Care Quality Commission

Royal Cornwall Hospitals NHS Trust

West Cornwall Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at West Cornwall Hospital

Inspected but not rated

Royal Cornwall Hospitals NHS Trust provides acute hospital services from West Cornwall Hospital, Royal Cornwall Hospital, St Michael's Hospital and St Austell Hospital. The trust employs approximately 8,000 staff.

We carried out an unannounced focused inspection of West Cornwall Hospital's urgent treatment centre on 8 and 9 March 2022.

As this was a focused inspection at West Cornwall urgent treatment centre, we only inspected parts of five our key questions. We inspected parts of safe, responsive, caring and well led using our focused inspection framework. We did not inspect effective at this visit but would have reported any areas of concern. We did not rate the service as part of this inspection.

This inspection was carried out to evaluate how the organisation was responding to patient's needs; we had not inspected the urgent treatment centre since September 2018. The urgent treatment centre was previously rated as good overall.

We looked at the experience for patients using urgent and emergency care services at West Cornwall.

A summary of CQC findings on urgent and emergency care services in Cornwall.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Cornwall below:

Cornwall

The health and care system in this area is under extreme pressure and struggling to meet people's needs in a safe and timely way. We have identified a high level of risk to people's health when trying to access urgent and emergency care in Cornwall. Provision of urgent and emergency care in Cornwall is supported by services, stakeholders, commissioners and the local authority and stakeholders were aware of the challenges across Cornwall; however, performance has remained poor, and people are unable to access the right urgent and emergency care, in the right place, at the right time.

We found significant delays to people's treatment across primary care, urgent care, 999 and acute services which put people at risk of harm. Staff reported feeling very tired due to the on-going pressures which were exacerbated by high levels of staff sickness and staff leaving health and social care. All sectors were struggling to recruit to vacant posts. We found a particularly high level of staff absence across social care resulting in long delays for people waiting to leave hospital to receive social care either in their own home or in a care setting.

Our findings

GP practices reported concerns about the availability of urgent and emergency responses, often resulting in significant delays in 999 responses for patients who were seriously unwell and GPs needing to provide emergency treatment or extended care whilst waiting for an ambulance. GPs also reported a lack of capacity in mental health services which resulted in people's needs not being appropriately met, as well as a shortage of District Nurses in Cornwall.

A lack of dental and mental health support also presented significant challenges to the NHS111 service who were actively managing their own performance but needed additional resources available in the community to avoid signposting people to acute services. The NHS111 service in Cornwall worked to deliver timely access to people in this area, whilst performance was below national targets it was better than other areas in England.

Urgent care services were available in the community, including urgent treatment centres and minor illness and injury units and these services were promoted across Cornwall. These services adapted where possible to the change in pressures across Cornwall. When services experienced staffing issues, some units would be closed. When a decision was made to close a minor injury unit (MIU) the trust diverted patients to the nearest alternative MIU and updated the systems directory of services to reflect this. However, this carried a potential risk of increased waiting times in other minor injury units and of more people attending emergency departments to access treatment. This had been highlighted on the trust's risk register.

Due to the increased pressures in health and social care across Cornwall, we found some patients presented or were taken to urgent care services who were acutely unwell or who required dental or mental health care which wasn't available elsewhere. Staff working in these services treated those patients to the best of their ability; however, patients were not always receiving the right care in the right place.

Delays in ambulance response times in Cornwall are extremely concerning and pose a high level of risk to patient safety. Ambulance handover delays at hospitals in the region were some of the highest recorded in England. This resulted in people being treated in the ambulances outside of the hospital, it also meant a significant reduction in the number of ambulances available to respond to 999 calls. These delays impacted on the safe care and treatment people received and posed a high risk to people awaiting a 999 response. At the time of our inspection, the ambulance service in Cornwall escalated safety concerns to NHS England and NHS Improvement.

Staff working in the ambulance service reported significant difficulties in accessing alternative pathways to Emergency Departments (ED). When trying to access acute assessment units, staff reported being bounced back and forth between services and resorting to ED as they were unable to get their patient accepted. Many other alternative pathways were only available in specific geographical areas and within specific times, making it challenging for front line ambulance crews to know what services they could access and when. In addition, ambulance staff were not always empowered to make referrals to alternative services. The complexity of these pathways often resulted in patients being conveyed to the ED.

