



Royal Cornwall Hospitals NHS Trust

Progress following the Healthcare Commission's intervention report

March 2009

The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare. In this work, we collaborate closely with the Healthcare Inspectorate Wales, which is responsible for the NHS and independent healthcare in Wales.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health
- Be independent, fair and open in our decision-making, and consultative about our processes.

On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, will take over the Healthcare Commission's work in England. Healthcare Inspectorate Wales will become responsible for carrying out our activities relating to Wales.

Background

In April 2006, the trust's initial assessment against Department of Health core standards was that it was fully compliant for the year 2005/06. However, the trust initiated a review shortly afterwards, which led to the trust being identified as meeting just 25 of the 44 part of the core standards. A new chief executive was appointed in January 2007 and other key changes to the leadership followed, including an interim chair in June 2007. The new chief executive ordered a further review of the trust's compliance with the standards. This found that, for the year 2006/07, the trust could only confidently declare that it was compliant with 13 of the 44 parts of the standards.

This saw the trust being ranked as "weak" for quality of services for the second year running in the annual health check. It was also scored "weak" for its use of resources, partly due to an accumulated deficit that impacted on the financial standing of the organisation. There were also weaknesses in the trust's financial management, reporting and internal control systems, which meant that it was unable to demonstrate that it was providing services that were good value for money.

The purpose of the intervention was to ensure that, in the light of such poor compliance, services were safe, and to establish whether, in recognising the extent of the previous problems, the trust was now taking the necessary action to deal with them. Since the intervention visit, the trust's chief executive and also the acting director of nursing have been suspended, following the publication of a report on financial management and governance at their previous trust. Currently an interim chief executive and a further acting director of nursing are in post.

Methodology of the follow up visit

Members of the review team included staff from the Healthcare Commission and two independent experts, in infection control and governance respectively.

The follow up of the intervention involved:

- Reviewing documentation – prior to the follow-up visit, we requested a number of key documents from the trust to show the rate of progress against the recommendations of the intervention report.
- A follow-up visit to the trust in early December 2008, when we interviewed 47 members of staff; as well as representatives from the Cornwall and Isles of Scilly PCT, the maternity services liaison committee and the patients' forum, and revisited wards at both the main hospital and west Cornwall sites.

- Review of statistical information in relation to MRSA and *C.difficile* infection rates.
- Review of serious untoward incidents (SUIs) at the trust recorded between January 2007 and December 2008.

Findings

This update follows the order of the original recommendations published in our intervention report.

Maternity Services

Recommendation 1

The trust should urgently complete work necessary to bring the maternity services building to the required standards and should commit to a strategic plan to provide suitable alternative accommodation for these services. Urgent works must be complete by the end of April 2008 and the estates plan completed by December 2008.

The maternity unit (neo-natal, delivery suite and post natal units) has undergone a major refurbishment. Aside from essential works, the total internal fabric of the unit has been renewed and equipment replaced. The result is an improvement on the environmental challenges under which the maternity members of staff worked previously and the team noted an overall general satisfaction with the new environment.

The director of estates and facilities has started to produce an overall estates strategy for the hospital site that will include the relocation of the maternity unit and a mixture of new build and relocation of existing accommodation. This strategy gained board approval in June 2008. A significant determining factor in achieving the overall strategy will be the way in which the trust's substantial historic financial deficit is handled to avoid delays to necessary capital investment arising from the strategic plan.

Recommendation 2

The role of the maternity services liaison committee should be developed to ensure it discusses how local maternity services could be improved and make suggestions about areas for review and monitoring. The effectiveness of the committee should be reviewed in September 2008.

The maternity services liaison committee (MSLC) was re-launched in January 2009. The committee has strengthened ties with the PCT, coming under its auspices in January 2008. We found no evidence of a mission statement or terms of reference for this committee. There is also no website to publish and promote the work of the MSLC. Our view is that the MSLC chair would benefit from assistance from the PCT and the acute trust to develop terms of reference, a mission statement and a website.

The MSLC will be a key influence in the planning of the new maternity unit and we feel that the trust should encourage the involvement of the MSLC in this role. There are particular issues in relation to the integration of maternity

services across the remoter areas of Cornwall and this too is an area for the MSLC to address, given that it represents service users and individual user groups across the county.

Services for older people

Recommendation 3

The trust's board should implement their "Let's Respect" programme in relevant clinical areas throughout the trust and take further action by the end of October 2008 to promote the privacy and dignity of older people receiving care and treatment.

The "Lets Respect" programme started as a collaboration between several eldercare nurses at the trust looking after patients with dementia, stroke, learning difficulties and any other conditions that could inhibit communication. The spread of the programme has improved, but does not yet cover all wards at the trust. This is because no protected time was allocated to allow coverage on the wards when trainers were training. The trust has now committed to protected time to roll out the programme to the rest of the trust between January and March 2009.

