another environment. The level of clinical exceptions was high: it would be expected to be around 5%, but was running at this hospital at around 9%. This suggested too many patients were being classified as clinical exceptions.

The assessment of patients in the community was being done well to avoid attendance at A&E but the department was still challenged by the demands on its services. The hospital had worked with commissioners, GPs and others to raise awareness of alternative pathways of care. GP practices were, for example, sending patients directly to the minor injuries unit, and children were diverted to the paediatric department of A&E. The hospital also had GPs working in the Treliske hospital emergency department, providing care for patients who did not need specialist treatment. The hospital also provided support and advice to all the minor injury units in Cornwall.

We visited the department at a weekend and in the evening as part of our unannounced inspection. At that time patients were being seen within the four-hour waiting time and people were able to move to an appropriate ward. This was because the hospital had available bed capacity, and, at that time, 70 beds were available throughout the hospital.

Vulnerable patients and capacity

If an unconscious patient was admitted, any treatment was provided in the best interests of the patient. Staff understood the law in regard to a patient temporarily not being able to provide consent due to their condition. For patients who were not able to provide consent, or did not have people to speak for them, A&E staff had access to an Independent Mental Capacity Advocate and The Advocacy Service for support.

The matron confirmed other specialists were available for patients who were vulnerable. This included specialist learning disability nurses, children's services, and the mental-health team.

Leaving hospital

Patients were given appropriate information when they left the hospital. For example, patients leaving the department, having had treatment for minor head injuries, were given a leaflet about head injury. This leaflet contained information on how a patient may feel, and advice on what symptoms to look out for and when to seek expert advice.

When patients were admitted onto a ward from A&E they were sent with appropriate records. This included the treatment already given and any medication administered. One patient and their relatives confirmed they were told why they needed to be admitted to a ward, and what follow-up treatment they would receive. Another patient with a serious condition was informed that the treatment plan in place would continue, and they would need a follow-up appointment with another department. This appointment had been made for the patient. Another patient we observed was informed that a care package would be arranged for them at home if they were discharged that day. They were told that an occupational therapist would come to assess them at home for this care package.

Are accident and emergency services well-led?

Good

Vision, strategy and risks

The hospital trust had used experience and feedback from the community and patients to design and improve A&E services. The feedback from patients around privacy and waiting times had been addressed with the new A&E department. Risks the department faced were analysed each quarter. We saw from the hospital risk register that the failure to meet waiting targets was included and action plans presented at board level.

Governance arrangements

The A&E department had a good governance structure in place to monitor and improve practice for patients and

staff. The department met each month by clinical specialty. These groups reported into the clinical governance group for the division. This meant that individual specialties were looked at in detail following a standardised agenda. Serious incidents were reviewed at these meetings each month. On a quarterly basis, the meetings reviewed incidents and accidents, complaints and any risks. The divisional clinical governance group reported to the divisional management board.

The department had other formal and informal sessions with staff. These included, for example, micro training sessions held regularly at 08.00 hours; development and regular review of the emergency department handbook to ensure consistency in practise; a communication board and folder in the staff room; and weekly teaching sessions.

Leadership and culture

Most of the clinical and medical staff said they felt well supported by senior staff in the A&E department. Staff spoke about "good leadership" and "excellent support". We observed and heard about some excellent clinical practices. We were told there was good morale among the medical staff, with ready access to a consultant for advice. We observed and heard from junior staff about the good leadership and direction from the executive nurse (sometimes known as the chief nurse or director of nursing) during our visits.

Managers said morale was "excellent", but some nursing staff and doctors said morale was "low". Some felt senior management in the department were "remote" and "do not listen". Some staff felt the department was unfairly blamed for some performance issues. They felt the availability of beds in the wider hospital, and issues with patient discharge were beyond their control or influence, but they were made to feel responsible. They felt this was affecting the morale of some staff.

Staff told us counselling support was available to help them if they were struggling emotionally with work. Other staff members said they used the senior staff for support and guidance. One member of staff, who was on their induction, said the nurse in charge had "taken them under their wing to help me settle in".

Patient experiences and staff involvement and engagement

Many staff told us that, following the opening of the new A&E department, things had been getting better. These staff felt that the care and treatment people received as they entered A&E had improved. The department was undertaking a consultation to determine appropriate staffing levels for the department. The matron leading on this work said it would address the pressures that staff described to us after the increase in the number of beds.

The department sought the views of its staff to identify areas for change. Staff had been asked to describe their views on, for example: 'things we still need to improve upon'. Staff were also being consulted about the review of staffing levels following the opening of the new department. Staff said they had seen improvements in the department as a result of staff involvement. An example of a recent improvement was that the department had increased the presence of nurses at night.

Staff held monthly departmental meetings, and every Monday there was a catch-up meeting to see how things had gone over the weekend. At the Monday meeting staff discussed their work and any breaches of patient waiting-time targets. One newly employed staff member said they felt "very much a team/family". This staff member said they did not have a buddy or mentor, but shadowed a member of staff on each shift.

Learning, improvement, innovation and sustainability

The structure of staffing in the department had been recently reviewed. We were told that this had provided a development which better utilised staff skills. Some staff felt that the restructure of the band 7 nurses (sisters) had improved the department. Others felt unsettled by the changes. Prior to the changes the A&E department had seven band 7 nurses. Following the restructure there were now four band 7 nurses working on A&E. They each had a lead role. For example, one led on majors (seriously ill patients) and another led on resuscitation. These staff now had clear management duties, including monitoring sickness and staff training. The matron said the restructure was not a money-saving exercise, but that the department needed, and now had, strong team leaders with clear responsibilities to run the department effectively.

Good

Accident and emergency

The A&E department had a nurse in charge each day who was not working clinically. This was to allow them to monitor patients and possible breaches of waiting times, and put an action plan into place. We observed the nurse in charge monitoring the number of patients, the computerised record of who was currently in each cubicle, and the progress of the current treatment plan. Each band 7 nurse was expected to have one day each week spent on their management role. However, this has not been happening recently due to the increased pressure on A&E.

Requires improvement

Medical care (including older people's care)

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

Information about the service

The trust has two acute medical assessment wards and a further 10 medical wards specialising in providing frailty assessment and elderly care, stroke care, gastro and endoscopy medicine, renal and endocrine medicine, isolation care and respiratory and cardiac care. The cardiology speciality department includes two cardiac catheter laboratories, a cardiac investigations unit, a coronary care unit and a coronary care ward. The hospital also provides a medical day-ward to provide care for elective patients with medical needs, but who did not require admission.

During our visit, we visited the medical wards, including the cardiac, stroke, gastro, elderly care and respiratory wards. We also visited the medical admissions unit (MAU) and medical day-ward. We talked with 54 patients, 10 relatives and 58 staff, including nurses, doctors, consultants, therapists and support staff. We observed care and treatment, and looked at care records. We received information from our listening events, focus groups, interviews and comment cards. We used this information to inform and direct the focus of our inspection. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Staff provided a safe service to patients receiving medical care, but there were some concerns when staff were busy, and also about the management of safe record keeping. We saw that medical and nursing staff were busy, and when they were short staffed, they sometimes felt that care was not as effective as it should be. Staffing shortages were being addressed by the trust by recruitment, and with staff from a contingent workforce, including agency staff. Full staffing levels had not yet been achieved. We saw that not all patient records were being fully maintained or accurately completed. This placed patients at risk of not receiving the correct care.

Staff worked effectively and collaboratively to provide a multidisciplinary service for patients who had complex needs. We saw that sometimes, the environment of wards and units were less than suitable for the purpose of supporting patient care, and promoting their health and safety.

Staff were caring. Patients spoke highly about the care they received, and the kindness and helpfulness of the staff. However, we had concerns about delays in the 'flow' of patients through the hospital. We saw that patients were often delayed and that staff were put under pressure by this. Whist we are aware of some actions taken to address this problem, this is an area of improvement for the trust.

The service was well-led. We saw at ward level that staff felt supported by the senior staff and, in turn, senior staff told us that they felt supported by the

management of the hospital. Medical staff told us that they considered there had been improvements in the leadership of the hospital, with a positive outcome for patients.<Summary here>

Are medical care services safe?

Requires improvement

Safety and performance

We saw that medical and nursing staff were busy, and while patient care was safe during our inspection, staff told us that when they worked short of the correct staffing level, they sometimes felt care was not always as good as it should be. Nursing and medical staff told us they felt stretched, particularly some junior doctors at night. Some ward staffing levels were particularly highlighted as "always being insufficient". Staff told us on the stroke ward, Medical Assessment Unit, elderly care ward, gastroenterology ward and renal/endocrine wards, the correct level of nursing staff was not being consistently achieved. We looked at staff rotas for some of those areas, and found this to be correct. Agency and bank staff were being used as a contingency workforce until full recruitment was achieved. The NHS staff survey recorded work pressure felt by staff was higher than the national level. This had been recognised by the trust and they were continuing to actively recruit staff.

Management staff in the service told us that recruitment of nursing staff was ongoing. Staff told us that as a result of being short of staff they had to cover more than their allocated patients, and this put them under pressure. They told us this happened regularly, and impacted on the care they provided for patients with complex needs.

Junior doctors told us the levels of cover overnight were, in their opinion, sometimes not safe. Doctors told us the geographical layout of the hospital made it challenging to see patients quickly. This was particularly the case when medical patients were being cared for on surgical wards. This had been recognised by the senior management of the trust. Junior doctors told us that monitoring had taken place, and in some places these concerns were starting to be addressed and were slowly improving.

Nursing staff were aware of the use of the "Safety Thermometer" to measure risks of falls, catheter and urinary tract infections, and pressure ulcers. The NHS Safety Thermometer Report 2012 - 2013 showed a higher than national average for new pressure ulcers, and patients with catheter and urinary tract infections. We saw that the trust monitored these areas each month, and wards and units displayed their monthly performance results. Staff

told us that these areas continued to be monitored, and action plans put in place to address concerns. The trust had a Safe and Suportive Observations policy which, when followed, provided clear assessment criteria for providing staff to ensure one to one care where this is required. The trust told us that they monitored this closey. However staff expressed concerns about the management of falls. They told us that while they knew about how to manage the safety of patients, they did not always have the time to supervise elderly patients to the level they felt appropriate. Staff felt that this increased the risk of falls. The rate of patients over 70 who experienced a harmful fall was below the England average for most of the year but there were some increases in specific months namely, March, June and August 2013.

Staff told us that they had received training in the safeguarding of vulnerable adults and children, and knew the process to follow should concerns be identified, to ensure the safety of vulnerable people. This was supported on review of the relevant documentation.

We spoke to the relatives of a patient who had high levels of need and was vulnerable. They told us that chemotherapy was not given on time for two days. This was alerted to staff on the first day, relatives were promised it would not happen again, but it was late again on the second day. The care plan the family had provided was not being met. They felt unable to leave the patient, as they considered this to be unsafe. However, this was the only instance we saw of this kind.

We spent time on wards looking at the care provided to patients. We saw that regular rounds took place when staff monitored the pain, skin integrity, food and fluids taken, and the patients overall wellbeing. While we saw some excellent care, some records were not completed fully or accurately, and this posed a risk to those patients. This was particularly evident on the elderly care and stroke wards. These records included the recording of falls and risks assessments, however these were not always completed therefore there was a risk that there could be a lack of learning from falls and amendments to risk assessments. Some records were inconsistent and unclear in specifying which equipment should be used, and how many staff were needed to safely move people. We found some gaps in the monitoring of regular two and four hourly care provided to prevent pressure damage to patients' skin. In two cases, these gaps were between five and 10 hours. This placed those people at risk of skin damage. Records about patients' mental and physical deterioration were not consistently maintained, and rationale for action was unclear.

Patients on the medical units and wards told us that they felt safe and "in good hands".

Learning and improvement

We saw signs and instructions for staff, patients and visitors about hand washing to prevent the risk of cross infection. The staff survey noted that only 61% of staff said hand washing materials were always available. Staff members were allocated to provide teaching sessions to other staff, and monitor hand washing performance. We saw that some wards monitored their success in hand hygiene each month, and displayed their results. On the Medical Assessment Unit for December 2013, scores rating staff in their hand hygiene practice had achieved only 80%. We saw staff moving from patient to patient without using the hand gel provided. Three bottles of hand gel were seen to be empty. The 2012 Adult Inpatient Survey asked patients if hand gels were available for people to use. The response level was worse than other trusts. We observed other medical wards, where staff were not observed to wash their hands between supporting patients.

Systems, processes and practices

When there was insufficient space for all patients being admitted to the medical wards, patients sometimes had to be admitted to the surgical wards, and be cared for there by the medical teams. Each of the surgical wards used to care for medical patients had a dedicated speciality medical team. The aim of this arrangement was to match patients' medical conditions to the specialty team so that patients were managed by the correct specialty team on a surgical ward. On each day of our inspection, six to eight medical patients were on surgical wards. On the day before our inspection, there had been 14 medical patients being cared for in other wards. Staff said that, at times, there were up to 33 patients who were not in the most appropriate ward. Bed management meetings took place three times a day, and a whole hospital review of patients took place twice a day. The patients being cared for in other wards were identified at this time. Alerts were made to consultants to inform them of which wards their patients had been admitted to. Systems were in place to ensure patients were seen regularly, and received the correct medical care. Surgical wards 'buddied' with medical wards,

Medical care (including older people's care)

to ensure that those patients admitted were cared for appropriately, and care and treatment was not delayed. One patient felt this was managed well, and they saw their medical doctor and consultant daily.

Monitoring safety and responding to risk

Staff had a verbal handover of information, and a handover sheet for each shift. This was more accurate and informative than some of the records we saw, but the differences between the handover information and the documentation about patients' care varied. Staff told us that they had difficulties due to staff shortages, and not enough time for keeping care records up to date. This posed a risk that staff would not be aware of patients' needs changing, and so appropriate care may not be given.

Staff told us that they were encouraged to report concerns about safety through the incident management system, and told us they received feedback from their notifications if requested. As feedback was not consistently provided, staff told us that learning from incidents was not routinely shared. Some staff told us that this kind of reporting was sometimes used as a threat to other staff members, to put them under pressure. For example, junior doctors reported that they were very busy at night. Sometimes they would get repeated calls from nurses to attend wards. Some of these doctors reported that staff had said they would "datex them", meaning they would complete an incident from if they did not come and see the patient straight away. This approach did not promote a positive response to managing risks.

Anticipation and planning

We saw as part of the hospital trust's planning, a new unit of 28 beds (the Frailty Assessment Unit) had been opened shortly before Christmas 2013. This unit had been opened in response to an identified need for a specialist unit to support those patients who needed help, but only in the short term, to quickly return home. A specific assessment tool was being used to identify patients who would benefit from this new service. Staff were very motivated and passionate about this new unit, and patients all spoke positively about their experience of care there.

As a result of planning to meet patients' needs, increased consultant hours had been implemented in the Medical Assessment Unit (MAU). Plans had also been implemented for specialist consultants to visit the MAU earlier each day. This meant patients waited less time to see a consultant to be assessed, and progressed with their admission or discharge. Staff on the MAU felt this had been an improvement and provided more effective care.

Are medical care services effective?
(for example, treatment is effective)

Good

Evidence-based guidance

The hospital trust participated in national audits to measure the effectiveness of their service. These audits included the monitoring of mortality rates for specific areas and times, and appropriate action was taken when trends were noted.

We visited the oncology ward, and saw that development of staff practice to support people with cancer was continually being developed. Staff were innovative and creative in their support of patients. Staff were passionate to ensure that their patients received good care and treatment in line with current best practice. Staffing levels had increased and this enabled work to be undertaken on Saturdays, as well as mid-week. There were good comments about the management of complex pain control, and dedicated rooms had been allocated for use by teenagers who needed cancer care.

We saw the management and staff of the respiratory and renal wards were proactive in developing the service they provided. They were enthusiastic and receptive to developing new ways to ensure good and effective care. We were told by staff about the good leadership and support they had received to promote and develop their practice.

The pathways used for those patients who had suffered a stroke were in place, and success rates monitored to develop the service being provided. The hospital was performing well against the majority of the targets for the care of patients with suspected stroke, for example, 84% of patients received a CT of their head within one hour of arrival against a target of 50% and 100% of CT of heads were performed within 24 hour of arrival.

The hospital recognised that the development of good dementia care required more work, to ensure patients with dementia receive a person-centred level of care. Some changes were being made. We discussed with the Elderly

Requires improvement

Medical care (including older people's care)

Care Specialist Nurse how care plans were developed, with the input of family members and health professionals. These were detailed to include prompts and triggers for behaviour, and how this information would be used to promote staff understanding of the patients' dementia care needs.

Staff, equipment and facilities

Staff told us a positive factor of working at this trust was "good team working". Clinical nurse specialists worked throughout the hospital to ensure patients with specific needs, for example, elderly or respiratory care patients were supported, to have a smooth journey from admission to discharge.

We saw on the new Frailty Assessment Unit equipment was being made available to support patients to be comfortable and promote independence. Staff told us on all wards, requests for equipment were answered quickly, and this promoted a positive outcome for patients.

Staff told us that sometimes equipment being used was unsuitable. The use of the electronic board for patients having an endoscopy procedure meant that they had their details wiped from the board once they left the ward. The details then had to be re-entered by staff to ensure their recovery pathway was followed. This was not a good use of staff time, and the equipment had not proved effective in this case.

Multidisciplinary working and support

We saw some patients had multiple health needs which required the input of several teams; for example, the surgical input in the care of a medical patient to ensure all needs were met. There was a good sense from staff that they worked together to promote patient care and were proud of this relationship.