Hospital wards were frequently being adapted to meet changes in demand and due to the impact of COVID-19. There was a significant number of people who were medically fit for discharge but remaining in the hospital impacting on the care delivered to other patients. The hospital had created additional space to accommodate patients who were fit for discharge but were awaiting care packages in the community; however, staff were stretched to care for these patients.

Our findings

Delays in discharge from acute medical care impacted on patient flow across urgent and emergency care pathways. This also resulted in delays in handovers from ambulance crews, prolonged waits and overcrowding in the Emergency Department due to the lack of bed capacity. We found that care and treatment was not always provided in the ED in a timely way due to overcrowding, staffing issues and additional pressure on those working in the department. These delays in care and treatment put people at risk of harm.

In response to COVID-19, community assessment and treatment units (CATUs) had been established in Cornwall. These wards were designed to support patient flow, avoid admission into acute hospitals and provide timely diagnostic tests and assessments. However, these wards were full and unable to admit patients and experienced delayed discharges due to a lack of onward care provision in the community.

Community nursing teams had been recently established to support admissions avoidance and improved discharge. This work spanned across health and social care; however, at the time of our inspections it was in its infancy so we could not assess the impact.

The reasons for delayed discharge are complex and we found that discharge processes should be improved to prevent delays where possible. However, we recognise that patient flow across the Urgent and Emergency Care pathway in Cornwall is significantly impacted on by a shortage of staffed capacity in social care services. Staff shortages in social care across Cornwall, especially for nursing staff, are some of the highest seen in England. This staffing crisis is resulting in a shortage of domiciliary care packages and care home capacity meaning many people cannot be safely discharged from hospital. A care hotel has been established in Cornwall providing very short-term care for people with very low levels of care needs; this is working well for those who meet the criteria for staying in the hotel, however this is a relatively small number of people.

Without significant improvement in patient flow and better collaborative working between health and social care, it is unlikely that patient safety and performance across urgent and emergency care will improve. Whilst we have seen some pilots and community services adapted to meet changes in demand, additional focus on health promotion and preventative healthcare is needed to support people to manage their own health needs. People trying to access urgent and emergency care in Cornwall experience significant challenges and delays and do not always receive timely, appropriate care to meet their needs and people are at increased risk of harm

Summary of CQC findings on services at West Cornwall Hospital.

- The service mostly had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse and acted on any concerns. Patients had an assessment of their infection risk and other clinical risks on arrival at the centre and were treated according to their priority of need. Clinical areas were visibly clean and staff managed safety well.
- Staff were empathetic and caring when treating patients and demonstrated an understanding of how patients may be feeling when receiving treatment. Patients felt informed of their treatment choices and praised staff for care they received. Staff worked together as a team to benefit patients. They supported each other to provide good care. Key services were available seven days a week to support timely patient care.
- The service planned care to meet the needs of local people, including times of extreme capacity pressures to help staff provide safe care and treatment for patients. Staff worked hard to meet individual needs of patients and made co-ordinated care with other services and providers.

Our findings

- Leaders managed the service well and used reliable systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They were focused on needs of patients receiving care. Staff were clear about their roles and felt supported by local and trust-wide managers.
- Local managers demonstrated the skills and abilities to run the services. They understood and managed the risks and issues the services faced. Level of capacity pressure for the service was communicated to executive leaders and across the trust. They were supportive and caring for patients and staff.

However:

- There was a risk of patient needs not being met when the urgent treatment centre changed to a minor injuries and illness unit at 8pm each day. This was particularly concerning when acutely unwell patients were cared for overnight in the urgent treatment centre because there were no available ambulances to transfer them to the Royal Cornwall Hospital.
- There was a risk to patients when safeguarding concerns were not assessed and addressed on discharge. Staff did not consistently complete the adult safeguarding checklist prior to patient discharge.
- There were not always enough nursing staff to cover the planned rotas for each shift in the service. However, managers regularly reviewed staffing levels and skill mix to maintain patient safety as much as possible.