The overall philosophy and practice of the "Lets Respect" programme has contributed to improvements in patient care for the elderly at the trust. Members of the patient advisory liaison services (PALS) team reported a significant drop in complaints relating to the care of older patients. Instead of complaints being received in themes, only individual complaints were being received in relation to older patients housed in wards that are not designated for older patients, for example the medical assessment unit, A&E or surgical wards. There has been a similar drop in complaints relating to ensuring the dignity of patients. The PALS team also reported that complaints relating to mixed sex wards were now less frequent and limited mainly to emergency admissions.

The management and control of infection

Recommendation 4

The trust's board must immediately assure itself that the trust has satisfactory arrangements in place to prevent and control infection, and review the arrangements in June 2008.

Recommendation 5

The trust should take further steps to ensure that, by August 2008, it has a substantive director of infection and control, who either has the expertise in infection control or has ready access to that expertise, and is accountable directly to the board, reporting to the chief executive.

Recommendation 6

The trust should review its arrangements in relation to the requirements of the hygiene code and consider whether the resources devoted to controlling infection are adequate in terms of the demand on the team. A business plan should be submitted to the trust's board for approval by the end of March 2008.

Progress has been made in relation to raising the profile of infection control, coupled with real improvements at ward level. Despite the suspension of the director of nursing who was also the trust's director of infection prevention and control (DIPC), the current interim DIPC has not only managed to maintain impetus with his high profile presence and availability to promote "ground floor work", but has also been able to continue the work begun on infection control policy and planning. It is noted by reference to the tables below that, while there has been some improvement, the measures taken so far have yet to bring healthcare-associated infection rates down to the same level for similar trusts.

We saw evidence in all the locations we visited of examples of good cleaning standards, good state of cleanliness of commodes, and evidence from cleaners that hygiene and cleaning are being carried out and audited on a very regular basis. An isolation ward has been set up for cases of *C.difficile* and there is a computerised system for prioritising the availability of side rooms across the trust to enable patients who need to be isolated to be located in available side rooms.

An external consultant and a consultant nurse have been brought in to assist in developing policies on hand washing, general infection control and antibiotic prescribing.

There are still challenges ahead. The infection control team is still not large enough for a trust of this size, lacking an infection control consultant and insufficient microbiologist cover. The absence of these posts is posing a threat to the team's overall ability to focus on key risk areas. A lack of sufficient personnel is causing problems of stress, including long-term sickness absence within the team. The infection data update shown below indicates that this lack of resource may still be a factor in below average performance by the trust in this area, despite the measures already taken. The trust still needs to ensure that the infection control team has sufficient capacity to address these challenges.

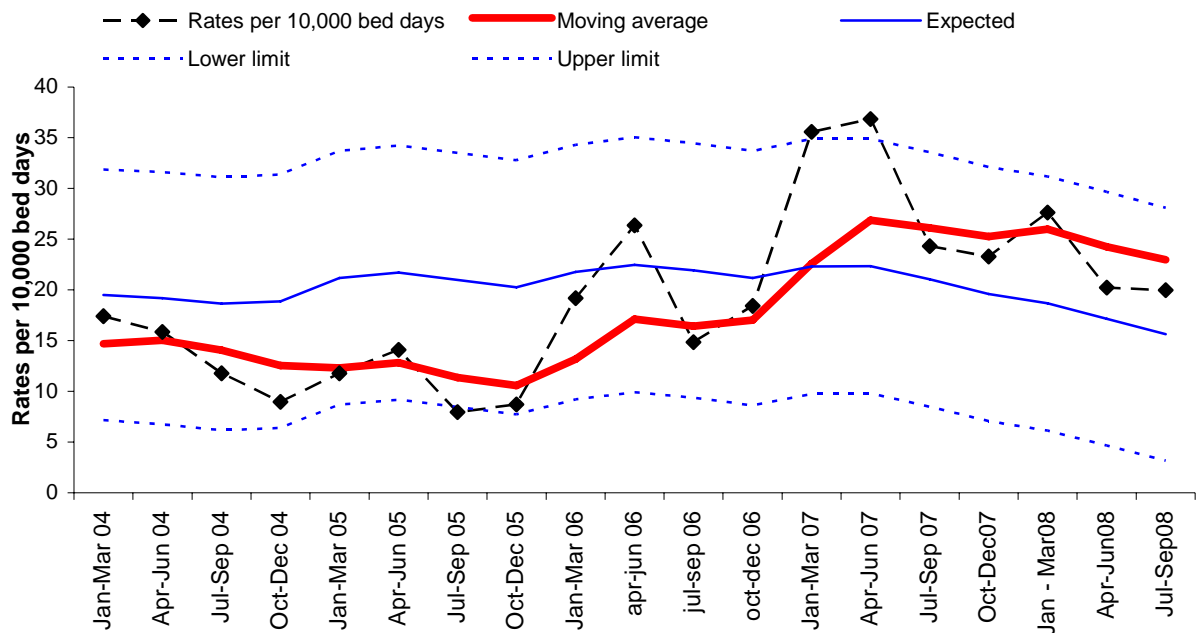
Infection data update – Royal Cornwall Hospitals NHS Trust – January 2009