Staff told us they had access to learning and development plans to improve their skills, but some staff told us time and support from senior staff to access training could be limited.

The family of a patient with a learning disability spoke with praise about the input of the Learning Disability team, while being a medical patient and spoke highly of the care overall.

We followed the pathway of some patients through the hospital from their admission, and discussed the care they had received on each part of their journey by a variety of specialists. Patients told us they had been kept informed and updated, and mostly they were confident in the care they had received.

Are medical care services caring?

Good

Compassion, dignity and empathy

We saw staff speaking to patients quietly, and relatives being included in discussions when appropriate.

We observed curtains were pulled around patients when care was given, and call bells were to hand.

Patients told us, and we observed with only few exceptions, they were treated with dignity, respect and compassion by all staff. Patients told us staff went above and beyond what was expected of them to meet their needs, and those doctors and nurses were caring and considerate.

We did, however, overhear a staff member speaking over a patient in a disrespectful manner, saying within the hearing of the patient, other patients, visitors and CQC staff: "look, she's filthy". We did not consider this comment to be caring or respectful.

We received many positive comments which included: "nothing is too much trouble, they (the staff) are all very kind", "they are right on the ball, I feel confident in them and any queries my husband and I have had have been answered" and "I have had a wonderful week's holiday, couldn't be treated better if I was the queen". Patients spoke positively about the doctors and commented: "doctors are wonderful and I won't hear anything said against them" and "the doctor was so kind".

Involvement in car and decision-making

Patients told us mostly they felt involved in the decisions about their care; they told us staff asked for their consent to treatment, and kept them updated about what was happening to them. Patients said: "they are as good as gold they are, always nice, always caring".

Trust and communication

Staff developed trusting relationships and communicated respectfully with patients and those close to them. However, we saw a couple of examples where communication could have been improved. A person had

Medical care (including older people's care)

not been helped to put in their hearing aids, and the devices had been left on the table. Staff did not offer to help the patient with this, and they could not manage this alone. This limited how the patient could communicate. A further patient was seen to have only one contact lens in since admission, and this may have impacted on their level of co-operation with care.

Should a translator be needed, they could be contacted to assist. This ensured all decisions and understanding by the patient was well managed.

Emotional support

Patients told us there were appropriate arrangements for single-sex accommodation on the medical wards. When the environment did not allow for much privacy, staff would ensure an appropriate room would be found to have quiet discussion, or allow privacy for changing clothes. Patients told us medical and nursing staff were supportive within the available time constraints.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

We were told of two patients being transferred late at night to local hospitals and we asked the trust to provide us with further information. We saw that during January 2014 two patients were transferred from the emergency department after 23:00hours. A further 11 patients were discharged from various departments between 21:00 and 23:00hours. In addition one patient told us they had been moved three times in 24 hours since admission. We asked staff about the movement of patients between wards, or discharged home at night, especially those patients who were vulnerable. Staff told us that work had been undertaken to ensure any reason for movement of patients at night was seriously considered and movement monitored. A member of staff told us: "there must be a balance to get acute patients through the unit". Monitoring was undertaken to learn how this issue could be improved. Each patient who needed to be moved must have a risk assessment in place, and policies were in place for staff to follow, so that each patient must be considered individually. Discharge for vulnerable patients stopped at 20.00 hours and any movement of frail or confused patients, or those with end of life needs, was not considered after 23.00 hours. Staff told us that, for people who were nearing the end of their lives, "we think seriously about moving end of life patients at all".

The trust acknowledged that due to pressure on resources and beds it was sometimes necessary to move patients in the interest of patient safety. A contributing factor to this pressure was the lack of capacity in the community for people to be discharged to.

We saw some parts of the hospital environment were not suitable for purpose. The Medical Day Ward was cramped, with chairs and equipment for between 18 and 22 patients each day. Patients were sat closely together, and movement was limited. A side room had to be used for any privacy. However, the patients on this unit felt the good standard of care provided outweighed the poor environment.

On the gastroenterology ward, the toilet doors were not able to be closed, and so did not ensure the privacy of patients. On the stroke ward, the ward space was cluttered and had only one assisted shower room for 24 patients.

The trust has a policy to proactively manage patients if an infection broke out on a ward. There was a designated infection control ward with a side room available. However, staff told us that when an infection broke out on a ward it meant, in some cases, that a whole four or eight bedded bay was closed, because there is nowhere to put the patients who were infected. We also saw that one isolation room did not have an en suite facility, and so a commode was used which had to be carried through the ward to be emptied. A further infection control side room did not have an alert sign on the door to warn people about the precautions needed before entering.

Access to services

We were told by staff that the amount of patients admitted was not influenced or limited by staffing levels, and only limited by the availability of beds. The information provided to us by the hospital about the bed occupancy rate (it was below the optimum rate of 85%) was confusing, because the hospital appeared much busier. This was because the figures included beds in other hospitals in the trust, which were less busy. In fact bed occupancy in the medical service at this location had been up to 95% and

regularly ran in the 90s. In the week before our inspection, one elective surgery list had been cancelled because there was a lack of inpatient beds available for those patients post-surgery. We were told by staff this was because the surgical beds held medical patients.

When the amount of beds was limited, and when admissions were planned and predicted, the hospital would consider 'escalation beds'. This had happened for two days the week before our inspection.

We attended the hospital bed meeting where the anticipated admissions and discharges were monitored, and planned admissions confirmed if beds were available. We saw there was very little capacity for admissions, and room depended on discharge to make beds available. Staff told us a variety of ways of working being used to ease the flow of patients through the hospital.

Vulnerable patients and capacity

Patients with a level of dementia or confusion were not consistently supported by the hospital's dementia policy. Staff were alert to the potential for distress and prioritised these patients where possible. We saw that some confused patients were not well supported to be reassured and helped to cope in the hospital environment. This impacted on other patients around them, causing anxiety and distress. Staff on the Medical Assessment Unit told us that, when confused patients were admitted, the staffing levels were not increased to support them, and staff absorbed this extra work. They told us they sometimes tried to manage confused patients in a group. We saw that, when needed, a best interests meeting was held to support the choices of patients who were not able to make decisions themselves. This ensured decisions were made within the legal framework of the Mental Capacity Act 2005.

Some efforts were being made to assist confused patients introduced in the Frailty Assessment Unit, by using a reminiscence table. This had information and items for people with memory problems. A day room was being furnished, to support people to have a break from their bedside, and provide a structure to their day.

We spoke with the family of another patient with learning disability needs, who told us they were more than happy with the care their relative had received. They had a long history of care at the hospital, and were confident in the care being provided and that staff responded to their relative's needs.

Leaving hospital

Patients received appropriate information about discharge, including leaflets and specific information relating to them.

Many patients and staff told us about the difficulties, with people being delayed in leaving hospital and how this slowed down and sometimes stopped the movement of patients through the hospital. Four patients told us their discharge had been delayed due to the lack of availability of community care when they got home. We visited the hospital bed meeting and whole hospital handover, and saw that issues relating to flow of patients and delays in discharge were discussed, and options for management considered. Delays were proactively managed and there was evidence that the trust and community providers were working together to resolve this. However the pressure caused by the lack of capacity in the community for people to be discharged to remained.

The transport office at the hospital closed at 8pm. Discharge arrangements could be made using an electronic system to book patients transport after this time for instance for patients who had attended A&E. Patients were seen to be sat waiting for transport to go home. We were told a discharge lounge was sometimes available, but it was not open during this inspection. This was not a permanent space, and staff told us a space was made available when needed.

Learning from experiences, concerns and complaints

We were told about the difficulties of recruiting to the area for both medical and nursing staff. The trust has taken a generic approach to advertising for vacant posts and during the selection process staff would be recruited to the most appropriate role matching their skills and experience. It had been identified that recruitment to areas including the Medical Assessment Unit was not suitable for generic recruitment, due to the specific nature of the work. Recruitment had now been redefined for those acute areas, to ensure only appropriate and suitable staff were employed in those areas.

Themes and trends from complaints were viewed at specialty meetings with areas of concern escalated to the divisional management board. Themes and trends from complaints were also reviewed at this board on a quarterly basis and actions discussed and agreed. Learning from

complaints was fed back to ward staff through the Ward Newsletter. An example of action and learning from complaints was the undertaking of a documentation audit which showed a lack of appropriate documentation.

Are medical care services well-led?

Good

Vision, strategy and risks

Staff at all levels told us they knew there were historical problems in the organisation, but they all felt improvements were being made. They told us they were proud to work in the hospital and felt included in the developments taking place. Staff told us care had started to improve, and there had been a real move to patient-focused quality care**.** Senior medical staff told us: "the board feels good now - previously turbulent" and they were optimistic for continued improvements.

We observed a variance between wards. Some wards were well staffed, clearly managed, proactive in their development and showed good record keeping. However, two wards in particular showed record keeping was poor, staff were unclear in the care needed, and we visited one ward twice without being approached or our presence questioned.

Governance arrangements

Ward staff showed us the monitoring arrangements and feedback about ward performance. Clinical governance meetings were held, and incidents, complaints and concerns were identified. The trust risk register identified the most serious patient safety risks, and those breaching waiting time targets or good practice guidance. Ward staff meetings were held when staff received feedback and could discuss monitoring results. Senior management clinical governance took place to review all areas of care provided.

Leadership and culture

Medical and nursing staff were dedicated and committed to providing good patient care, and to improving care. They told us communication was good and this promoted change. Staff said generally they felt supported by their line managers; however, we were told some supervision of band 7 nurses and above was not always taking place. Doctors told us they felt they could call for help when needed and felt appropriately supervised to provide a safe level of care.

Patient experiences and staff involvement and engagement

Staff told us in different parts of the hospital about the difficulties in the accessing information from different technology systems. We were told six to seven different IT programmes, both paper and electronic, were used at the same time. These issues slowed down the service being provided and the systems were not interlinked and so not always suitable for purpose.

While the majority of patients spoke highly and positively about their care, we received information, primarily about the elderly care and stroke ward, when patients and their relatives had not been happy with the care provided. In these instances some had complained to the trust and some had been directed to do so. Two patients who had raised complaints through the Patient Advice and Liaison Service (PALS) said they were not happy with how the complaint had been managed, and resolution had not been achieved.

Learning, improvement, innovation and sustainability

Implementation of new systems, including electronic prescribing, had taken place recently. Following a settling period staff confirmed this was an improvement for the hospital. We were aware a review of cardiology services had been undertaken in 2013. Staff told us that following this review, an action plan had been implemented and some improvements across cardiology services had been seen.

Requires improvement

Surgery

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

Information about the service

The acute surgery division at Royal Cornwall Hospital provides over 7,000 emergency and around 20,000 elective operations each year. Elective admissions at the hospital are through the Surgical Admissions Lounge, Theatre Direct, the Newlyn Unit, and Tolgus ward. Emergency admissions are through the St Mawes Surgical Receiving Unit, the Emergency Department, Tolgus Ward and the 56-bedded Trauma Unit. There are five surgical wards: Pendennis, South Crofty, Wheal Coates, Tolgus and the Surgical Admissions Lounge. The hospital has 16 operating theatres in three locations and provides a range of surgery, including trauma, orthopaedic, ophthalmic, urology, gynaecology, vascular and general surgery.

We talked with 27 patients, four relatives, and 49 members of staff. These included all grades of nursing staff, healthcare assistants, domestic staff, consultant surgeons, consultant anaesthetists, junior doctors, and senior management. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Safety, effectiveness and responsiveness in surgery were good in many areas, but improvements were needed in others. The performance and outcomes for patients from the surgeons and theatre teams were good. The staff teams in theatres used safe systems to ensure that there was no avoidable harm to patients. The compliance with these systems had improved, although this needed to be continued and maintained. Staff spoke highly of one another, and received good peer and management support. The division learned from incidents, and made improvements to practice. Patients were listened to, and the division learned from criticism, comments and complaints.

To improve safety, the security arrangements for one theatre area needed to be addressed. To improve effectiveness and responsiveness, the hospital needed to reduce cancelled operations, and those starting or finishing late. Beds and recovery services needed to be available at the right time, and in the right areas. Patient records needed to be improved, and completed with care and consistency on some wards.

Most staff were caring, considerate and kind and put their patients first. Most patients felt included and involved in their care. Staff in all areas were said to be mostly open, honest and approachable. We met some exceptionally caring, experienced and dedicated staff. To help the more vulnerable patients in their care, there was an outstanding innovative service for patients with

learning disabilities. Patient consent was done well, and best-interest decisions were taken with an inclusive approach for patients who could no longer make their own decisions.

To improve care and effectiveness, the hospital needed to address the lack of privacy and dignity for some patients, particularly in theatre recovery. Some patients were remaining on the post-operative recovery wards for too long, as there was no bed available for them. A number of patients told us that administration procedures were a cause for concern, leading to missed or duplicate appointments and wasted time. The leadership needed to consider and address the risks from patient flow being poor at times, and where it could make changes to reduce subsequent risks for patients.

Are surgery services safe?

Requires improvement

Safety and performance

The data we reviewed showed the performance of surgeons at the hospital was good. The division performed well against targets for patients being returned to theatre. Returns due to issues such as infections were low. The performance of individual consultants was presented to the trust governance committee in October 2013, and outcomes in five specialties reported upon were within the acceptable range or performing better than national averages. If patients needed to be readmitted to hospital, most were readmitted within 28 days. No patient had an urgent operation cancelled more than once. All of the surgical services had complied with any safety alerts from organisations such as the NHS National Patient Safety Agency, in records we reviewed covering March to October 2013.

Safety in theatre was good in some areas, but needed improvement in others. The Royal Cornwall Hospitals Trust (RCHT) had reported three never events relating to surgery in the last 12 months. Never events are largely preventable patient safety incidents that should not occur if preventative measures are taken. One of these occurred at the Treliske site. As is best practice, RCHT used the World Health Organization (WHO) surgical safety checklist in operating theatres, which is a system designed to prevent avoidable errors. We saw good use of the sign-off procedure in the checklist in one theatre where we observed practice. The theatre staff we spoke with in theatres 1-5, including an anaesthetist, a nurse, a theatre assistant, the nurse in charge, and a surgeon, said the checklist was done well, and all staff were properly involved. One member of staff said almost all the procedure was done well, but they were concerned about the confirmation of a pregnancy test having been done (if appropriate). They felt there was too much reliance upon verbal confirmation from pre-operative assessment staff. A member of staff in theatres 12-13 described the use of the checklist as “patchy”. We noted from governance committee papers in September 2013 scores of compliance with WHO checklist internal audits had been noted as “dropping”. The hospital undertook a further audit in December 2013. Theatres 1-5 scored 92% in a review of 85

records, theatres 6-11 scored 88% in 86 records, and theatres 12-13 (it was not appropriate in theatre 14) scored 100% in 65 records. Organisations where never events have occurred should be performing at 100% in all circumstances, to ensure patients are protected from avoidable errors.

We had a varied picture of patient record keeping. On some wards we found the records to be good, with a few gaps, but overall well completed. We looked at records in South Crofty ward and there were a few gaps, but they were mostly completed well and gave staff the right amount of information to make decisions about their patients, and evaluate effective care and treatment. Patients had been risk-assessed for development of pressure ulcers, and where risks were identified, interventional care, such as a pressure-relieving mattress, or increased repositioning of the patient in bed, was organised. Records we looked at on Tolgus ward and the Trauma ward gave cause for concern. Some observational checklists had no entries for several days and some were incomplete. One record showed a patient with no pressure ulcer on one day having developed a category two ulcer the following day, with incomplete hydration assessments and no wound care plan in place. Another patient's records were confusing. Nursing records documented a category two pressure ulcer on the patient's right heel however two days later it was recorded that the patient was nursed on their side due to a category one pressure ulcer on their sacrum. The patient was assessed as incontinent of urine but no care plan was in place. The recent trust performance against national levels of hospital-acquired pressure ulcers was poor at times. In the last year, the rate had fluctuated, and in some months was very low, but was over the national average in eight of the 13 months from November 2012 to November 2013. The trust had recognised this and had a comprehensive action plan in place.

The security and safety of one theatre suite was unacceptable. We found, when arriving at theatres 1-5, the entrance doors from the main corridor to be open and the reception unoccupied. When we contacted the nurse in charge and were escorted into the main theatre corridor, which we were otherwise free to have accessed, we found a drug cupboard open and unsupervised. Flammable products used in theatre were stored, as required, in a locked metal cupboard, but this was located close to a paediatric waiting area. A member of staff explained they were aware of this, but there was no evidence of any action requested or plans to move it. When we left the theatre suite, the main doors had been closed and entry was restored through use of a swipe card. The resuscitation trolley checks were done well, and the security of the equipment was good. We did not observe any unsafe practice by staff in any theatres or on the surgical wards.

Learning and improvement

The hospital mostly learned from incidents and took action to avoid recurrence. The hospital had recently had an unacceptable level of incidents with damaged packaging around theatre sets. These are sets of surgical instruments and equipment which have been sent to the sterilisation services unit and returned prepared for individual procedures. The recurring damage to sets had resulted in cancelled operations, as staff had followed procedures and not used sets with damaged packaging, and there were often no other sets available due to keeping storage to a minimum. The trust had investigated this problem through the risk management process and changes had been made to the packaging, storage on the ward, transport and checking of sets. Staff told us the problem had reduced, and the damage to sets was now less frequent.

The hospital learned from experienced specialists. A locum consultant anaesthetist was involved with an incident with a piece of equipment. The consultant was able to pass on their experience of using this equipment, and had recognised where it was not used correctly. Actions were taken and all staff were informed of changing practice, and being more vigilant with this equipment in the future.