How we carried out the inspection

At West Cornwall Hospital, we spoke with nine patients and their families, eleven staff, including nursing, medical, administration staff and service leads. We observed care provided, reviewed relevant policies, documents and patient records.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Urgent and emergency services

Inspected but not rated

West Cornwall Hospital provides urgent treatment centre services for adults and children. It has two medical wards and an out of hours GP service within the hospital.

The urgent treatment centre operates between 9am and 10pm seven days a week. Between 10pm and 9am, the service operates as a minor injuries unit.

The centre provides urgent medical care for fractures, deep cuts, non-life-threatening head injuries and minor falls. Patients with more severe injuries are directed to attend the Royal Cornwall Hospital emergency department for treatment.

The average daily attendance at West Cornwall urgent treatment centre between September and December 2021 was 38 patients. An average of 91% of patients spent less than four hours in the urgent treatment centre.

There is no separate waiting area for children and adults, however a dedicated waiting area for children is not a requirement for urgent treatment centres.

Staff ask patients COVID-19 screening questions when they arrive at the urgent treatment centre and isolate patients appropriately if concerns are raised.

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff consistently completed the adult safeguarding checklist before patient discharge.

Staff had completed safeguarding training and were confident when discussing the action to take to ensure patients' safety and demonstrated awareness of different types of abuse including female genital mutilation and how to escalate this. The safeguarding policies provide detailed guidance for staff to identify safeguarding concerns across a wide range of scenarios and includes a separate policy for children's safeguarding supervision.

Receptionists completed a safeguarding checklist for adults and children during the booking-in process for clinical staff to continue during treatment. We found that the safeguarding checklist was not completed by clinical staff for two out of six adult patient records that we checked. The service was fully compliant with the children's records.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, not all staff were fully compliant with mandatory training.

All areas we visited were visibly clean and had suitable furnishings which were well-maintained. Chairs and flooring were wipeable and easy to clean. We did not find any dust or dirt in hard to reach places.

Urgent and emergency services

Managers audited staff compliance with infection control practices as part of a wider COVID-19 assurance framework. Staff compliance was reported to infection prevention and control specialists within the trust and actions needed were fed back to staff in the urgent treatment centre. Managers monitored and reviewed all areas of the urgent treatment centre each month and documented areas that needed more cleaning or repairs. This information was fed back to cleaning or maintenance staff for action. Staff cleaned equipment after patient contact. Rarely used equipment was labelled to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff being bare below elbows for more effective hand-washing and wearing surgical masks at all times. Staff wore disposable gloves and aprons when assisting patients with personal care. Hand hygiene audit results for September 2021 to February 2022 showed 100% staff compliance.

Staff screened patients for signs and symptoms of COVID-19 when they attended the urgent treatment centre. Patients brought in by ambulance were screened in the ambulance on route using a lateral flow device. If patients tested positive, the ambulance crew took patients straight to the Royal Cornwall Hospital.

Not all staff were up to date with infection prevention and control training. Records from February 2022 showed 100% compliance with Level 1 training but only 41.7% of medical staff were compliant with Level 2. Hospital managers told us that training compliance has been impacted by short term COVID-19 related staff absence and they had developed a plan to achieve 95% compliance by August 2022.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, communication to patients about the level of treatment available at different times could be improved.

The design of the environment followed national guidance for safety. Each cubicle had a privacy curtain with call bells available throughout.

The unit did not have a designated waiting area for children, however this is not a legal requirement for urgent treatment centres. Children were accompanied by an adult and prioritised for triage by clinical staff.

Staff had enough suitable equipment to help them safely care for patients. Staff consistently carried out daily safety checks of specialist equipment. The resuscitation area was equipped with the correct equipment and was regularly reviewed. Staff had access to emergency resuscitation trolleys for adults and children and knew where the nearest one was.

Staff disposed of clinical waste safely. Staff used separate and designated waste bins for general and clinical waste disposal and specific sharps disposal bucket for sharp instruments such as needles used for injections.