Commentary for *Clostridium difficile*

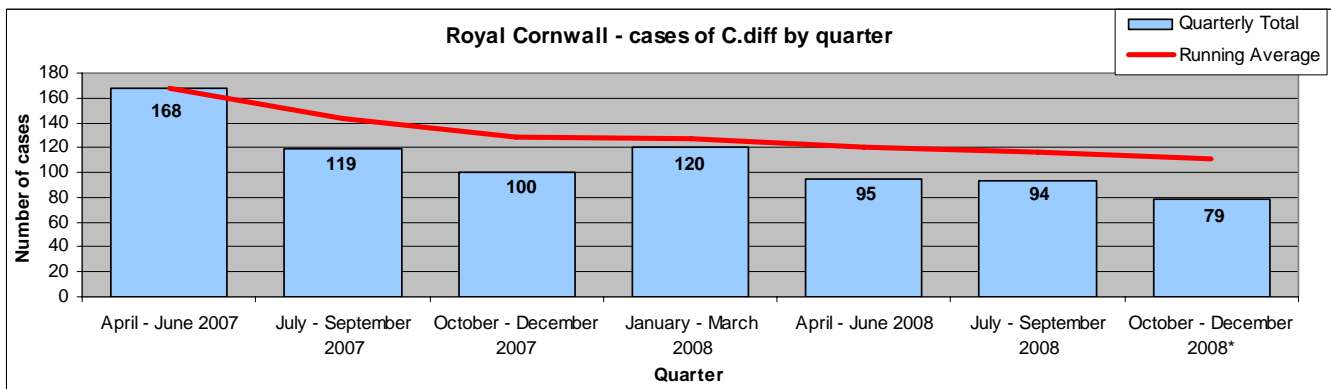
The trend data graph for *Clostridium difficile* (below) shows that, since April 2007, rates for the 65+ age group have shown an overall reduction. This is also supported by the 'amber' z-score for *C.difficile* relative to short-term trend, and the table and graph showing raw counts of *C.difficile* (for all ages) over the last seven quarters from April 2007 to December 2008. However, rates of *C.difficile*

for this trust are still above the average for similar trusts, and their rates have increased overall during the last 10 quarters from March 2006 to September 2008. This is further illustrated by the 'red' flagged z-score of +3.06, which indicates the extent that their rate has increased over the long-term compared to the national average trend for similar trusts, which has in fact reduced over the same period. The trust, in common with some other trusts, tends to show a peak in rates over the winter months, and there is some evidence in the graph to suggest that the extent of their winter peaks might be beginning to ease if January to March 2008 is compared with January to March 2007. However, although the trust are now reducing their rates and appear to have begun to move in the right direction, it is difficult to predict whether this trend will be maintained, particularly over the higher risk January to March 2009 period.

Trend data for *Clostridium difficile* for the 65+ age group
(EWMA= exponentially weighted moving average)