Systems, processes and practices

The wards had systems and practices to follow to help ensure care was delivered consistently and safely. For examples, there were standardised care plans on wards and pre- and post-operative assessment units to ensure each patient had all aspects of their care considered. There was, however, an inconsistency across wards as to how well they were used. We saw a focus upon audits of practice in, for example, South Crofty ward, and where performance fell, staff were reminded of the systems and processes they were required to follow until standards improved.

Information governance rules were not always being followed, and we noticed several examples of patients' notes in wards being unsupervised or not secure.

Requires improvement

Surgery

Monitoring safety and responding to risk

There was a varied approach to monitoring safety on theatres and wards. The new wards and theatres in Trelawny building were designed to promote safety and reduce risks. The older wards on the Tower had less space for patients and staff.

There had been issues with the most recent staff survey and the Adult Inpatient Survey, in relation to a poor provision of hand-sanitiser gels or hand-washing facilities. We saw gel at the end of each bed and in other areas. It was not, however, always located at the entrances to wards, and sometimes not clearly sited. The new wards and units had been designed with hand-wash sinks and equipment placed outside bays and in corridors.

Anticipation and planning

Anticipation and planning for surgical procedures was done well. For non-emergency procedures (elective), the trust data showed little variance with the anticipated work-load planning.

Are surgery services effective?

(for example, treatment is effective)

Requires improvement

Using evidence-based guidance

Guidance was being followed to deliver effective care. The surgical services had complied with all the guidelines issued by the National Institute for Health and Care Excellence (NICE) in records we saw from March to October 2013.

Performance, monitoring and improvement of outcomes

The hospital participated in national audits to measure outcomes for patients. National clinical audits were completed, such as the national bowel cancer audit, and the trust performance was better than expectations in each of the five measures. Information on patient reported outcome measures (PROMs) was gathered from patients who had groin hernia surgery, hip or knee replacement, or varicose vein surgery. Patients were asked about the effectiveness of their operation, and the response data showed no evidence of risk and good outcomes for patients. The trust achieved compliance with the nine standards of care measured within the National Hip Fracture Database. There were rarely any surgical patients at the hospital who were not on an appropriate surgical ward. The governance committee were informed about the contribution to and progress with trust audits. The surgical division were on track to complete all their trust-defined high priority clinical audits and most of the second to fourth priority.

Staff, equipment and facilities

Mandatory staff training was on track to meet trust targets. For the wards in the surgical division, the average compliance rate by the end of December 2013 was 78% with three months left of training time available to staff. Staff said they were encouraged and supported to complete their mandatory training, although they sometimes struggled to find enough time if their area was short-staffed. A number of staff said training was the first thing to be cancelled if there were unexpected absences on the ward.

Some training was not provided to all staff where it might have made a difference to patients. Training for managing confused patients, such as those living with dementia, had not reached all staff. We spoke with a mixed staff group, including domestic staff, nurses, a newly qualified nurse, and a healthcare assistant in Theatre Direct. They felt training delivery and support for caring for people with dementia was inconsistent. The domestic staff had no training in this area, and were concerned they would not know the right thing to do for a patient with dementia. They said they were often asked questions by patients who were confused, and were concerned about giving the wrong response or doing the wrong thing.

Availability of equipment was variable. Staff in theatres 1-5 said they had cancelled procedures, as equipment which should be available was missing or had moved, usually having been borrowed by another theatre. Staff we met said this was one of the most frustrating concerns. One theatre assistant, who was asked what one thing they would like to change, said: “have enough equipment”. We were told by senior staff that the theatre departments would not work as well without the support of the portering team who would, for example, urgently collect equipment.

The trust had a Safe and Supportive policy in place, which provided clear assessment criteria for when to provide one-to-one care. However, staffing levels were not always preserved in situations involving vulnerable or high-needs

patients. Nursing staff said they were concerned staff who had been tasked with providing extra support to patients with mental health needs were sometimes the first to be asked to move to other duties when there was an unexpected shortage of staff. They said this was particularly a problem with night-shift staff.

Multidisciplinary working and support

Staff we met spoke highly of their colleagues, managers, teams and mutual support. In theatres the staff we met said they felt part of a close-knit team. We were told junior and new staff were encouraged by all staff to feel confident and contribute fully in meetings and discussions. All the staff we met said they felt confident to report any concerns within their department to their line-manager or a more senior member of the team.

Are surgery services caring?

Good

Compassion, dignity and empathy

Patient experience of care was mixed. Almost all patients we spoke with in the surgical unit told us staff were caring and kind. We observed good care on the wards in almost all interactions. Patients on the Surgical Admissions Lounge told us they were well treated. One patient said the staff were "wonderful" and another said staff were "really excellent and I've really no complaints". We observed a member of the nursing staff on the Trauma ward talking about patients in a way that did not preserve their privacy and dignity. We considered the nurse to be rude to another member of staff, and this equally showed a lack of empathy for a patient. Patients on South Crofty and Wheal Coates wards said they were treated with dignity and respect, and staff were caring. One patient described South Crofty as "the best ward I've ever been on". This was despite both South Crofty and Wheal Coates being short-staffed at times. The ward performance report for these wards from October 2013 showed them as scoring high for quality, but low for staffing levels. We had a mixture of comments about the care patients received one patient said at times they witnessed some "brilliant compassionate care" but "overall it was awful". We also received some very positive comments. A patient who wrote to us said the consultant and nursing team were "excellent both during and after surgery". Another described their care as "brilliant" and "could not praise them enough". A patient we met at the listening event said "I've had nothing other than the best first-rate care".

We observed a lack of privacy and dignity for patients in some areas. On the Surgical Admissions Lounge we were told by staff they sometimes had to measure patients for surgical stockings in the corridor if there was nowhere for them to be seen privately. This ward struggled, with very little space for patients or staff. We observed that the screens in the recovery area for theatres 1-5 did not fully obscure the patient as they did not fully close. We saw a female patient lying next to a male patient and her legs and abdomen were visible. The recovery area for theatres 6-11 was newly opened, and curtains here pulled right around the patient. On Tolgus ward there was restricted space, leading to issues with confidentiality for gynaecological patients. There was little room for administration staff, and patient records were being kept in boxes on the floor. There was a shortage of rooms to see patients, and staff said patients had been seen in the sluice room or interviewed on the corridor to avoid delays to their procedure.

Involvement in care and decision-making

Most patients felt they were appropriately involved with their care. One patient told us they wanted to know "the absolute minimum to be honest" and said staff had respected this "without being patronising and seeing it from my perspective". All the patients we met on wards said they felt involved with their care. They said consent procedures had been done well. They did not feel pressurised to make decisions, or follow a treatment plan they either did not understand or were not happy with. Patients said staff introduced themselves and explained what they could and could not do. If a patient had a question the staff could not answer, patients said staff knew the right person to talk with to get an answer.

Trust and communication

Patients said staff were open, honest and sensitive. Staff said they were given time and privacy with patients and their families if they needed to deliver bad news. Staff said they had access to translation services for people who had different communication needs. This included people for whom English was not their first language, or who were vision or hearing impaired. Information on the trust website in relation to surgery services was poor. The 'surgery' area directed us to a section on 'vascular services' and there was

no other information. There was a section on 'theatres' which redirected us to the 'anaesthesia' page, but this was only a list of senior staff in that department. The website could be translated into a number of different languages and there was a section on 'staying in hospital' which had a British Sign Language translation.

Emotional support

Patients said staff recognised they were all different and needed different levels of support. We met a consultant anaesthetist who was the lead for the surgical division for people with learning disabilities. The consultant recognised the difficulties many people with learning disabilities had with medical treatment, and often any form of intervention, such as cutting nails or hair. The hospital had a group of learning disability liaison nurses who would assist the consultant with a 'special needs list' which might involve chiropody, immunisations, scans, dental treatment, and even haircuts. The team had also carried out home visits and, under carefully assessed circumstances, carried out sedation at the person's home, so they could safely attend hospital for procedures. The patients, carers, and when required, pharmacy staff, community dental team, social workers and paramedics had taken part in making sure everything was considered and discussed. The operating department practitioners were described as "fabulous" in their assistance with these procedures for people with learning disabilities.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

Patients' needs were not always being met. Many patients we met on our visit were happy with the care and said their needs were being met. On one ward there was some confusion when a patient went outside with permission to smoke a cigarette in the morning (in spite of the hospital being a strictly no smoking site). The patient had missed their theatre time. The ward staff had not been given the correct information about the procedure. The theatre time was, however, then rescheduled and the patient was collected in the afternoon. We had some information from patients who wrote to us saying they had poor experiences.

One patient told us they were admitted one evening into the Surgical Assessment Lounge. They told us they were put onto a bed at 17.00 hours, the curtains drawn, and did not see anyone until 22.00 hours. The person who came to their bedside did then not know who they were. They were seen again at midnight and told they should have gone to theatre. During their stay, the patient said call bells were regularly not being answered and some patients were not being helped to eat.

Patients were sometimes remaining in post-operative recovery for longer than required. We were told this was due to the lack of available bed on the wards, including the critical care unit. Some patients had been moved from recovery in the Tower to the recovery unit in Trelawny. The Tower theatre service was not a 24-hour service and patients were transferred to Trelawny if an operation had run late or the unit was full. We observed a bariatric patient being cared for in the Trelawny recovery unit. The patient remained on a trolley as a suitable bed was not available. We observed this was causing the patient to develop red marks on their arms from the unsuitable nature of the trolley. Staff in both the Trelawny and Tower recovery units said they had been reporting this issue and other problems through the incident system in the past, but had "given up" or "lost the will to live" due to the time the form took to complete and nothing being done to change practice. Staff also told us surgery would be started on a patient when staff knew there was no bed available. A consultant anaesthetist we met on Newlyn unit said no vascular surgery would be started without ensuring a bed was available. Another consultant said they knew the practice of starting surgery without a bed occurred. There was no data available to say how often this happened, but it was confirmed by a number of staff.

Access to services

Performance in the surgery division was good in some areas and needed improvement in others. Too many sessions in theatre were not being used and operations were being cancelled. Data showed an average of 27 theatre sessions were unused each month in March to October 2013. Theatres were routinely unable to adequately fill sessions because there were bottlenecks elsewhere in the hospital caused by a lack of intensive care beds, or ward beds. Operations were also cancelled as the patient had not turned up; the patient was not adequately assessed; or the patient was unfit for their surgery. In the eight-month period from March to October 2013 an average

of 10% of operations were cancelled. Staff we spoke with in the theatres 1-5 said operations were cancelled or started late due to equipment not being available as expected. An average of 64 hours had been lost each month in March to September 2013 due to operations starting late. Staff said one of the main reasons for this was the lack of facilities to assess patients and discuss formal consent with them on the female surgical admission Tolgus ward. Following the recommendation from the gynaecology review Tolgus ward was reconfigured as a female surgical admission ward. However, Tolgus ward had not been configured to efficiently admit female elective surgical patients. The main problem was that surgeons and anaesthetists found there were often not enough rooms available to see their patients to discuss the procedure and get their consent without their theatre start-time being delayed.

Some patients were not satisfied with administration procedures. We received a number of concerns and comments about administration for patients booked for surgical procedures, follow-up appointments, or pre-operative assessments. One patient wrote to us with a catalogue of cancelled appointments, requests to repeat appointments already attended, and arriving for appointments for which there was no clinic. This was the case for a number of patients we met at our listening event; mentioned by others who wrote to us; and patients we met on the wards. An orthopaedic patient travelled some distance for a wound check only to find there was no clinic. Staff said of the error of there being no clinic: “oh they are always doing that”.

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

Vulnerable patients and capacity

Patients, carers and staff said consideration for a person’s mental capacity was done well. Patients who were not able to make a decision for themselves due to a lack of capacity had the decision made for them in their best interests and in line with the Mental Capacity Act 2005. Records we saw in patient notes showed staff completing paperwork to show how they had assessed a person’s mental capacity to make a decision. The records then went on to describe who was involved with any decision and how the decision had been made. A carer for a patient living with dementia confirmed this assessment had been done, and they were included in the process of the best interest decision. Another carer we met said their relative had learning disabilities. Staff at the hospital had assessed their relative and decided they had capacity to make their own decisions. They said they agreed fully with this assessment. Theatre staff we met said best-interest meetings were done well. A consultant anaesthetist described how all the people who spoke for the patient, both personally and professionally, were involved with these decisions.

Leaving hospital

Most patients said they had been given information about their discharge from hospital. Patients we met in the surgical short-stay ward said they knew when they were expecting to be discharged. One patient who was almost ready to go home said staff had checked with them again if their relative was coming to collect them as already discussed. They had been asked if they felt well enough, and told who they should contact if they had concerns when they got home. They were asked about access to the bedroom and bathroom at home, and given advice about keeping themselves safe when moving around. The patient said they had stayed at the hospital before, and that the information they were given was helpful last time. They said they were given leaflets about their procedure and after-care, and the medicines they needed were delivered with advice from the pharmacist in good time.

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

Learning from experiences, concerns and complaints

The surgical division captured patient feedback. This included results from the Friends and Family test, complaints and comments, patient experience groups, and the Trust CARE (C - communicate with compassion, A - assist with toileting, R - relieve pain effectively, E - encourage adequate nutrition) campaign. The Friends and Family test responses from patients, and scores given were

above the trust target. One area patients had criticised was noise levels on wards. Staff had acted and now ensured ear plugs were available for all patients. There were also criticisms around patients not getting the best pain relief. This aligned with an audit that had identified some pain medication being missed. Posters were placed on drugs trolleys to remind staff to ask patients about pain relief, and staff said the issue was rarely mentioned now. Patients we met confirmed they were consulted about pain relief and felt it was well managed.

Are surgery services well-led?

Good

Vision, strategy and risks

The overall strategy for the surgery division was evolving and not all risks had yet been addressed. The hospital benefited from a new surgical department in the Trelawny building. This had resulted in a number of specialties moving into different areas. There were some concerns among staff about the effectiveness of the new arrangements and risks to patients. For example, patients who were admitted through Tolgus ward in the Tower building could sometimes not be returned to Tolgus ward for day care. This was due to Tolgus not having enough beds or chairs for people to use as new admissions arrived. In these circumstances, patients were transported to Theatre Direct or another ward in the Trelawny building for care before they went home. Some surgery had been cancelled as a result of the consultant's concerns for the risk to their patients, on the day of our visit, as these patients were not able to be received back to Tolgus ward.

Governance arrangements

The surgical division had recently evolved as a merger of the surgery, trauma and orthopaedics division with the theatre and anaesthetics division. This change was still very recent, and governance procedures still reflected the previous arrangements. Each specialty in departments had a named governance lead which was usually a consultant or associate specialist. The newly merged division now had an appointed administrator, and a standardised format for specialty meetings had been developed. There were monthly governance newsletters shared with staff which included: the risk register, incident updates, and patient safety and experience.

Leadership and culture

Staff said they were well supported. There was a mixture of new staff and others with many years of experience among the teams in the division. New staff said they had been made to feel welcome and there was a planned and prescriptive induction to follow. None of the staff we met said they would have any hesitation about reporting poor care or other concerns to their line manager or senior management. Staff we met at a number of wards or focus groups said the Nurse Executive (sometimes referred to in the NHS as the Chief Nurse or Director of Nursing) provided good support, leadership and mentoring to the nursing team throughout the hospital.

Patient experiences and staff involvement and engagement

Staff said they felt involved and informed about patient safety and experiences. The division held regular staff meetings where all staff could participate. Staff on the wards said they attended or were represented at handover meetings when shifts were changing. They said patient safety was the main theme of handover sessions. Staff also felt part of the hospital and wider trust. They said they had newsletters, and were able to hear patient views gathered from other parts of the service through meetings with their peers and senior management presentations.

Learning, improvement, innovation and sustainability

Staff we met said they felt encouraged within their division to learn and improve. The General Medical Council reported that the trust was mostly similar or better than expected in results from the National Training Scheme Survey for doctors. A consultant anaesthetist told us that the trust enabled them and colleagues to attend professional development courses and national conferences, and gave them time to travel and stay overnight when needed.

Good

Intensive/critical care

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

Information about the service

The critical care department includes the intensive therapy unit (ITU) and the high dependency unit (HDU). These are located in a new unit (opened in 2012) with 15 open beds: although the space is configured for 19 beds. A critical care outreach nurse assists with the care of critically ill patients on other wards throughout the hospital. There is consultant cover on the department 24 hours a day.

We talked with two patients, one relative visiting the department and 10 members of staff. These included nursing staff, the outreach nurse, critical care assistants, a consultant, junior doctors, and senior management. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Patients received safe and effective care, although sickness levels, the amount of training undertaken and the availability of the outreach service were a concern. Clinical outcomes, including mortality, were good and often above the national average. The caring, consideration and compassion of staff was excellent, and patients we spoke with, and who contacted us, praised the department. The department was well-led.

Due to pressures on bed capacity elsewhere in the hospital, the critical care department was not responsive enough to the needs of patients. A lack of effective patient flow through the hospital meant that most patients were not being discharged when they were ready; too many were being discharged at night; some were not able to access critical care at times; and some were being discharged early when staying longer might have improved their outcomes.

There were high levels of sickness among staff, although the trust had responded by providing bank and agency staff, and permanent staff worked extra hours.

There was a lack of resilience in some areas. The outreach service was understaffed and not able to provide a full service, particularly in the follow-up of patients. The knowledge and skills needed for the computer-based patient record system resided in one member of staff. Business cases had been submitted to the trust for future improvements in the outreach team, but not for increased electronic record system expertise.