Hospital entrance signs advised patients that the urgent treatment centre was available 24 hours each day, however the entrance doors to the centre provided the correct operating hours of 9am and 8pm each day.

Urgent and emergency services

Assessing and responding to patient risk

Staff completed triage assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration, however they sometimes remained in the urgent treatment centre due to a lack of ambulances. Also, not all staff were compliant with basic life support training.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. This included tools to record vital observations and to assess for possible sepsis (severe reaction to an infection) for adults and children of different ages in accordance with national guidance. Early warning scores were used to monitor patients' vital observations. This information was logged and documented electronically to provide clinical oversight to senior clinicians.

Staff completed risk assessments for each patient on arrival using a recognised tool, and reviewed this regularly, including after any incident. Staff used an admission safety checklist in accordance with national guidance. This checklist prompted staff to complete and record observations and risk assessments hour by hour. These risk assessments included vital and neurological observations, signs of sepsis and pain as well as immediate investigations to ensure these were timely.

Staff received training in how to recognise signs and symptoms of sepsis. During the COVID-19 pandemic to alleviate pressures on NHS services and allow staff to prioritise clinical need, NHS trusts had received guidance that, as a temporary measure, audit data collections would not be mandatory.

Staff knew about and dealt with all specific risk issues. Care and treatment were provided in accordance with national clinical guidelines. Patient records were maintained electronically with access for trust-wide colleagues and local GPs.

Staff had access to guidance, policies and procedures about treatment pathways for patients presenting with different health conditions.

The service did not have an on-site mental health liaison team. Staff had 24-hour access to mental health support from colleagues at Royal Cornwall Hospital. Ambulance transfers for patients with mental health concerns were streamed directly to Royal Cornwall Hospital. Walk-in patients were discussed with clinicians and transferred to Royal Cornwall Hospital where necessary.

Shift changes and handovers included all necessary key information to keep patients safe. Nursing and medical staff attended handovers when they first commenced their shift. We observed a doctor to nursing staff handover which was clear and included relevant information and discussion about patient treatment.

Not all staff were up to date with basic life support training. Records from February 2022 showed 33% compliance for medical staff and 80% compliance for other clinical staff (including nurses) with Level 2 paediatric life support training and 63% compliance with Level 2 adult basic life support training. Hospital managers told us that training compliance has been impacted by short term COVID-19 related staff absence and they had developed a plan to achieve 95% compliance by August 2022.

Nurse staffing

The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift.

Urgent and emergency services

The service did not always have enough nursing and support staff to keep people safe. Bank and agency staff were often needed to provide patient care. Data provided by the service showed an average of 93% nurses hours were filled and 83% of health care assistant hours were filled between mid-December 2021 and early March 2022.

Data provided showed a current nursing vacancy rate of 15% in February 2022, reduced from 18% in December 2021 and January 2022. Managers demonstrated awareness of this and provided support to staff.

Staff raised concerns about clinical safety of the unit overnight due to looking after patients who were too unwell to be treated at a minor injuries unit. However, they told us that they received support from clinical colleagues at Royal Cornwall Hospital. Staff and managers said that a twilight shift between 12pm to 8pm has been introduced to increase staffing levels and an additional healthcare assistant has been introduced to provide overnight support.

Managers informed us that staffing was monitored daily to ensure safety of patients and officially reviewed as part of regular hospital-wide performance evaluation.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly review staffing levels and actively requested locum staff to provide cover.

Medical staff were employed to work at the service between 9am and 10pm. Data showed 100% cover between mid-December 2021 and early February 2022, only four shifts were not covered between mid-February and mid-March 2022.

Clinical oversight was provided by a doctor until 10pm. This was two hours after the urgent treatment centre closed at 8pm and was designed to support the transition to operating as a minor injuries and illness unit. However, this time was not always adequate to see all waiting patients and medical staff said they stayed beyond their shift if required. After 10pm the emergency nurse practitioner would need to contact Royal Cornwall Hospital for advice if required.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Children who needed urgent care were directed to Royal Cornwall Hospital where there was a 24 hour paediatric urgent and emergency care service.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We saw staff interactions were respectful and kind between each other and with patients and families. Staff used curtains for privacy and lowered their voices so as not to be overheard. A separate room was available for families who received distressing news or needed a greater level of privacy.

Urgent and emergency services

Patients said staff treated them with kindness and were happy with the level of care they received. Patients valued the care provided and how welcoming staff were.

Staff expressed and demonstrated how they kept patients at the centre of care they provided. Staff understood and respected the individual needs of each patient. They showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs and liaised with to the mental health liaison team when needed. We observed staff explaining treatment with kindness and compassion.

Reception staff provided compassionate support to patients' relatives while staff provided immediate clinical treatment at the time it was needed.

Staff considered patient comfort and offered food, fluids and pain relief when they needed it. Staff showed understanding of how patients might be feeling and explained treatment in different ways to ensure understanding. Every patient we spoke with knew the next stage of their treatment plan and were very happy with the level of care they had received. Results from a patient survey in 2020 demonstrated 98% of patients felt treated with respect and dignity and were listened to by staff at the urgent treatment centre.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Is the service responsive?

Inspected but not rated

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. However, patients did not always receive the right care promptly due to ambulance transfer delays.

Managers monitored waiting times and adapted services to support patients' access to emergency services. Data provided showed that 89% of patients were treated within four hours in February 2022. Management anticipated potential increased demand on the service and provided extra staffing during bank holiday and school holidays.

The service did not have any ambulances queuing outside during our inspection. Staff said they received phone calls from ambulance crews to discuss if the urgent care centre could meet the patients' needs and triaged quickly upon arrival.

Staff completed efficient initial assessments for patients who attended the urgent treatment centre. Out of the four patient records that we reviewed, three were triaged within a few minutes of arrival and the other patient was triaged within thirty minutes.

Management attended trust-wide bed management meetings several times each day to discuss flow throughout the hospital and wider trust. Hospital management team facilitated their own hospital flow and released beds to Royal Cornwall Hospital where appropriate.

Urgent and emergency services

Managers and staff worked hard to make sure patients did not stay longer than they needed to. Four hour performance data confirmed it was not always possible to transfer more acutely unwell patients to Royal Cornwall Hospital in a timely manner. Data provided by the trust confirmed that patients waited for an average of seven hours for an ambulance transfer to Royal Cornwall Hospital. Managers told us that this was their highest item on their risk register and staff said they received effective support from clinical colleagues at Royal Cornwall Hospital.

Staff told us that some acutely unwell patients had remained at West Cornwall Hospital when they should have been transferred to Royal Cornwall Hospital for treatment due to ambulance delays. Data provided following our inspection confirmed there were 33 incidents raised from 1 April 2021 until 11 April 2022 due to lack of ambulance availability. This placed the nurse in charge under extreme pressure and there was an increased risk of patient harm. However, local management were aware of this risk. It was their highest item on their risk register and they had taken steps to address this by providing increased staffing.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership of the urgent treatment centre comprised of two clinical leads (managers), a general manager and a matron who covered West Cornwall Hospital and St Michael's Hospital. Each of the leaders had a defined role between the hospitals.

West Cornwall Hospital's leadership team were committed to safe patient care and supporting their staff. They demonstrated to us they had the skills and abilities to run the service, particularly in such a challenging environment in which to provide safe and quality care and treatment. They clearly articulated the challenges within the urgent treatment centre, as well as celebrating the successes they had achieved.

The service did not have on-site mental health facility. However, ambulances took patients with mental health conditions were streamed/directed to Royal Cornwall Hospital and walk-in patients were provided with telephone support and advised to attend Royal Cornwall Hospital if additional support was required.

We observed effective leadership in the urgent treatment centre on the day we inspected. Clinical decisions and shift handover were discussed as a team with inclusive discussions from health care assistant to doctor. The hospital manager and matron provide out of hours support to staff in addition to on-call manager facility from the trust.

The duty doctor and emergency nurse practitioner in charge provided good leadership and retained oversight of demand and capacity in the urgent treatment centre.