Good

Intensive/critical care

Are intensive/critical services safe?

Requires improvement

Safety and performance

The department had a good record for safety and measuring their performance. The critical care department produced and analysed data, to check their performance and how they ranked against similar departments in other hospitals. The hospital trust contributed their data to the Intensive Care National Audit and Research Centre (ICNARC), in order that they could be evaluated against similar departments nationally. Each month, the department produced a performance and assurance framework report which carried data on, for example, incidents, complaints, the Friends and Family test, and infection control, and which was discussed by the division. This information, called the 'clinical dashboard' was available to all clinical staff to review at all times and discussed at divisional meetings each month. Specific infection control performance indicators were presented each month at the divisional governance management meeting.

Patients and their carers felt care was safe. Patients we met on the ward, and who wrote to us about their care, said they felt safe in the department and with staff. We observed care being given and saw staff following guidance in the personal protective equipment they were wearing and using. The unit was calm, well-lit, spacious, clean and tidy when we visited. The environment was safe and well maintained. Staff were seen checking and completing charts, and monitoring patients' clinical indicators.

Sickness levels were reducing but remained high. Some staff were concerned about maintaining safe nursing staffing levels at all times due to sickness absence. Data showed there were high levels of staff sickness on the department each month in 2013. Levels had reduced since the peak of July 2013, but were still 8% on average. This was significantly higher than the overall sickness absence rate for at the trust (April 2012 to March 2013) which was 4.5% (slightly above the national average of 4.2%). Nursing staff said they were sometimes asked to work on other wards in the hospital when their department was well staffed. Senior staff said they would refuse to transfer staff if this made the department unsafe. The transfer of staff had been rated as high on the divisional risk register, and was added in October 2012. Staff told us the trust responded to sickness absence and other unplanned absence. Senior staff were able to call upon agency and bank staff when required without restriction. However, some staff said they were also working extra hours to keep the department safe, and there was a reliance on the goodwill of staff.

Each patient in an intensive care bed had dedicated one-to-one nursing care to meet their high-dependency needs. Patients in high-dependency beds had one nurse for two patients. This followed national guidelines about caring for critically ill patients.

There were sufficient medical staff, and consultant staff were on call out of hours and at weekends. Junior doctors told us they felt well supported. Staff told us there were insufficient critical care assistants who carried out roles such as cleaning and preparing bed spaces. The posts had not been increased since the increase in beds in 2012. This was said to be a factor in delaying the turnaround with beds and causing delays with admissions. A business case had been submitted for the 2014/15 budget.

Patient needs elsewhere in the hospital were not always met. The department had an outreach nurse who supported critically ill patients elsewhere in the hospital, responded to emergencies, and held follow-up assessments with discharged patients. Due to only having one member of staff in the outreach team (who was a highly qualified and experienced nurse), the post-critical care follow-up service was described by staff as "inadequate". The outreach service to the whole hospital was staffed for 7.5 hours per day on Monday to Friday in daytime hours. This was placed on the trust risk register in March 2010. A business case had been made to increase the team to three members of staff.

Learning and improvement

Staff told us, and records showed, they learned from untoward events. There were no serious incidents reported in 2013, but three were reported in 2012. We saw that these were recorded through the incident reporting system, and then analysed and discussed through the divisional governance meeting. Learning included replacing all the critical care beds to help prevent pressure ulcers, and training delivered on the placement of catheters.

Good

Intensive/critical care

Systems, processes and practices

Systems for patient records were effective. The department had a system for recording patient notes based solely upon computerised records. This information was backed-up and could be transferred into paper records if the computer system failed for any reason. An electronic report of a patient's records was produced and stored in the system every four hours, which could be retrieved if the computer system failed. The system included patient care plans and prescription drug charts, and was designed to prompt staff when any interventions or care was required. This included giving medicines or monitoring indicators. Staff said the system was "brilliant" and "invaluable".

Monitoring safety and responding to risk

The critical care department recognised and understood its risks. It ensured these were highlighted to the trust board through the registers of risks. The department or ward manager decided what risks were escalated to the service risk register if they could not be managed at ward level. Higher-rated risks were elevated through the divisional register and to the trust-wide register.

The department responded to risks. The department had undertaken an investigation into the cause of an outbreak of methicillin-resistant staphylococcus aureus (MRSA). We met and discussed this with the nurse-director of infection prevention and control (D-IPC). The investigation had involved specialist staff including Public Health England. Each incident had been reviewed independently and the outbreak then reviewed overall. An action plan to avoid a recurrence had been drawn up, and staff confirmed the actions had been taken. This included a bed-space checklist for cleaning which we checked and saw had been fully completed in one randomly-selected bed-space. We saw hand-washing materials placed in appropriate places.

Anticipation and planning

The department was well planned and able to develop further. The unit was opened in 2012 to a specification designed by the trust's critical care specialists. It was designed for 19 beds, although currently being funded for 15 beds by NHS health commissioners. There was therefore room to expand the service in future.

Are intensive/critical services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance

Patient's received care is in line with national guidelines. There was a set of criteria for patients to be admitted to critical care from wards, theatre or the emergency department. The early warning system (EWS) was used on wards to determine if patients met the criteria to be referred to critical care. The outreach nurse said the EWS system was used relatively well. Patients having surgery at the hospital were assessed for the need of post-operative critical care. The division had recently introduced a diary system to book surgical patients into a critical bed in advance where possible, to improve access to an available bed.

Performance, monitoring and improvement of outcomes

Outcomes for patients were good. Patients told us care was centred on them and that treatment was effective. A patient who spent a long time in the department wrote to us and described the consultants as "comforting and very knowledgeable in ensuring the best possible care". They said they "couldn't fault the service".

The patient mortality rates on the critical care department were low when compared with national levels. Data in the ICNARC report showed the department mortality rates were consistently below those of similar units since 2008. This was the case despite admissions to the department having doubled in number when the new unit opened in 2012. The department had reported that no patients had needed to be transferred to another critical care unit in another hospital for non-clinical reasons since the data was started in 2008. There had been under 2% of patients transferred out for clinical reasons in the period January to September 2013 (when the published data ends). Up until September 2013, almost all patients leaving critical care had the same or greater independence.

Staff, equipment and facilities

Mandatory training was behind schedule. The department was the lowest within the hospital for completing mandatory training. Staff had completed 56% by December 2013, and there was only a quarter of the time remaining to complete necessary training. The average for the rest of the hospital wards for the same period was 79%. Almost all

Good

Intensive/critical care

staff had completed equality and diversity training for the division in which critical care sat. Safeguarding adults and children level 1 training was well attended, but safeguarding adults' level 2 was poorly attended. Staff told us their appraisals were held each year and all those we spoke with said they were up to date.

Facilities in the department were of a high standard. One patient told us that the facilities were "superb" and another wrote to us and described them as "impressive and we are extremely fortunate in Cornwall". The department was a purpose-built critical care unit designed by experienced critical care staff. Staff said they had all the equipment they needed. The unit was designed with space for 19 beds, and currently funded for 15 beds. One of the side rooms was fully equipped and able to be used as a training and simulation facility.

Multidisciplinary working and support

Staff told us they worked well as a team. One member of staff said they were a "committed team" and another said the support to and from one another was "brilliant". Staff said they were motivated to come to work by the support and collaboration of their colleagues. The critical care unit was a small department and staff said this meant the nurses were fully consulted by the doctors and vice versa.

Are intensive/critical services caring?

Good

Compassion, dignity and empathy

Patients we met and people who wrote to us said their care was good. One patient who spent a long time in the department wrote to us and described the care as "magnificent" and the consultants were "wonderful". Another patient wrote to us and said the staff in critical care were "super … from the cleaner and tea lady to the consultants". Staff spoke of their patients and also their family and carers with dignity and empathy.

Involvement in care and decision-making

Patients were involved in all aspects of their care. A relative and patients we spoke with in the hospital, and others who wrote to us, said they were closely involved with care and decision-making. Nursing staff we spoke with described how they made sure decisions were taken alongside the patient and/or those close to them. If a patient was not able to take a decision, staff said that they involved people who could speak for the patient to ensure care and treatment was in the patient's best interests.

Trust and communication

Patients and their relatives said they received regular communication. A relative wrote to us and said the staff had talked to the unconscious patient "all the time and told them what was happening. I don't know if [the patient] could hear, but it was important for me too. It showed a depth of feeling". A patient who contacted us said: "although I wouldn't suggest knowing about the skills they [staff] need to give, I felt comfortable with placing my trust in their hands totally. They gave you that much confidence."

Emotional support

Patients and carers received emotional support. Staff told us they were encouraged to be open and honest with patients and to help them cope with their stay in hospital. There was space around a bed for carers to visit comfortably and not feel they were in the way. We were told staff had arranged to take a ventilated patient out to the pub for a welcome change of scene. This was carefully risk-assessed and staff were proud of being able to provide this experience. A local well-known chef had also visited the hospital to help prepare menus and dishes to tempt jaded appetites. A patient said the food at the hospital was "wonderful".

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

Patient flow into and out of the department was not effective. The critical care department had many patients whose discharge was delayed or not at the optimum time. These were patients who were medically fit to be discharged to a ward, but no beds on wards were available. This meant sometimes beds were not released in critical care, and patients who needed them were not admitted to

the department. Conversely, when the department was under pressure to admit patients, and beds were available elsewhere, there was early discharge for patients who would have benefited from a longer stay.

Some discharges were not at the optimum time. The latest ICNARC report showed the department had performed out-of-hours discharges (those between 22.00 hours and 07.00 hours) significantly above the national average since the beginning of 2012. Around 15% of patients were discharged out of hours in the last two years, with the national average of around 9%.

Many discharges were delayed. Around 60% of all discharges were delayed over the last three years (the national average was around 40%) and around 70% were delayed by more than four hours (the national average was around 55%). Most delays were less than one day, but some were four to five days and a small percentage had been delayed by more than a week. This was a concern for all the staff we spoke to in critical care and had been an entry on the risk register since October 2012.

Access to services

The lack of patient beds affected other departments and services. At times, patient surgery was being cancelled due to a lack of access to critical care beds. There was also a lack of access to specialist care for first level high-dependency patients due to the bed shortage and limited capacity of the outreach nurse. Sometimes, when critical care beds were not available, patients who needed intensive therapy were not admitted to the department. In the week before our visit, the critical care department was full, and had opened another unfunded bed (to take 16 patients in total) and four patients were being cared for in the recovery ward.

Information given to patients could be improved. Information on the trust website, in relation to critical care, was poor. There was no information about what a patient, carer or family member could expect from this often daunting area of care. The website could be translated into a number of different languages and there was a section on 'staying in hospital' which had a British Sign Language translation. Relatives arriving on the critical care unit were guided to the waiting room lounge and able to have a hot drink. A private room was available if staff had to give a patient and/or relative bad news. There was no accommodation for visitors to stay, but the private room could be adapted for family to stay. There was a file available with information on critical care, but there was only one copy available between the two family rooms. There were, however, a lot of leaflets with relevant information for patients and relatives to take home.

Vulnerable patients and capacity

Patients who lacked the mental capacity to make a decision were supported. The nursing documentation included some specific areas for consent to be considered, such as catheter care. Recognised techniques and scoring mechanisms were used to assess patients' mental capacity and any possible delirium through sedation, which may have a temporary effect on their ability to take a decision. Care records had an area for staff to complete, to say they had considered consent and to record any decision taken to treat a patient in their best interests. We saw a set of patient notes which showed how the best interest decision had been captured and recorded.

Leaving hospital

Patients were discharged with helpful information. Patients who left the unit for other wards or hospitals had a record of their electronic notes produced to accompany them. Information was provided for certain circumstances. For example, if a patient was transferred to Derriford Hospital, staff would provide the family with information about accommodation in that area to help them plan. If patients were transferred onto other wards in the hospital, or sent home, they would leave with a leaflet about leaving critical care which was a guide for recovering patients. They were given relevant information about how they might feel, recommended therapy, and access to the Patient Advice and Liaison Service (PALS).

Learning from experiences, concerns and complaints

The department captured patient feedback. This included results from the Friends and Family test, complaints and comments, patient experience groups, and the Trust CARE (Communicate, Assist, Relieve, Encourage) campaign. The five people who had responded to the recently introduced CARE campaign had given a 100% positive response to the eight questions asked of them. The department said it learned from comments and suggestions from patients, and had recently improved its documents around decision-making, and keeping people's property safe when they moved to and from critical care.

Good

Intensive/critical care

Technology resilience

There were some concerns about the resilience of technology used in the department. The critical care department maintained all patient records on a computer system. The system was provided by a major software company, but had been adapted by a Trust clinician for use in the department. This member of staff was the key person in the trust who could make adaptations and changes, and work with problems identified by staff. Although there was a good system for returning to paper-based records and backing-up data in the event of system failure, there was no succession planning for the clinician who was approaching retirement, and no cover for their planned or unplanned leave, or over weekends.

Are intensive/critical services well-led?

Good

Vision, strategy and risks

Patients were the focus of the department's strategy. The critical care department's vision and strategy, which we heard about and read in their documentation, put patients at the centre of future plans and current practices.

Governance arrangements

The critical care department had a good framework for monitoring the quality of its service. The department had its own governance team who met monthly. There was attendance on the governance meetings from all areas of the department, although the critical care assistants said they usually did not have time to attend. They felt they were represented by their nurse manager. The department was represented at divisional governance meetings, and this flowed through to the executive team and trust board. The divisional director and management would meet regularly to review safety and quality data, and risks.

Leadership and culture

All the staff we met told us on our visit told us they felt well supported. There was a stable staffing group in the department and many years of experience among the team. Staff variously described other team members as "passionate about quality", "the patient is everything to them", and "they are very inclusive in their approach". None of the staff we met said they would have any hesitation about reporting poor care or other concerns to their line manager or senior management. Staff told us they were very proud of their department and the work they did.

New staff coming to the ward were mentored and worked alongside experienced staff until they felt confident and were approved to work on their own.

Patient experiences and staff involvement and engagement

Staff felt involved and informed about patient safety and experiences. The department held regular staff meetings where all staff could participate. The critical care assistants said they felt part of a team and were able to look after patients as part of their duties. All staff told us they attended or were represented at handover meetings when shifts were changing. They said patient safety was the main theme of handover sessions. Staff felt also part of the hospital and wider trust. They said they had newsletters and were able to hear patient views gathered from other parts of the service through meetings with their peers and senior management presentations.

Learning, improvement, innovation and sustainability

Staff we met said they felt encouraged within their department to be innovative. They were able to attend national conferences, and the hospital hosted the regional annual intensive care conference in 2013. The General Medical Council survey of training said doctors in the division in which critical care sat reported the trust performed better than expected for regional teaching and feedback to doctors.

Good

Maternity and family planning

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

Information about the service

The Royal Cornwall Hospitals Trust maternity service delivers over 4,700 babies annually, of which 600 are born in the community. There are three community based birthing units. Home births are also supported, running at just over 200 per year.

The maternity unit at Treliske Hospital has an early pregnancy assessment clinic, day assessment and foetal assessment unit, antenatal ward (Wheal Rose), delivery suite, and postnatal ward (Wheal Fortune). There are two dedicated theatres within the unit which are used for assisted births and associated care following the birth, and for planned and emergency caesarean sections.

We received information from people who had contacted us before, during and after our inspection visit with their views of the service. We also reviewed information requested from the trust regarding the hospital's performance and national data.

We visited the antenatal, day assessment and post natal wards, and the delivery suite. We talked with eight patients, five relatives and 22 staff, including midwives, doctors, consultants, therapists and support staff. We observed care and treatment, and looked at care records. We received information from our listening events, focus groups, interviews, comment cards and from members of the public following the inspection. We used this information to inform and direct the focus of our inspection.

Summary of findings

The maternity unit at Treliske Hospital provided safe care. The ward-based staff were busy, and on occasions there had been insufficient staff to meet the needs of individual women in the maternity department. Medical cover was arranged and in place, including consultant, senior and junior doctors. Staff worked closely with one another across the maternity unit, to provide a multidisciplinary service for patients who often had complex needs. There were specialist midwives and volunteer staff available to provide additional support to women while they were in the maternity unit.

The maternity unit was clean and hygienic in appearance, with sufficient and appropriately located hand washing facilities and anti-bacterial gel. Women and their babies were protected by the training provided to staff and the systems in place, to ensure the environment and equipment was safe for them and the staff to use.

Staff were caring. Women spoke highly about the care they received, and the kindness and empathy shown to them by clinical staff within the maternity unit.

The service provided to patients in the maternity unit was not always responsive to their individual needs. There were delays at times on each ward, often due to high numbers of women attending the unit, and insufficient beds or staff to support them. This meant that patients were not always cared for in the most appropriate area or ward.

The service was well-led. Staff generally felt supported by the senior staff; although we did hear that, at busy

Good

Maternity and family planning

times, clinical managers could make staff feel pressured and were not so supportive. We met with senior managers for the maternity services who were positive in their comments regarding the recent changes in the hospital management team.

Are maternity and family planning services safe?

Good

Safety and performance

The maternity unit provided safe care to pre and post-natal women.

Women and babies were protected from the risk of abuse as the hospital delivered training each year to all staff regarding the safeguarding of vulnerable adults and children. Staff we spoke with, and ward managers, confirmed this was ongoing, and all were aware of their responsibilities and the reporting procedures.

We saw from information provided to us by the hospital, the sickness absence rates amongst midwifery staff were higher than the national average. Staff told us the midwifery unit was a busy place to work. Staff on the delivery suite and post natal ward told us they were confident that there were sufficient staff to support and care for patients. A recent system had been put into operation to manage midwifery support workers centrally, and allocated on a daily basis to the area in the greatest need of additional staff. We had concerns raised to us that if other wards were busy, the antenatal ward would be the first ward staff moved from. We were given examples of when this had happened, which had caused stress and pressure to the staff remaining on the ward, as they had been, at these times, unable to provide care in line with the hospital and national clinical guidelines.

There was consultant cover in place for the maternity unit each day with medical cover at all times. Dedicated anaesthetic cover at consultant level was available between the hours of 08.00 hours to 20.00 hours, Monday to Friday. Outside of these times the anaesthetist cover came from the main theatre department. We were told by medical and nursing staff that regular communication took place between the maternity unit and the neonatal ward. This ensured that any women whose condition indicated their babies would possibly require care and treatment from the neonatal unit were identified and the care planned for. We spoke with a paediatric consultant who informed us that weekly meetings took place between the units to develop care pathways and plans.

Good

Maternity and family planning

The wards had commenced an improvement scheme known as 'the productive ward'. The aim of this was to improve ward processes and environments. This was to help nurses and midwives spend more time on patient care, while at the same time improving levels of safety, efficiency and providing information to people. For example, information regarding the staffing levels was displayed on a ward noticeboard. This provided open and transparent information to patients and visitors to the ward. We reviewed the staffing levels and were told that only minimal shifts were not up to the required staffing numbers. At the beginning of the week, we saw there were gaps on the duty rota for the antenatal unit at the weekend. These had been filled by appropriate staff by the time the shift commenced.

We were concerned that, at times National Institute for Health and Care Excellence (NICE) guidelines for checks on women during labour were not always recorded at recommended intervals due to the recognised safe ratio of women to midwives not being met. The hospital had a Birthrate Plus2 standard which was made available to us prior to our inspection. This was a recognised tool developed for the maternity service to identify the number of midwives required based on clinical activity and risk. It showed the midwifery workforce numbers were below the standard.

The maternity wards looked clean and there were plentiful supplies of hand gel and hand-washing facilities located throughout the wards. We observed, and patients confirmed, staff washed their hands regularly and used personal protective equipment when necessary. Relatives told us they had been encouraged to use hand gel while on the wards. This showed the control of infection was promoted and the risk of cross infection reduced. Domestic staff were aware of their roles and responsibilities, and told us about, and showed us the cleaning schedules in place.

Learning and improvement

The hospital had been proactive in meeting women's needs in the day assessment unit as the service had recently been expanded to open seven days a week and for longer each day. This made the antenatal ward more manageable for staff and safer for patients, as they were assessed more promptly.

Staff were provided with guidance and information regarding the control of infection and prevention of cross infection. Staff told us this information was updated as necessary, and in line with national guidance and good practice recommendations. We saw notices displaying information for visitors to the ward, and the results of hygiene audits were also displayed, which showed attention was paid to the control of infection on the wards. Guidance was available for staff regarding hospital acquired infections, the tests required and when a patient met the criteria to warrant a test. This ensured each newly admitted patient was assessed and action taken to reduce risks of infection.

Systems, processes and practices

Information we hold about the hospital raised concerns about the level of incidents being reported. Our information showed reporting was low when compared against a similar hospital. We spoke with staff about this who had variable experiences when it came to reporting concerns. Some staff told us they had had no problems with issues being escalated and action taken. Other members of staff said they were reluctant to escalate areas of concern as they had not had a positive response before.

We followed the processes when a patient required surgery on the maternity unit. The equipment in use had been checked, maintained and was clean. As is best practice, the hospital used the World Health Organization (WHO) surgical safety checklist in operating theatres, which is a system designed to prevent avoidable errors. We observed for one patient that the checklist was used as part of surgical checks and documentation for caesarean sections.

Staff were provided with, and staff we spoke with confirmed they were aware of, written protocols, policies and procedures which were available on the wards and on the trust intranet. These informed staff of safe working practices and procedures. We spoke with a senior house officer who told us they were easily accessed and user-friendly.

Throughout the maternity unit, there were emergency trolleys and associated medications available for medical emergencies. The equipment and drugs were checked to ensure they were fit for use and a signature recorded to evidence this had been done. The equipment and medication were securely stored and easily accessible for use. We observed fridge temperatures, for example, in medication fridges, were checked and recorded daily to ensure medication and other products which required cool storage were safe to use.

Good

Maternity and family planning

Attention had been paid to ensure patients were protected from the risks associated with medication, through the training staff received and actions they took when they administered medications. We observed staff administering intravenous medication. We saw they wore tabards which identified they were involved in medication administration and could not be distracted. Two members of staff checked the medication, witnessed it being given and signed the Medication Administration Record (MAR). Staff were clear in their discussions of their responsibilities when administering medications.

Monitoring safety and responding to risk

A process of triage was in place for patients during antenatal visits and on admission to the day assessment unit. The day assessment unit operated this triage system, which meant each woman was individually assessed and allocated a time frame for their care and treatment according to their assessed need. This service had recently been expanded to open seven days a week and for longer each day. This made the antenatal ward more manageable for staff and safer for patients, as they were assessed more promptly during the hours when the day assessment unit was staffed.

We observed staff communicated well on each ward and between wards, to ensure, whenever possible, women were provided with care in the most appropriate place. For example, transfers took place between the antenatal ward to the delivery suite when a woman was in established labour. This was so the woman could give birth on the delivery suite where the facilities were available to enable them to make choices and decisions regarding their birthing plan.

Each ward had an identifiable midwife in charge of the ward and were told, wherever possible, that this person was supernumerary and did not provide one-to-one support to women. This meant staff had access to a supervisor for additional support and to refer concerns to.

There was poor guardianship of patient records. Records were in trolleys on the ward and in offices which were not secured and at times unattended by staff. This meant that there was a risk of patient's personal and confidential information being accessible to others.

Anticipation and planning

Data showed the average length of stay of women in the hospital, following delivery, was one day, compared to the national figure of two days. Two patients told us they had been able to stay longer because they or their baby required additional care. Staff told us there was a pressure on beds on occasion, and they actively encouraged all women to go home as soon as they were able with the support of the community midwives. There was a slightly higher than expected number of readmissions to the maternity unit when comparing the hospital's data to national figures.

Data provided showed the number of births within the hospital had increased by 20% since the year 2000. Several members of staff, from different wards in the maternity unit, told us the wards and community midwives were busy, which caused pressure on the beds available to expectant and newly delivered women, at times. We saw there were plans in place to extend the facilities and to have a birthing centre built on the hospital site. There was no firm date for this to happen.

It had been recognised by the medical staff that there was a need to extend the hours worked by consultants, and to this end a business case was being presented to the executive board of the trust to increase additional consultants' hours. The senior clinical managers of the maternity unit felt supported by the executive board and able to present this case to them.

Are maternity and family planning services effective?

(for example, treatment is effective)

Good

Evidence-based guidance

The hospital had protocols to ensure safe and effective care was provided. Staff we spoke with were aware of where to find policies, procedures and up-to-date guidance.

Specialist midwives were appointed and included lead midwives for safeguarding, bereavement, infant feeding, diabetes, and to support specific patients and staff. Part of their role was to cascade information and training throughout the units. Staff we spoke with told us they felt supported by the specialist role.

A medical termination of pregnancy service was available at the trust, provided by a dedicated team consisting of a

consultant, doctor, nurses and support workers. Cover was in place for when any member of the core team was on leave or away. We spoke with medical and nursing staff who provided this service, and during our discussions, found the national guidelines were followed and legal frameworks understood and implemented by the staff team.

Performance, monitoring and improvement of outcomes

Information we received from the hospital said monthly monitoring identified 97% of women received one-to-one care during labour. Patients we spoke with during our inspection visit confirmed this had been their experience, and added their midwife had also personally introduced and handed their care over to an oncoming midwife when they went off duty.

Staff, equipment and facilities

There was obstetric and gynaecologist consultant and anaesthetist consultant cover on the unit for 45 hours spread over Monday to Friday (i.e. nine hours per day). A business case had been made to increase this. A consultant interventional radiologist was available if needed in theatre.

The day assessment unit was managed by a triage midwife and was for women with a pregnancy of 14 weeks gestation to attend as required. We were told this unit currently cared for 15-20 patients per day.

Systems for managing medications were effective. Patients we spoke with told us the staff managed their medication efficiently. Two patients told us they had received adequate pain control during and after their labour. We were shown that specific and relevant information was provided to patients while in hospital and on discharge. For example, patients who required anti coagulation therapy on discharge were provided with an information leaflet, an explanatory DVD and information on how to use the safe disposal box for their used syringes and needles.

A wide and well stocked range of information leaflets, on subjects such as breast feeding, were available on the wards. Patients and visitors were able to help themselves to these.

One member of a team of trained volunteers attended the wards most days to provide help and support to new mothers around breastfeeding. The volunteer spent periods of time with individuals or small groups as required. People we spoke with expressed positive comments about this service.

There was a mix of staff rotation throughout the maternity unit, with some staff remaining in one area. Staff were able to specialise in areas where they wanted to work, and others were able to have the opportunity to work with different areas. We heard that this system was working well for women, and staff and patients confirmed that seeing the same staff throughout their pregnancy was of benefit to them.

Multidisciplinary working and support

We observed good communication between departments within the maternity unit and with other departments in the hospital. For example, the paediatrics team supported the obstetrics medical staff following the delivery of babies requiring additional care and treatment. There was close liaison between the paediatric and obstetrics medical teams to ensure women and their babies received a good standard of care.

Family planning advice and guidance was provided to patients throughout the wards and, after they went home, by midwives during post natal checks and visits.

Clear discharge records showed relevant professionals had been contacted as part of the discharge plan in order to provide ongoing support to the patient if needed.

Are maternity and family planning services caring?

Good

Compassion, dignity and empathy

Staff we spoke with were passionate about their roles and strived to meet the individual needs of both ante and post natal patients. We observed a good rapport between staff and patients, and saw their privacy and dignity was respected. A warm and friendly atmosphere prevailed throughout the unit even at busier periods.

Involvement in care and decision-making

Patients we spoke with reported feeling part of decision-making and planning for both themselves and/or

their babies. However, we were told the quality of this varied dependent on the member of staff. Midwives included patient's birth plans and wishes into the development of individual care planning.

We heard information was provided to women on the telephone prior to them coming into the hospital, which enabled informed choices to be made. For example, we heard one midwife discussing the options regarding when and how the woman could come into hospital. The midwife told us that, following the telephone call, the woman planned to attend the assessment unit to receive further guidance and advice on the stage of their pregnancy/ labour. We heard another midwife discussing the care and admission to hospital with a community midwife who was with a patient in their own home.

Trust and communication

Communication between the midwifery staff and patients and their families was good. Patients we spoke with told us the midwives listened to them and while they respected their birth plans, when necessary, alternative advice had been given to them in their best interests. Patients said they had been given time to digest information and suggestions from medical and midwifery staff.

There was a mix of staff rotation throughout the maternity unit with some staff remaining in one area. We heard this system was working well for women and staff.

Emotional support

Positive comments were made by patients regarding the emotional support they received from midwives and nursing staff, but we did hear some patients did not feel as emotionally supported by medical staff.

The antenatal ward had a newly refurbished bereavement suite supported financially by a charitable organisation. The facilities provided included a separate entrance from the ward, kitchenette and bathroom, which gave patients and/or their partners, privacy at such a sensitive time.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Requires improvement

Meeting people's needs

The antenatal unit and day assessment unit staff worked collaboratively to ensure women who required admission were cared for safely. We were told, at times, patients had to wait in the lounge/dining area while a bed was arranged. This area had access to a small kitchen area for drinks and armchairs. There was no form of leisure activity, such as a television or magazines. A concern was raised that, at times, there was nowhere for patients to lie down while waiting for a bed to be available, if they felt unwell. Staff said there were systems in place to identify and escalate situations such as this, which were a risk to women on the unit or compromised the care provided to them.

Access to services

We were provided with information prior to our inspection about the capacity of the maternity unit. During our discussions with staff and patients, we found, at times, there were delays in the care of patients due to the problems of being able to transfer them to the most appropriate ward in the maternity unit. This was due to both insufficient beds and midwife availability at peak times. These delays had resulted, at times, in patients' experiencing labour and delivering their baby on the antenatal ward. We were told by midwives that four women had delivered their babies on the antenatal ward in the month prior to our inspection. The implications of this were that some patients could not make full choices during the birth of their baby. For example, only certain pain relief was available in the antenatal ward for safety reasons.

Patients who were awaiting admission to be induced were frequently risk assessed and if safe, their admission could be delayed due to pressure on beds on the antenatal ward.

Staff we spoke with were aware of the staffing levels and skill mix of staff that was appropriate to their ward. We were told by clinical managers and midwives that, sometimes due to shortages within the maternity unit, staff were

moved to other areas to meet the greatest need. The antenatal staff provided care to newly admitted patients who were at varying stages of labour, and to women in the bereavement suite.

A pilot programme to reduce the delay to women who required elective caesarean sections was in operation, which involved patients going to theatre in the afternoons. Previously elective caesarean sections had been scheduled to be carried out in the mornings. However, we heard concerns voiced by medical and nursing staff, regarding the number of operations cancelled due to emergency procedures taking precedence. During our inspection one patient's delivery was delayed to the following day. We received comments from both medical and nursing staff that consideration would be given to the women's physical health prior to delaying their operations. However, concerns were raised by medical staff and two midwives regarding the emotional effect this had on the patient, who had been prepared for theatre and was anticipating giving birth on that day.

Vulnerable patients and capacity

All clinical staff we spoke with were aware of their responsibilities when caring for vulnerable patients. Policies and procedures were in place to assist staff with issues regarding the mental capacity of patients in their care.

Additional support was available on the maternity unit from an independent advisor in domestic violence. Support for patients around parenting skills was available, and there was a 'baby care room'. This had the equipment and space to provide a teaching environment on subjects such as changing of nappies and sterilising bottles.

Leaving hospital

Patients who were well enough following delivery could be discharged after a minimum of two hours, with support provided at home from community midwives. For women who needed additional care, they remained on the delivery suite, or were transferred to the postnatal ward, if there was a bed available.

Medications, including tablets for women to take home, were managed electronically, which assisted with the discharge process. Medical and nursing staff on the ward were able to arrange and dispense the patient's tablets from the ward stock. Staff told us that this had reduced delays in discharge, as patients were not relying on pharmacy deliveries for their medication.

We were told discharges were delayed at times due to the unavailability of appropriate staff to carry out a pre-discharge baby check.

Learning from experiences, concerns and complaints

The hospital trust had made a decision to move the post natal ward to a modular ward, which was located in an external building. This would mean there would be limited movement through any communal area as the corridor would be widened and brought closer to the lifts on the ground floor. The move is essential in order to relocate the neonatal unit into a larger environment and provide a birth centre. However, we received many concerns about this from the midwifery staff during our inspection visit. They felt patients' privacy and dignity would be compromised, as they felt access to the proposed ward would be through communal areas. Staff felt this would impact on patients following delivery, and when necessary, accessing the neonatal unit.

Staff were clear that the hospital trust planned to carry out work on the environment to ensure it was clean and fully equipped.

Are maternity and family planning services well-led?

Good

Vision, strategy and risks

The hospital was working towards ensuring continuity of medical care in the maternity unit by taking action to ensure long-term medical locums were in place, and recruitment was ongoing for clinical staff.

The hospital had responsibility for the maternity care of women who lived on the Isles of Scilly. There were arrangements in place which ensured their safe and effective treatment and care. During our inspection we saw how one woman had flown over from the Isles of Scilly following complications with her labour. The GP and midwife on the Isles of Scilly had liaised with the hospital to arrange this transfer.

Good

Maternity and family planning

Governance arrangements

We discussed the management of complaints. We were given an example of one informal complaint having been dealt with successfully at ward level and to the satisfaction of the patient. However, we were also provided with information, following and during the inspection, of people's dissatisfaction with the service they had received. One patient we spoke with during the inspection had concerns regarding the information they were provided with following the birth of their baby. They told us they had spoken to the midwives about this, had felt listened to and supported to obtain further information. They had been advised on how to make a formal complaint. We also received further information via our website about a concern which a patient had regarding their care and treatment while at the hospital. We were told within the information provided to us that they were aware of the hospital's complaints procedure and knew how to proceed with their complaint.

A system was in place to monitor the quality, safety and key performance indicators within the maternity unit. This was achieved through a reporting system, known as a dashboard, which was reviewed monthly in the risk management forum. Midwives were invited to attend the monthly governance meetings, which provided a venue to share concerns and good practices.

Reporting of incidents was ongoing and tracked through the maternity dashboard. This ensured incidents were raised at the risk management forum. Staff we spoke with were aware of how to report incidents and felt confident to do so. However, we were told the staff did not always receive full feedback on the outcome of incidents, or changes to practice or processes as a result, despite the trust having strengthened the incident reporting process to mandate the feedback of findings and actions to the reporter of the incident.

Leadership and culture

There was support and supervision from senior staff. The midwives were supported by supervising midwives and we heard from newly qualified midwives that the induction programme and mentor system in place was efficient and worked well.

Midwives told us they had good working relationships with medical staff and knew how to escalate concerns, would be able to do so, and were confident action would be taken. Medical students we spoke with were positive about their placement, found it a good learning environment, and had been made welcome to the team.

Senior staff reported that the changes at executive board level had been positive and they felt well supported by the executive team, and particularly by the recently-appointed chief executive. However, a doctor told us they felt "undermined" by senior colleagues and this created a "blame culture". As a result, the doctor stated they completed detailed documentation regarding their work. A midwife told us that, at busy times, they had experienced clinical managers sometimes being subject to increased pressure, and consequently, they had not been so supportive.