Managers closely monitor staffing levels and demonstrated different recruitment exercises to support staff, including provision for new Band six nursing roles within the urgent treatment centre.

Urgent and emergency services

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, some staff have regularly finished late due to work demands and had not received regular appraisal and career development conversations.

Staff within the urgent treatment centre demonstrated strong and respectful working relationships between each other. Staff were very proud to work at the centre and in the wider organisation. Staff spoke of inclusive managers who listened to their ideas and provided support in addition to management support from the hospital trust.

Staff were encouraged to report incidents. Staff said that they would report high risk incidents but not always report lower risk incidents due to workload pressures. Staff said that they received briefing on serious incidents and were included in discussions about lessons learnt.

Managers and staff did not have any local specific wellbeing initiatives, all staff have access to trust-wide wellbeing tools. All staff have been given an extra day's annual leave to recognise their work during the COVID-19 pandemic.

Patients and their families could raise concerns, they were monitored by hospital managers and discussed at oversight meetings. The urgent treatment centre did not have any outstanding complaints at the time of our inspection. Data from a patient survey (2020), highlighted very positive results about the urgent treatment centre's culture.

The service had adopted the trust-wide duty of candour policy rather than having a dedicated policy of their own. Staff and managers showed a good understanding of this and the importance of being honest with patients and families when incidents occurred.

Some doctors told us they regularly finished late due to work pressures, other staff said that some doctors have resigned as a result. Local hospital management confirmed their awareness of this and actively planned recruitment to maintain patient safety.

Staff had not all received up to date appraisals from their managers. Data supplied from February 2022 reported that 50% of doctors and 81% of other clinical staff (including nurses) had received their yearly appraisal.

Management of risk, issues and performance

Leaders and teams mostly used systems to manage performance effectively, however this had not been completed recently. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff have access to a trust-wide quality improvement programme, however no current initiatives were being considered.

The most recent performance report was completed in October 2021 and related to August 2021 data and covered all departments within West Cornwall Hospital. This document analysed many aspects of performance and risk and actions to address any concerns. Overall appraisal compliance was reported as 62% against a target of 90%, with medical appraisal compliance recorded as only 35%, however this was an increase from 29%. Formal performance reviews had not been completed since September 2021 due to operational pressures.

Urgent and emergency services

There was an urgent treatment centre risk register and risks were reviewed and reported through an assurance report to the emergency care board. Management highlighted the risk of delayed treatment for overnight emergency patients at West Cornwall Hospital as their biggest risk.

Managers and staff felt the urgent treatment centre was a highly valuable resource, particularly considering its isolated location in Cornwall.

On-site security was provided by staff who undertook dual roles as porter and security staff. Security was provided 24 hours each day, seven days a week. Security staff said that police would attend if required. West Cornwall Hospital management used security video footage to identify people who had behaved violently and highlighted this to site security staff and receptionists.

Managers had initiated recruitment for an additional clinical team leader role to provide overnight support to urgent treatment centre nursing staff, a longer-term plan was being developed.

Local hospital management provided documentation about the trust-wide quality improvement scheme. One suggestion was submitted in December 2021, there were no current quality improvement ideas being considered for the urgent treatment centre.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust SHOULD take to improve:

West Cornwall Urgent Treatment Centre

- The service should explore ways to reduce risk of harm to acutely unwell patients who remain at West Cornwall Urgent Treatment Centre overnight.
- The service should improve compliance with safeguarding checklist before patients are discharged from the urgent treatment centre.
- The service should improve communication with trust-wide bed management colleagues to ensure consistency regarding potential patient discharges.
- The service should continue with recruitment to improve staffing levels for nurses and medical staff to full establishment.
- The service should improve compliance in adult and paediatric Level 2 basic life saving and infection and prevention control Level 2 training
- The service should encourage staff to submit quality improvement ideas to facilitate staff input to improve the service.
- The service should improve hospital signs to confirm availability of urgent treatment care services.
- The service should improve staff appraisal and career development compliance.

Our inspection team

The team that inspected the service comprised of one CQC inspection manager, one CQC inspector and one clinical specialist. The team was overseen by Catherine Campbell, Head of Hospital inspections.