The latest NHS staff survey reported the percentage of staff experiencing physical violence, bullying, harassment or abuse from patients, relatives or the public was higher than the national average. We were told by some staff that they had experienced verbal abuse on several occasions. This was often in relation to being unable to transfer patients to the delivery suite, as there were no beds available. Staff told us that at such times they did not feel safe.

Patient experiences and staff involvement and engagement

Staff told us there was effective team-working across departments and all grades of staff. Patients we spoke with found the staff team to be approachable. A patient told us they had been able to have a second opinion from the medical team when they had further concerns to discuss regarding the medical care which had been initially provided.

Learning, improvement, innovation and sustainability

The hospital had 11 supervisors of midwives, which did not provide the cover recommended by the National Midwifery Council. In response, the hospital had encouraged and supported three midwives to complete the supervisor's course. This was in progress and once completed and the supervising midwives appointed, would exceed the recommended ratio of 1 supervisor to 15 midwives.

The midwifery staff were required to attend annual mandatory training each year, with additional specialist training available. However, midwives told us some training, which they felt was beneficial to their roles in

caring for patients, was completed in their own time and paid for by themselves. We were told they chose to do this as the training provided by the hospital, for example, regarding bereavement, was brief. There was additional training provided locally that staff said was more informative and beneficial to support in their roles.

Additional non-clinical staff, such as ward clerks and housekeepers, were in the process of being appointed, to release midwives to have more time for the provision of clinical care.

Good

Services for children & young people

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

Information about the service

To provide children and young people's care at Treliske hospital, there is a neonatal unit located in the maternity unit and two inpatient wards for children which provide care for children up to the age of 16 years. Services provided include day surgery, high dependency (HDU), and oncology with support from Cancer and Leukaemia in Children (CLIC) nurses, adolescent care and assessment. In total, the hospital has 41 beds available for the care of children. A new children's area has been developed in the accident and emergency department. Care is also provided to children in the outpatients departments.

We visited the children's wards, the neonatal unit, outpatients and the emergency department. We talked with 12 parents and children, and 17 staff including doctors, nurses, health care assistants, domestics and managers. We observed care and treatment, and looked at health care records. We received information from people at our listening events, and from people who contacted us to tell us about their experiences. Before the inspection we considered performance data about the trust.

Summary of findings

Children received safe and effective care throughout the hospital. The staff were aware of best practice guidance, and followed this when delivering care and treatment. Children and young people's health was monitored using a recognised assessment tool. Parents told us that the staff were kind and caring to both their child and to themselves. We found the paediatric services in the hospital were well-led.

The service was not always responsive to the needs of children and young people. We found that the service provided to young people without additional needs stopped at 16, with no formal care pathway for young people aged between 16 and 18. Parents found that there were excessive waiting times to see a doctor, when attending the assessment unit.

Good

Services for children & young people

Are services for children & young people safe?

Good

Safety in the past

Hospital data showed, and staff said, paediatric trained staff provided care and support to children within designated areas. For example, there were dedicated paediatric wards, and a unit for children and young people in the emergency department (ED). The hospital had recruited paediatric trained nurses for the ED, although not to the full complement identified to meet patients' needs. Another member of staff had been recruited for the paediatric ED, but had not yet started in post. Until the full complement of paediatric trained staff was completed, children and young people would, at times, receive care from staff who had not received formal paediatric training. The clinical manager of the department said there were sufficient staff with paediatric knowledge and experience who worked in the main ED. The manager was confident the care and treatment of children and young people was safe.

Infection control audits were regularly carried out and action taken to address any identified issues.

It had been recognised that there were environmental issues with the neonatal unit; mainly due to a lack of space. For example, there were concerns regarding infection control due to limited space between cots. The trust was working towards moving the neonatal unit to a more spacious environment.

Learning and improvement

Staff we spoke with were aware of the incident reporting processes in place, and confirmed they felt supported to raise incidents and/or concerns, and were confident action would be taken if necessary.

Systems, processes and practices

Nursing and medical staff had regular handover meetings. This was to ensure that staff coming on duty were fully aware of the care and treatment requirements for children and young people on the wards and in departments.

There were hand-washing facilities and personal protective equipment for staff use on the wards. Throughout the wards there were strategically placed anti-bacterial gel dispensers for staff and visitors to use. In the paediatric emergency department, which had opened immediately prior to our inspection, there was no hand gel in the entrance or public areas.

We observed staff adhered to infection control procedures when caring for children on the wards, emergency department and on the neonatal unit. We saw staff wash their hands before and after providing care and treatment to children. They wore personal protective equipment, such as gloves and aprons, when necessary. Staff were knowledgeable about the cleaning of spillages and bodily fluids, and we saw one member of staff take appropriate and prompt action to safely clean an area in which a child had been unwell.

Medication management on the wards was carried out through the use of the electronic prescribing system as used throughout the hospital. Staff had been trained to use this system, and the ward manager told us the system had been implemented and was working well.

The A&E department had an area that was for the use of children only. We observed a member of staff letting two adult members of the public, who had finished their treatment; walk through the children's area unaccompanied to leave the hospital. The staff member had used their security card to gain access to allow the members of the public through this secured area. This practice could place children at risk.

The hospital had a paediatric early warning score system (PEWS). This was a system to standardise the assessment of sick children with indicators of when to escalate their care needs. This ensured children received the medical care and treatment they required.

Monitoring safety and responding to risk

Staff were provided with annual training in relation to child safeguarding, although based on figures provided to us by the hospital, approximately 30% of staff training required updating. Staff were knowledgeable about their responsibilities regarding child safeguarding, and were clear about the action they were required to take, and the reporting process in place.

Records were maintained and audited by the hospital for safeguarding referrals that staff had made in relation to the protection of children and young people. This information was provided to us prior to the inspection. One referral had been recorded as a serious incident, and reported through

Good

Services for children & young people

the Strategic Executive Information System (STEIS). Staff we spoke with were aware of their responsibilities and accountability to respond and take action to protect children and young people from harm.

The wards and the neonatal unit were safe and secure. Visitors were required to ring the doorbell and say who they were. Identification was checked on entry to the neonatal unit, to ensure people had appropriate reasons for being there.

Children in the emergency department were treated in a designated paediatric area not accessible to adults attending the main emergency department. However, we saw that the children were required to use the same waiting area as adults when waiting for an X-ray. Observations during our unannounced visit found that one child became distressed during this time.

The hospital had an electronic incident reporting system, and although we did not see examples of completed reports, staff told us about previously submitted reports. Staff said reports had been made in the past about young people who had been on the ward for extended periods of time due to mental health issues. This had ensured concerns were raised to enable appropriate support to be made available for the child.

The hospital maintained a risk register, and we were provided with information regarding issues that had been included on the register, together with the action taken to reduce the identified risk. This showed that the hospital took identified risks seriously and took action to reduce further incidents.

Anticipation and planning

We spoke with medical staff who had responsibility for the care of children on the wards and in the neonatal unit. They said procedures were in place to ensure children received appropriate care and treatment. The medical and nursing staff liaised closely with the Bristol Children's Hospital in relation to all children in the intensive care unit. For critically ill children who required specialist care in a paediatric intensive care unit, transport and staff were arranged from Bristol to retrieve the child.

Are services for children & young people effective?

(for example, treatment is effective)

Good

Evidence-based guidance

The assessment documentation completed by staff when a child or baby arrived in the ED prompts regarding safeguarding of children and referred to the National Institute for Health and Care Excellence (NICE) guidelines. The guidelines were recommendations by NICE on the appropriate treatment, and were based upon the best available evidence setting the standard for high quality healthcare.

The service undertakes a variety of both local and national audits. For example, following a National Patient Safety Alert (NPSA) about hyponatraemia a regular audit of the appropriateness of IV fluids was introduced. The department also takes part in a range of national audits, for example Diabetes and has shown consistent compliance with national guidelines across a range of areas.

Performance, monitoring and improvement of outcomes

The paediatric pain nurse specialist provided support to children and staff in the paediatric wards and emergency department. They had responsibility for auditing the effectiveness of pain control for children and young people who attended the hospital. As part of their role, they visited the wards and ED on a daily basis, to follow-up on any particular issues that staff had identified with children in their departments. There had been an audit carried out on the pain control of children and young people on the wards. We were told this was in the process of being reassessed, which demonstrated ongoing monitoring of the care provided to children and young people. During our inspection visits, we observed pain relief was offered to children regularly.

Staff, equipment and facilities

The nursing staff on the paediatric wards were all trained children's nurses. Health care assistants told us they received training and support to provide care to children and young people safely.

Improvements had been made to the operating theatre arrangements to ensure there was a theatre with specialist equipment available for paediatrics. There was a designated paediatric recovery area and equipment.

Good

Services for children & young people

A new designated area for children was available in the ED department. We saw children were using this facility during our inspection. One parent, who was attending the department with their child, stated that the children's designated area was a major improvement on the previous facilities.

Staff we spoke with were satisfied with the equipment provided to them, and told us they were supported by their managers to obtain additional equipment when needed.

We spent time, and made observations, in the children's assessment unit. Children were referred to the

assessment unit by their GP, health visitor or emergency department, and some parents brought their child directly to the unit. We saw children were triaged by trained paediatric nurses, and medical assistance sought as appropriate.

The trust employed five play specialists, who supported other departments, where children received care and treatment. For example, they worked in the outpatient and ED departments. The play specialists organised daily play and art activities on the wards, and we saw there was equipment and space available for this to happen. We also heard how the play specialists prepared children for, and helped to provide a distraction during, hospital procedures and tests.

A teacher was available on the wards during school hours to support children and young people with their education, particularly when they were admitted to hospital for long periods of time, or experienced frequent stays in hospital.

Multidisciplinary working and support

We spent time on the wards and other departments within the hospital which provided care and treatment to children. For example, theatre, recovery ward and critical care unit (CCU). We observed that the teams worked well together and communicated the needs of the child well. The outreach nurse from the CCU visited the paediatric high dependency unit (HDU) each day to liaise with staff regarding children's care needs, and to plan for any necessary transfer to the CCU.

The parent carer council for Cornwall provided information and support to families, to assist them to gain a knowledge and understanding of the services available to them. Parent carer council links were maintained by staff on the ward to support parents of children and young people who required care and treatment in the hospital.

The hospital had developed integrated care pathways with external organisations, particularly for children who had life-limiting or long-term conditions. We saw evidence which demonstrated care had been provided in other approved locations to prevent the child having to come into hospital.

Data provided to us prior to the inspection identified that the trust took part in national clinical audits and responded to the Department of Health appropriately. For example, the hospital was involved with the national child health programme, and the paediatric asthma audit managed by the British Thoracic Society. This showed a willingness to work collaboratively with national organisations.

Are services for children & young people caring?

Good

Compassion, dignity and empathy

Parents we spoke with made positive comments about the care their child received. They expressed satisfaction with the nursing and medical support received.

The ward environments were child-centred, with toys, books and games available for children and young people when they were in the hospital.

Parents who were with their babies in the neonatal unit told us they found the staff polite and helpful, and showed kindness and empathy to them and their babies. One person told us they trusted the staff implicitly to care for their baby when they left the unit to go home.

Involvement in care and decision-making

Parents told us they were consulted and informed about their child's care. We did not see any evidence of their involvement or access to the care plans, but parents we met said they did not see this as an issue.

Good

Services for children & young people

Staff were knowledgeable and competent about obtaining consent from children, young people and their representatives. Consent was obtained following the Fraser Guidelines, which are in place to ensure consent is obtained appropriately from children and young people.

Children we spoke with said they liked the staff, felt looked after and one young person said they had been given sufficient information before and after their operation. They had known what to expect and that all their questions had been answered to their satisfaction.

One patient and their mother we spoke with had not seen their care plan, and it was not at the bedside as others were. Two other parents confirmed they had not been shown or involved in the development of the care plan. This did not provide evidence of patients or their parents being fully involved in the planning of their care.

Trust and communication

We spoke with the parent of a child who was brought by ambulance to the assessment unit. The parent told us that, due to their child's medical condition, they had open access at any time to the assessment unit and/or ward. They said that, on previous admissions, the care had always been good and communication effective. The staff demonstrated good interactions with the parent and child.

Emotional support

We observed staff spoke respectfully to parents at all times, offered reassurance and showed empathy and understanding towards them. We were provided with positive feedback from parents and grandparents regarding the support they had received while their child or grandchild was receiving treatment.

We observed parents' were included in the consultants ward round on the neonatal unit, and were given the opportunity and time to ask questions, which were responded to appropriately. We spoke with four parents who were with their babies in the neonatal unit. All of the parents made positive comments regarding the support and care they received from the staff. We were told: "they are brilliant here. They keep us updated and informed about everything".

Are services for children & young people responsive to people's needs?
(for example, to feedback?)

Requires improvement

Meeting people's needs

Staff developed care plan documentation for each child admitted to the ward or assessment area. We reviewed a number of care plans, and found some had not been completed to identify the specific care needs for the child.

There was a separate paediatric emergency department; however, children were currently triaged by the main emergency department (ED) staff. This was due to the lack of triaged trained nurses currently employed. There were recruitment plans in progress, which would ensure there was a paediatric nurse rostered across any 24-hour period. The nurse would be available to both triage and provide treatment for children. The resuscitation room in the main ED department had a separate area, with appropriate equipment, to provide treatment for children who required resuscitation and suction. From information provided to us by the hospital, it was evident that not all staff who worked in the paediatric ED department had been provided with training to ensure they were competent in the resuscitation procedures for children. The paediatric department of ED was only opened the week of our announced inspection.

During one of the visits we noticed a child who had attended the ED department waiting with their parents for an X-ray. The child became distressed due to an adult in the same area who was disruptive. Staff called security, who arrived to attend to the disruptive patient. The incident was not reported back to the ED department. One senior staff member said that they felt the lack of a separate area for children in X-ray was a flaw in the new department. There was a separate children's service, but all patients used the same X-ray facilities, which could place children at risk.

The hospital identified an issue with their paper-based records system, in that there was no access to records held by other providers. Work has progressed towards installing an IT system that would allow a joint record for children who received care from partner organisations such as the Cornwall Partnership Foundation Trust. This would ensure that up-to-date information about the child's care was accessible to all providers.

The hospital had a 10-bed adolescent unit caring for children and young people between the ages of 11 and 16

years. This unit was part of the overall paediatric inpatient bed base and, in times of high activity, these beds could be occupied by younger children. Young people between the ages of 16 and 18 were often cared for in adult services; however, the young person could choose whether to be in a paediatric unit or adult ward, and this choice was accommodated by negotiation with the unit. There were no formal care pathways for young people aged 16 to 18, when transitioning into adult services. The exception to this was for young people with additional needs, or who had long-term complex care needs.

We received feedback from two parents who had spent time with their children on the ward before and after surgery. They confirmed there had been sufficient communication with them regarding their child's care needs, and that there had been no difference in the quality of care or the staffing levels at the weekend.

Parents expressed concerns to us about the car parking charges in operation, which proved expensive when they were staying with their child for potentially long periods of time. We also received comments about the provision of food in the hospital, in that there was no access to a hot meal after 14.30 hours. We saw the hospital restaurant was open later than this, which suggested parents had not been provided with sufficient information regarding services available to them.

Access to services

Children could be referred to or access the service as needed. Children with long-term or life-threatening conditions had open access to the ward and/or assessment unit. We saw that one parent had brought their child to the assessment ward having previously been an inpatient on many occasions. Staff responded positively to the child, and welcomed them and their parent into the unit.

We heard from parents and from staff that, at times, there was a long wait to see a doctor in the assessment unit. Examples included a five-hour wait to see a doctor and 'all day' to see a surgeon. However, staff clarified that, while waiting for medical consultation, the nursing staff carried out observations and monitoring of the child's condition. This allowed a full assessment to be made and, in some cases, prevented an overnight stay in hospital.

We received varied views from parents regarding the care and treatment that their child received in the A&E department. One parent we spoke with had brought their child, who was in pain, into the emergency department. They were given pain relief when initially triaged, but then had to wait 90 minutes to see a doctor. They were unhappy with this length of time as their child remained in a lot of pain. Another parent with a young child in the emergency department said the care was good and that pain relief had been given to the child promptly. Two parents who were with their child told us they were pleased with the doctor's approach to their child. This included showing the child their X-ray, and clearly explaining the process and procedures being carried out.

We received concerns that, once discharged from the neonatal unit, babies could not be re-admitted back to its care. We were told that should a baby require further care they would be re-admitted to the adult intensive care unit. Staff in the adult intensive care unit were clear about the processes involved and had received training in the care of babies and children. They had access to the national network policy for paediatric intensive care (PICU), and maintained contact with the Bristol Children's Hospital PICU when caring for children and babies needing intensive care.

Vulnerable patients and capacity

We talked with staff regarding the care provided to children and young people who experienced mental health issues. Staff told us the wards worked closely with the Child and Adolescent Mental Health Service (CAMHS), who were part of the Cornwall Partnership Foundation Trust. Daily telephone contact took place, and young people were reviewed regularly by CAMHS. Specific training had been provided to the ward staff by the CAMHS team to enable them to ensure the safety of vulnerable young people when admitted to the wards.

The children's wards had access to a learning disability specialist team during working hours five days a week. This team provided support, advice and guidance for staff when caring for children and young people with additional needs.

Leaving hospital

We saw staff in the neonatal unit worked closely with parents to ensure they had confidence in providing care to their children both in the unit and when going home. Records showed communication took place between the staff on the ward, external professionals and community staff, to ensure continuation of the care of the child when they were discharged.

Good

Services for children & young people

Learning from experiences, concerns and complaints

The views of parents, carers, children and young people had been sought from the hospital. Parts of the wards had been redecorated and we were told this had been in a direct response to the feedback from young people. Attention was being paid to the menu choices provided to children and young people, and they were included on the working party.

Staff at the hospital said there had been a limited response to the completion of patient surveys. The survey form had been redesigned, and was now brightly coloured, and in a child-friendly format. We spoke to two parents who were aware of the form, and one had completed a survey, and the other intended to do so.

The hospital provided information to us regarding action taken after a complaint had been made. We were assured learning took place, and were given an example of how care pathways had been reviewed and developed to reduce delays to the care and treatment children received.

Are services for children & young people well-led?

Good

Vision, strategy and risks

The neonatal unit was located close to the delivery and post natal wards to provide good access for parents whose babies require specific care. It had been acknowledged by the hospital that the environment required updating and expanding. We were told plans were being made to move the unit into a larger ward space.

Risks had been identified by the trust regarding patient information not always being available when required. Action had been taken to address this by ensuring appropriate secretarial support was available to produce records.

Staff told us they had access to policies and procedures to ensure they were informed of working practices required of them. We were told by staff that the hospital reviewed policies and procedures, and provided information on the intranet to ensure staff were aware of any changes.

Governance arrangements

Care plans were not consistent in the detail included in them. This had been identified as an issue. We met with the matron for children who told us work was ongoing to review the documentation across the paediatric unit to improve its quality and effectiveness.

The hospital had identified the environment within the neonatal unit required updating. Action had been taken to address this and plans were in place for the transfer of the unit to a new area. Staff told us they had been consulted in these decisions.

We found the waiting times in the paediatric assessment unit had been identified as an area of concern by the hospital. The situation was being monitored with a record held in the IT system. To minimise risk, a handover took place at 16.30 hours each day, at which time a consultant assessment took place if required.

Staff in the paediatric department had commenced a governance scheme known as 'the productive ward'. The aim of this was to improve ward processes and environments to help staff to spend more time on patient care. Information regarding the outcomes from the productive ward could be seen on display.

Leadership and culture

Hospital staff said the trust sought the views of staff when planning developments. We heard from senior staff that the trust was keen to work collaboratively with them and external organisations. We were told there were bi-monthly meetings, which were held to develop an integrated children's partnership with external organisations. For example, with the Cornwall Partnership Foundation Trust and commissioning services. Staff said the trust were supportive in this process.

We were told that recently there has been more involvement with the hospital trust's board of directors. Staff were confident any issues or concerns relating to children at the hospital were addressed at a senior level. The parent care council had been invited, and had presented to the board their findings from working with parents and carers of children and young people who used services.

Patient experiences and staff involvement and engagement

We saw feedback had been sought from children, young people and their families following treatment at the

hospital. Change had been effected following feedback, including the development of a child-friendly feedback form, and the redecoration of parts of the ward. The information returned in completed forms was collated at ward level. The hospital had recognised that this information needed to be looked at centrally, and the matron and quality team were reviewing this.

Learning, improvement, innovation and sustainability

Staff told us they felt supported by their managers, and training and development opportunities were available to them. We spoke to a student nurse who was working within the paediatric department, and they were positive regarding the support they were provided with during their placement. Junior doctors were positive in their comments to us regarding the support and opportunities provided to them.

Participation in national audits took place, and we were told by senior staff that learning was taken from the results of these, and improvements made to the care provided to children and young people. For example, action had been taken and was ongoing following the South West Specialist Commissioning Group (SWSCG) assessment of the neo natal unit.

We were told the hospital liaised closely with the Bristol Children's Hospital regarding the shared care of children to ensure they received a consistent service between the two hospitals as needed.

Good

End of life care

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

Information about the service

The hospital's end of life care service includes ward-based end of life care services and dedicated inpatient and outpatient chemotherapy and radiotherapy for symptom control and pain management. The hospital's specialist palliative care team members and extended hospital palliative care team (which includes occupational therapists and discharge liaison nurse) are able to provide advice and support 24 hours a day, seven days a week, because of established links with a local community hospice who provide out-of-hours support.

We visited eight wards where patients were receiving end of life care. We spoke with three patients and relatives, and a range of staff, including the board director for end of life care, end of life care lead, divisional nurse, radiotherapists, nurses and doctors, mortuary staff, bereavement office staff and a chaplain. We observed care and treatment being given to people, and looked at 10 care records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Patients received safe and effective end of life care. Their care needs were being met and the service worked effectively with community services throughout Cornwall when patients were transferred into their care. The care team worked Monday to Friday. Out-of-hours support was provided to hospital staff by the local community hospice. This enabled clinicians across the hospital to access expert palliative advice and support 24 hours a day.

Most patients and their families were positive about the care and support they received, and said they were treated with dignity and respect by all staff they encountered. Staff had appropriate training, and supported patients to be fully involved in their care and decisions. The end of life team was well-led, and staff were dedicated to improving standards of end of life care across the hospital as a core service rather than a 'specialty service'.

Good

End of life care

Are end of life care services safe?

Good

Systems, processes and practices

We saw there were teams of staff within the hospital that were involved in end of life care and included the palliative care team, discharge liaison nurses, occupational therapists, pastoral care team, the bereavement service, the end of life education facilitator and the complaints team. We were given examples of how they worked closely together to meet patient's physical and emotional needs.

The End of Life Care Group had developed an end of life strategy based on the Department of Health End of Life Strategy 2008, to be implemented trust-wide over the next three years. The strategy described standards for best practice in end of life care, and a key aim was to embed these standards in care throughout the hospital.

Monitoring safety and responding to risk

Complaints to the trust that had an element of end of life care involved in them were reported to the End of Life Care Lead Consultant and End of Life Group to establish how they could improve the services they offered.

Learning and improvement

The hospital looked for ways to improve and avoid errors by examining procedures. Staff told us, for example, of how they had identified the systems in the mortuary which could have allowed for the incorrect release of a body. New more robust systems had been developed and staff told us they were confident no errors could be made.

Infection prevention and control

Staff on the oncology ward followed strict infection control protocols, including the use of personal protective equipment, such as aprons and gloves. Side rooms were clearly identifiable, which ensured patients were not exposed to infection risks. In all areas where people received end of life care, we observed staff following guidance on hand hygiene.

Anticipation and planning

When present, Allow Natural Death Orders (ANDO) were clearly seen in patients' notes. We saw ten ANDO forms and of these, seven had been completed appropriately. Three did not detail any discussions with the patient or their family (as appropriate) about their wishes.

Are end of life care services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

The hospital had used the Department of Health guidance 'National Strategy for End of Life Care (2008)' to develop a trust-wide end of life strategy. The Department of Health recently asked all acute hospital trusts to review patients on end of life care pathways in response to the national independent review 'More Care, Less Pathway: A Review of the Liverpool Care Pathway (2013)'. The trust had phased out use of the Liverpool Care Pathway, and as part of their strategy had appointed an End of Life Education and Training Facilitator, This role included helping to implement new end of life care planning systems and 'prompts and guidance' across the hospital. Wards where end of life care was often being delivered were used as pilot sites.

A resource file with end of life care information was available on most wards and departments. In most cases, staff were able to show us where the file was kept, and told us they had used it on occasion. Some staff, and the End of Life Education and Training Facilitator, told us that some of the information was out of date.

Meeting people's needs

Care records showed pain relief, and nutrition and hydration were provided according to patients' assessed needs and these were regularly reviewed. Risk assessments for pressure ulcers, falls and nutrition were documented in care plans and patients' wishes for their end of life care were clearly documented.

Patients received effective support from members of the specialist palliative care team, who were able to offer support and advice throughout the hospital and the wider trust. The care team worked Monday to Friday.
Out-of-hours support was provided to hospital staff by the local community hospice. This enabled clinicians across the hospital to access expert palliative advice and support 24 hours a day.

The hospital provided dedicated beds/areas for children and teenagers that may need end of life care.

Good

End of life care

Performance, monitoring and improvement of outcomes

The National Bereavement Survey (2011) for the Cornwall and Isles of Scilly (CIoS) clinical commissioning area showed CIoS was performing in the top 20% nationally for 17 of the 26 quality indicators. The trust had positive results for treating people with respect and dignity, but needed to do more around help and support for families at the time of death. The hospital had an End of Life Care Group that aimed to produce a work plan that would include projects to gain feedback about end of life care. There was a Bereavement Patient Ambassador who helped to gain relevant feedback about patient and families experiences of end of life care and support. The End of Life Group had a system in place to track complaints, reported incidents, comments from people who had contacted the Patient Advice and Liaison Service (PALS), and compliments with an end of life component or theme. These were analysed, and any emerging themes used to improve and develop systems already in place; for example, improving fast track discharges into the community.

Multidisciplinary working and support

The specialist palliative care team members responded quickly to referrals throughout the hospital, and this ensured patients received an effective end of life care service. The trust had developed a strategy for end of life care that included links with community hospitals, community services such as district nurses, and the local hospices. This ensured patients had support wherever they were. Staff working on the wards and departments we visited were familiar with care plan documentation for recording end of life care. We saw examples of the documentation having being completed, and an example of documentation being prepared for an admission. There was a chaplaincy service for patients, families and carers, and a bereavement office to provide advice and support to bereaved families.

Staff, equipment and facilities

The specialist palliative care team members had specialist training and skills to support staff, patients and their families. Staff on the oncology wards/departments showed an advanced understanding of end of life care. The end of life care team provided specialist advice to staff when required. End of life training was available for staff, starting at induction, and across all departments. Junior doctors, however, did not have access to end of life care training, and were expected to get their information and support from more senior doctors and consultants.

The oncology wards and departments had a range of facilities. Patients we spoke with had nothing but praise for the facilities in place.

We were concerned that the bereavement office was on a thoroughfare from the mortuary, meaning that bereaved people could see staff in scrubs involved in post mortems. Access to the mortuary viewing area was difficult for people with mobility aids. We saw from the End of Life Group meeting minutes that the issues had been recognised, but no timescale was in place to make improvements.

Are end of life care services caring?

Good

Compassion, dignity and empathy

Most patients and their families had positive views about end of life care. A few patients and relatives contacted us to share their experiences of care, and they reported poor communication and lengthy waiting times for transport on occasions. We observed staff to be caring and professional, especially on the oncology haematology wards. Patients' and families wishes were recorded in care plans. There were records of regular multidisciplinary discussions in response to the changing needs of patients. Staff on the respiratory ward told us that the ward was sometimes noisy, and there were not enough suitable side room facilities to manage good end of life care.

Involvement in care and decision-making

Most families, who contacted us before, during and after our inspection, told us they were kept informed of changes to care, and staff were sensitive and considerate. They told us staff asked their opinions when the patient was no longer able to convey their wishes independently. One relative told us: "you couldn't wish for better staff", "you only have to ask and it is done". We saw letters and cards on the wards we visited expressing thanks for "exceptional" end of life care and for the time and patience staff had shown in "difficult times".

We looked at the recorded choices of patients in the medical unit around the end of their lives, and should they

Good

End of life care

wish to be allowed a natural death, or be resuscitated. We saw most of these forms were fully completed and reflected how these decisions had been made, and with whose input. This was particularly important for those patients who lacked mental capacity to make these decisions. Staff told us what happened should information not be available, and the process staff followed to ensure as much personal consent as possible was included. We were told by staff that significant time and work had been put into getting this part of the admission process correct, and in place to support people's safety and choices.

Emotional support

Patients and families were offered support by the staff looking after them, and by members of the specialist palliative care team. We saw positive interactions between patients and staff, and staff spending time answering patients' questions.

Trust and communication

The hospital had a Bereavement Patient Ambassador who met with patients and families to gain their feedback about the end of life services offered. The End of Life Group minutes showed the End of Life Care Lead Consultant was actively looking at ways to gain relevant feedback from people at a sensitive time.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Access to the specialist palliative care team was available across the hospital during working hours and the local hospice (who were not owned or run by Royal Cornwall Hospital Trust) provided support and advice out of hours, and at weekends. Staff on the wards we visited told us that the specialist palliative care team and chaplaincy services always responded promptly to referrals. We looked at one person's end of life care plan on the oncology ward, and saw a fast track discharge was being planned. The multidisciplinary team within the hospital and community were working hard to respond to the patient's wishes.

One of the oncology wards had suitable facilities for teenagers who were receiving end of life care and support.

Relatives of patients from the Isles of Scilly, who were receiving end of life care could be accommodated locally if they wished to stay with the patient, although no dedicated accommodation was provided at the hospital.

Bereavement information booklets were available in the Bereavement Office and other relevant areas of the hospital. These were written in English, and there were none available in other languages or formats, such as large print or easy-read formats. Interpreters were available and staff gave us examples of where interpreters had recently been used, both via a telephone and in person.

Access to services

People could access the Bereavement Office during office hours. We saw from the minutes of the End of Life Group the Bereavement Office facilities were under review, as there were issues about disabled access and the viewing room in the mortuary. We saw people who had mobility aids would have difficulty accessing the viewing area. We were told there was only a curtain separating the viewing area from the storage fridges and this could sometimes make the viewing area noisy for relatives. The mortuary team can be contacted at any time 24 hours a day and an appropriate time for viewing will be agreed with family members.

Vulnerable patients and capacity

There were systems in place to assess patients' capacity to make decisions. On one ward we visited we saw a best interest meeting had been arranged to ensure decisions about the care and treatment for the patient were not taken in isolation, but as part of a multidisciplinary team.

Staff we spoke to had an awareness of safeguarding procedures and vulnerable adults. They knew about the hospital safeguarding nurse, and how to contact them if they had concerns about a vulnerable person being abused.

Leaving hospital

The trust had a fast-track discharge process for patients who chose to return home and there were good working relationships with community teams. We saw from care plans that, where possible, patients, and families, were fully involved in planning the discharge home. The systems in place ensured patients were discharged safely with the right care and support.

Good

End of life care

Learning from experiences, concerns and complaints

The End of Life Care Group tracked any complaints/ incidents that had an end of life component. They were analysed, and any emerging themes were taken forward to establish how improvements could be made.

Staff on the wards we visited said that, following incidents of unexpected death, for example, the staff were offered counselling, supervision and reflection sessions. They said a debrief took place immediately following such events, to establish if there were any learning points to take forward.

Facilities

The wards/departments we visited had quiet rooms/areas for families, although the standard of these facilities varied. We were told, and saw, the facilities in the Sunrise Centre were excellent, and despite the cluttered and apparent untidiness of Lowen Ward, the patients said their care was "second to none".

Are end of life care services well-led?

Good

Governance arrangements

The end of life strategy aimed to use a range of measures, including national data collection and local governance audits. This was in order to measure and assess the progress of the strategy and improvements as a result of its implementation. The strategy was presented to the trust's Governance Committee in October 2013. It was then taken to a 'Listening into Action' event to hear views of clinical staff in December 2013. A revised final document was expected to be presented to the Governance Committee in January 2014.

Leadership and culture

The end of life and palliative care team included staff who were passionate and committed to providing a good service. We spoke with the trust board director for end of life care, who was committed to introducing the end of life strategy.

The staff involved with end of life care worked well together as part of a multidisciplinary team within the hospital and with community services. The End of Life Care Lead Consultant was working with all those involved in delivering end of life care and strategies. This was to ensure national standards of best practice were embedded throughout the hospital, and co-ordinated with patient care in the community or at home. Staff said the nursing and care staff, bereavement office staff, mortuary staff and the chaplaincy department all worked well together.

Managing quality and performance

End of life care was enthusiastically led by the End of Life Lead Consultant who worked to best practice standards. They used information from incidents, complaints and patient experiences to lead improvements across the hospital. The End of Life Care Group met on a quarterly basis to monitor progress against the end of life strategy. Membership of this group included clinicians, nursing champions, specialist nurses, bereavement and mortuary services, the pastoral care team, quality and safety representatives, and learning and development representatives. The Nurse Executive (sometimes known as Chief Nurse or Director of Nursing) was responsible for end of life care at trust board level.

Patient experiences and staff involvement and engagement

The End of Life Care Lead Consultant showed us that the end of life strategy had been developed using information from patients and families, national surveys and staff involvement at 'Listening into Action' events. It had also incorporated information from organisations such as Healthwatch Cornwall and the Isles of Scilly. This meant local difficulties, for example, with travel from the Isles of Scilly, could be recognised in the development of services.

Some staff reported that they felt, while psychological support was available to staff, it was not a routine service. Clinical nurse specialists had to offer the support as part of their day-to-day job, and found it created limitations to the time they could spend with patients.

Learning, improvement, innovation and sustainability

The End of Life Care Lead Consultant was motivated and committed to providing good end of life care throughout the hospital. With the End of Life Group, they had developed an end of life care strategy to be implemented over a three-year period. The strategy included pilot projects that would run during the implementation as part of the national 'Transforming End of Life in Acute Hospitals Programme'.

Good

Outpatients

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

Information about the service

The hospital provides a range of outpatient clinics with around 480,000 patients attending each year. Clinics take place across 36 locations throughout Cornwall and the Isles of Scilly. During this inspection we concentrated on outpatient services being run on the Royal Cornwall Hospital site only.

The hospital has a dedicated outpatients department, but also offers clinics near to inpatient specialty wards. Some patients are treated in self-contained units, such as dermatology and sexual health services. Some outpatient clinics have dedicated staff, and others are managed by staff from the associated inpatient wards.

We visited nine outpatient services in orthopaedic, ophthalmology, dermatology, fracture clinic, radiology and oncology. We spoke with 18 patients and 24 staff, including consultants, doctors, matrons, nurses, radiographers, healthcare assistants, booking and administration staff. We received one comment card from two patients with current and previous experience of a department. We observed care and treatment. We received comments from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

Patients received safe and effective care, and staff were caring. Staff demonstrated robust understanding of child safeguarding. While there were no paediatric trained staff in clinics that saw children in the general outpatient setting, the staff were able to get support from paediatric trained staff or the play therapist, where appropriate.

Patients were seen within two weeks for urgent appointments. However, some clinics we visited, such as the fracture clinic, were very busy, and patients waited a long time to be seen, with no information about how long they might have to wait. All the outpatient clinics were managed differently by departments, and information on quality and safety was fed into individual divisions, such as the surgical division or the medical division.

Patients told us that the mammography clinic and dermatology service were outstanding. The services were well managed at a clinical and service level. The hospital was committed to reducing waiting lists where issues had been identified. It had brought in extra resources to ensure patients were seen within national targets. The hospital had introduced a 'text reminder service' to try to reduce the number of non-attenders.

Hand-wash gel and hand-washing advice for people visiting the main outpatients department in the Trelawney building were not prominent enough.

Many patients mentioned difficulty with the car parking being expensive and too far away from the clinics. However ,car parking charges were similar to other hospitals in the peninsula, there was also a park and

Good

Outpatients

ride service available. The hospital car parks were situated close to the majority of outpatient clinics and pick up and drop off spaces were available at the front door locations. Staff told us that some people had to wait a long time for patient transport services to pick them up once they had attended their appointment.

Are outpatients services safe?

Good

Safety and performance

There were adequate numbers of staff available to meet patients' needs. Staff told us they thought the outpatients department was well staffed. We observed that patients with mobility problems were appropriately supported by staff from waiting rooms into private consultations. Staff knew what to do in the event of an emergency and we saw resuscitation equipment in some of the outpatient clinics we visited. All staff we spoke with told us they had regular adult and child protection training.

Learning and improvement

Any concerns or complaints that related to outpatients department clinics were bought to the attention of the Outpatient Improvement Group. Areas for improvement were discussed. The hospital health and safety team would be asked to assess the environment if it was felt that a patient's safety had been compromised. We did not have any specific examples where this had been the case.

Systems, processes and practices

Most outpatient clinics were wheelchair accessible. The fracture clinic was in a temporary setting, although staff told us they had been there for over 12 months. The setting made it difficult for staff to observe people at all times. The morning clinic saw people referred from the emergency department or via their GP.

We saw that consent for specific treatments was obtained; for example, for some dermatology procedures.

Monitoring safety and responding to risk

Staff knew how to use the online system for reporting incidents and accidents. The Outpatient Improvement Group met monthly. The group was tasked with exploring "pathway redesign and future direction for outpatients" and "where improvements can be made to future practice".

The outpatient clinics were clean. Hand hygiene gels were not readily available in all outpatient areas. Where they were available, we saw that they were used by staff and patients. In X-ray we saw that there was nowhere to put used gowns. They were sometimes left in the cubicle after use.

Good

Outpatients

Staff told us that the fracture clinic was hot, and they were conscious that this could make people feel unwell. This was a cause for concern, as patients in the waiting room were not in direct sight of the reception of clinic staff. We were told air conditioning units had been in place, but they had recently been removed for servicing and not replaced. Staff did not know when they were being returned to the department.

Anticipation and planning

The hospital used the trust outpatient booking team of 26 staff (based across three of the trust's sites). Some specialties, such as endoscopy and clinical imaging, booked their own clinics directly with patients. Patients were referred by their GP via the Referral Management Service (RMS). RMS staff booked patients into outpatient clinic appointments. This system allowed for outpatient booking staff to anticipate the needs of the service and book clinics accordingly.

Patient records

Medical records were available for patients attending clinics. Records were stored securely, but accessible to staff in the outpatient clinics.

Are outpatients services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Evidence-based guidance

The trust had an access policy designed to ensure patients waiting for treatment were managed in line with National Waiting List Guidance. The policy aimed to ensure patients were treated in a "timely and effective manner" and to support the achievement of 'referral to treatment targets' (RTT).

Performance, monitoring and improvement of outcomes

Hospital staff told us they had weekly RTT meetings to monitor access performance**.** This included waiting times for first appointments; choose and book performance; two week waits; and follow-up appointments.

Staff said the Performance Assurance Framework (PAF) for each of the divisions (such as surgery) monitored performance against measures, such as cancelled clinics and 'did not attend'.

Different grades of staff in different departments told us that regular audits were carried out and they had to complete documentation for the audits. The Audit Commission had looked at the competency framework for reception staff as a result work was undertaken on improving local induction, education and support for new reception staff.

Staff, equipment and facilities

Patients told us they felt they were allocated enough time with staff when they attended the outpatients departments. The booking team and staff working in the departments told us new patients had longer appointment times to allow for investigations to be ordered and treatment discussed.

Patients told us that the staff were skilled and knowledgeable. Staff told us that some staff specialised in certain areas, such as ophthalmology or dermatology, while others were more generic and rotated around general outpatients departments. Staff told us they felt supported by their peers and managers. They told us they had access to relevant training, and time to complete mandatory training.

Multidisciplinary working and support

During and after the inspection visit patients told us how pleased they were in general with the outpatient services offered by the hospital. One patient's relative told us their family member had "always received great care there (ophthalmology) and I can't praise them enough".

Staff in the various departments we visited said they worked well in their teams, felt well supported and had access to mandatory and role specific training.

Are outpatients services caring?

Good

Compassion, dignity and empathy

We spoke with 18 patients in nine different outpatients departments. Most people told us they were happy and satisfied with the service provided. One patient told us they visited the unit twice a year. They said they "never had to wait very long" and they always felt "respectfully treated". Another patient said they were "always seen on time. I am very happy with the service" and the "staff are caring".

Good

Outpatients

Involvement in care and decision-making

Patients told us they were involved in making decisions about their care. One person waiting for an X-ray knew why they were there, knew which department they were going to next, and knew of their potential treatment options.

Trust and communication

Hospital staff told us customer service was very important to them. To ensure good customer service, outpatient reception staff were enrolled on a customer care training programme. Up to two members of staff attended every six months. The focus was to ensure patients were kept informed of waiting times if clinics were running late. This was a theme picked up in the last National Outpatient Survey (2011) and confirmed by a pilot survey carried out by the general outpatients department (Trelawney) in early 2013.

Patients we spoke with told us they were not always informed of waiting times on arrival at outpatient clinics. None of the patients we spoke with had been waiting long, and they had no issues with waiting times. We did not see any waiting times displayed in the clinic areas we visited. Staff in the fracture clinic told us patients often had a long wait during the morning clinic, as they took referrals from the emergency department and GPs, and could be very busy. We did not see the names of the doctors and nurses managing the clinics in all outpatient areas we visited.

Emotional support

We observed staff to be sensitive and caring to patients attending the outpatient clinics. Staff from several outpatient clinics told us that when they were preparing for clinics, they would review the patients' notes. This would alert them to patients who might be anxious or may need time to adjust to bad news. They told us there were private rooms that could be used, and staff available to support people.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

The booking team and administration staff were responsible for processing appointments and monitoring the capacity of clinics.

The hospital was meeting the Department of Health standards of two weeks for urgent cancer referral waiting times.

The hospital's Information Services Department told us around 6% of people had to wait 10 or more days for an appointment in fracture clinic. There was one case of someone waiting over 110 days. The MRI scanner team told us they had reduced their waiting list time from six to four weeks. They told us they operated the scanner seven days a week for 12 hours a day. This meant that people who worked during the week should be able to attend for a scan at a time more suitable to them.

We were told there were digital X-ray facilities for patients on the Isles of Scilly. This meant patients could have their X-ray on the island and the results could be interpreted at the Royal Cornwall Hospital. Results and treatment options were then communicated back to the patient.

The booking team told us they tried to give patients travelling from the Isles of Scilly appointments that fitted in with transport to and from the Islands, so they did not have to stay on the mainland overnight.

Access to services

We saw in the X-ray department that the facility to show waiting times had not moved with them to their temporary accommodation. This meant waiting times could not be shown. Staff had to go to the waiting area periodically to tell patients how long they may have to wait.

In the dermatology unit we saw an old department that had been optimised by staff, so they used the space effectively and made it as comfortable as possible for patients. Also in dermatology, the senior staff were concerned about the waiting list, because a consultant had

Good

Outpatients

left and not yet been replaced. A number of nursing staff were continuing to have specialist training to provide nurse-led clinics. This was one step which was helpful in maintaining the capacity of the department.

Hospital staff said they were currently improving facilities for outpatients as part of the Clinical Site Development Plan (CSDP). We saw ophthalmology services, including outpatients, had already been upgraded. One patient told us, however, that since the ophthalmology department had moved, they were no longer able to make the next appointment as they left the clinic. They said this was not as efficient as it used to be. They now have to wait for a letter and call the service if the allocated appointment time is not suitable.

Vulnerable patients and capacity

We observed staff responding to the needs of patients, especially those who were vulnerable and needed specific support. Nursing and support staff escorted patients to diagnostic tests in some clinics.

Staff told us a learning disability assessment service had been introduced for patients who required support and assistance at their outpatient appointment.

Staff we spoke with were aware of The Mental Capacity Act 2005 and the steps that needed to be taken if a person did not have the mental capacity to give consent for an investigation or treatment.

There were nurse-led clinics for children in dermatology. Staff involved in these clinics all had level 3 child protection training. We were told that they could access the play therapist from paediatrics if it was necessary for a complicated appointment. We saw that there was a separate waiting area for children, with some toys available.

Leaving hospital

Following their appointments, we saw that patients were often given leaflets about their condition or tests they had undergone; also contact numbers if they had any worries; and information about how to access the results of their appointment, by either contacting their GP in due course, or waiting for another outpatient appointment.

Some patients and staff told us there was sometimes a long wait for patient transport services arriving to collect people following their appointments. This had changed following the move to a new provider of this service. We were told all issues of this nature were reported to senior managers, who in turn reported the issues to the local clinical commissioning group (CCG) who had arranged this new transport provider.

Learning from experiences, concerns and complaints

Following feedback from staff, the system used to report errors, incidences or near misses had been improved to provide staff with feedback about actions taken as a result of their reporting. A change of practice had been made; for example, following a reported incident. In this case, it was recognised that cardiology outpatient bookings needed to be made integral to the cardiology department, and not done by the central booking team. This was due to the complex cardiology treatment. This allowed for better co-ordination of all aspects of a patient's care while under the cardiology team.

Any complaints or issues raised with the Patient Advice and Liaison Service (PALS) that had an outpatient's element to them, were discussed at the Outpatient Improvement Group. This identified if any changes of practice needed to be implemented as a response.

Patient information

Patient information leaflets were available in all outpatient clinics. We did not see any leaflets in a language other than English. We saw that, in ophthalmology, large print information was available to patients.

Are outpatients services well-led?

Good

Vision, strategy and risks

Staff told us the Outpatient Improvement Group met monthly, and explored the future direction for outpatient services, and where efficiencies and improvements could be made.

Staff told us they could not observe people who may be unwell, and children and adults were in the same waiting room. While there had not been any issues, they were concerned something untoward could occur.

Governance arrangements

Through the trust internal governance systems, the hospital had, in 2013, identified that the cardiology waiting

list was too long. Not all patients had had their follow-up appointments within the required timescales. In response, the hospital bought in extra staff, arranged extra clinic time and space, and have reduced the waiting list significantly. Patients are now seen within accepted timeframes. Analysis was underway as to whether patients who waited too long had suffered poor outcomes as a result. The hospital had worked with the local clinical commissioning group (CCG) throughout this piece of work.

The hospital had identified that the ophthalmology waiting list was too long, and were working to reduce it. This included providing extra clinics at the hospital and in a number of community facilities.

The access policy (updated November 2013) we saw was comprehensive, and in line with National Waiting List Guidance. We saw outpatient performance against the targets was monitored at the weekly referral to treatment (RTT) meetings.

Record keeping audits identified that storage for health records was insufficient. As a result, the hospital had secured additional off-site space to store records, which has begun to alleviate storage difficulties.

Leadership and culture

There was good clinical leadership visible in the outpatients departments we visited. The staff we spoke with were passionate and proud of the services they ran. Senior clinicians were present in outpatient clinics, and were knowledgeable and supportive to patients and staff. The outpatient clinics ran from a variety of areas within the hospital. Staff we spoke to generally knew from their managers how their particular clinic was moving forward, if there were waiting list issues, or any access issues.

Patient experiences and staff involvement and engagement

To gather patient views, the hospital told us they used the results of the National Outpatient Survey (which was generally positive in 2011, with a response rate of 63%); the pilot survey in the main outpatients department in early 2013; Patient Advice and Liaison Service (PALS) engagements; and complaints that have an element about the outpatient experience. They also used feedback on environmental issues collected by Patient-Led Assessments of the Care Environment (PLACE), in which the Royal Cornwall Hospital scored well in 2013.

Staff in all departments we spoke with said they felt supported by their peers and line managers. Not all staff knew the executive team and felt they were not always valued by them.

Staff in the fracture clinic knew their current clinic setting was temporary, but did not know when they would be moving to a more suitable setting.

Learning, improvement, innovation and sustainability

Hospital staff told us they had a number of 'key learning points' from complaints and comments in 2013. This included managing patients who told them they had not had appointment letters, by the introduction of a text and telephone reminder service. This was advertised with a recent publicity campaign, a project manager, and a small team of staff to ring patients during the evenings and weekends to remind them of their appointments. The new systems were primarily started to reduce the 'did not attend' rates, but would also hope to capture patients who had not had a letter in the first instance. The RTT meetings had discussed cancelled clinics, and monitored how people were contacted if a clinic had been cancelled. New seating and signage had been put in place in the main outpatient area, following patient feedback as part of PLACE.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	The provider had not ensured that patients were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of accurate records in respect of each patients care and treatment on some inpatient wards. This is a breach of Regulation 20(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider had failed to ensure patient records were kept securely at all times. This is a breach of Regulation 20(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. **How the regulation was not being met:** Patient records on Tolgus and the Trauma wards were incomplete in relation to recent observational rounds. There was conflicting and missing information in patient records in relation to pressure-ulcer assessment and management, and in care plan records or nursing notes. On Phoenix ward and Wheal Agar ward risk assessments, monitoring records and care plans were not all fully completed and were not explicit in how risks were to be managed and care was to be provided. This placed patients at risk of not receiving the care they needed. Patient records on the Surgical Admissions Lounge, the Frailty Assessment Unit, Wheal Fortune, Wheal Rose, Fistral, Polkerris and the Neonatal Unit were stored in areas that were not secured and at times were unattended by staff.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury	The provider had not ensured that patients were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of accurate records in respect of each patients care and treatment on some inpatient wards. This is a breach of Regulation 20(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider had failed to ensure patient records were kept securely at all times. This is a breach of Regulation 20(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. **How the regulation was not being met:** Patient records on Tolgus and the Trauma wards were incomplete in relation to recent observational rounds. There was conflicting and missing information in patient records in relation to pressure-ulcer assessment and management, and in care plan records or nursing notes. On Phoenix ward and Wheal Agar ward risk assessments, monitoring records and care plans were not all fully completed and were not explicit in how risks were to be managed and care was to be provided. This placed patients at risk of not receiving the care they needed. Patient records on the Surgical Admissions Lounge, the Frailty Assessment Unit, Wheal Fortune, Wheal Rose, Fistral, Polkerris and the Neonatal Unit were stored in areas that were not secured and at times were unattended by staff.

Regulated activity	Regulation
Treatment of disease, disorder or injury	The provider had failed at times to plan and deliver care to patients needing emergency care, surgical procedures and intensive care to meet their needs and ensure their welfare and safety. This is a breach of Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Compliance actions

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

Regulated activity	Regulation
Diagnostic and screening procedures	The provider had failed at times to plan and deliver care to patients needing emergency care, surgical procedures and intensive care to meet their needs and ensure their welfare and safety. This is a breach of Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. **How the regulation was not being met:** Too many operations were being cancelled or delayed due to a shortage of ward beds. Patients were not always being discharged or admitted to critical care in a timely way due to a lack of available beds in other areas of the hospital meaning patients were not discharged from a critical care bed in good time. Some patients were not getting enough time in critical care due the pressure to release bed space. Operations were starting late as patients were not able to meet their theatre team at the optimum time to gain consent and to ensure the surgical

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Compliance actions

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Regulated activity	Regulation
Surgical procedures	The provider had failed at times to plan and deliver care to patients needing emergency care, surgical procedures and intensive care to meet their needs and ensure their welfare and safety. This is a breach of Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. **How the regulation was not being met:** Too many operations were being cancelled or delayed due to a shortage of ward beds. Patients were not always being discharged or admitted to critical care in a timely way due to a lack of available beds in other areas of the hospital meaning patients were not discharged from a critical care bed in good time. Some patients were not getting enough time in critical care due the pressure to release bed space. Operations were starting late as patients were not able to meet their theatre team at the optimum time to gain consent and to ensure the surgical lists were on time. This was due to some admission wards not having enough space to carry out these confidential conversations. Theatre equipment was sometimes in the wrong place, delaying the start of some operations. Some patients were spending too long in the recovery wards or moving to other areas at the hospital to recover which may have compromised their safety. The accident and emergency department were regularly missing waiting-time targets due to the lack of available beds to discharge people effectively.