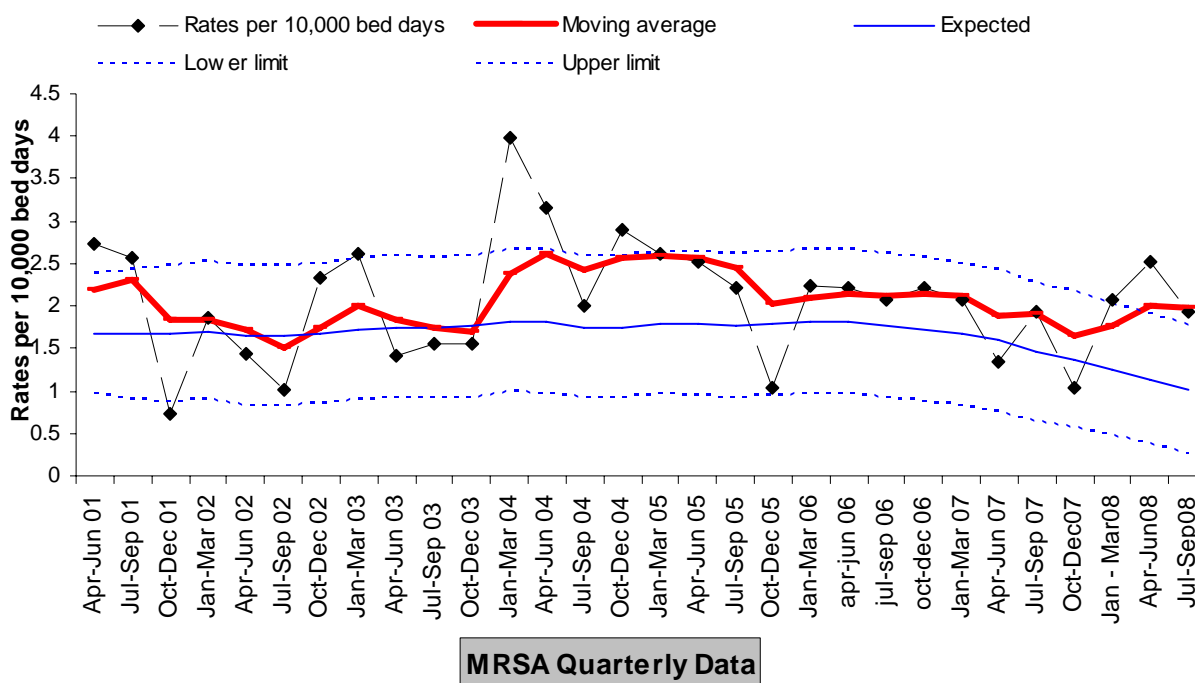
Clostridium difficile Quarterly Data



Commentary for MRSA bacteraemia

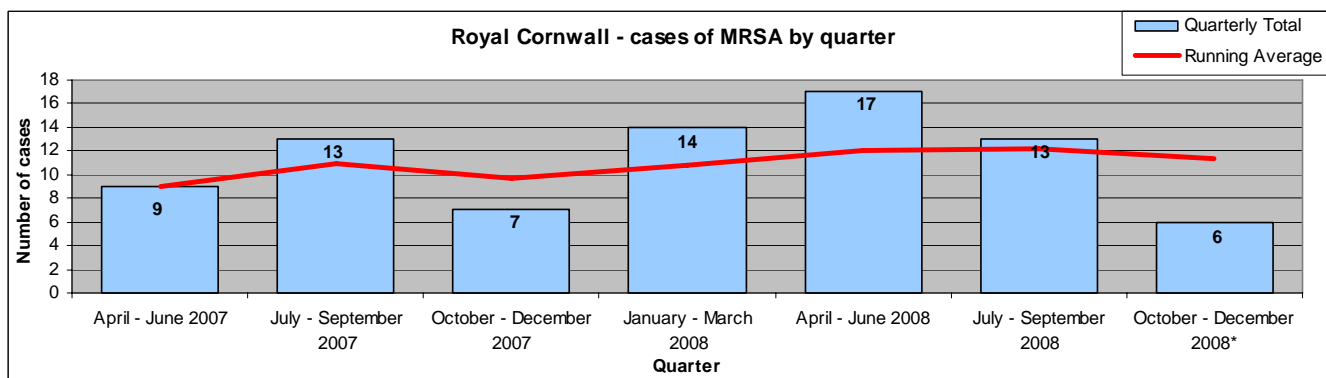
The trend data graph for MRSA bacteraemia (below) shows that rates for the last three verified quarters (January 2008 to September 2008) were high compared to the previous 10 quarters for this trust, and high compared to current national level for similar trusts, with a 'red' flagged z-score of +3.83. This peak in rates has put the trust above the 'upper expected limit' for similar trusts and this is further illustrated by the 'red' flagged z-score of +3.18 for MRSA relative to short-term trend. Rates over the long-term have also incurred a 'red' flagged z-score of +3.23 due to the moving average for the trust not reducing as quickly as for similar trusts over the last 10 quarters from March 2006 to September 2008.

Trend data for MRSA for all ages (EWMA= exponentially weighted moving average)



Source: Health Protection

Agency



Race equality

Recommendation 7

The trust's board should formally approve the latest version of the race equality scheme, with clear timescales for action agreed in the plan by the end of June 2008.

Recommendation 8

The trust should assess its current position in relation to compliance with race equality legislation and update the action plan within the race equality scheme to reflect this. The trust should then incorporate the action plan into its governance and assurance process, to ensure it appropriately monitors progress towards compliance with race equality legislation with the relevant core standards by the end of May 2008.

The trust race equality scheme was presented to the board in March 2008. The trust has reviewed the scheme and we were told that a draft of the new scheme was about to go to the trust strategic resources committee before submission for board approval. We were disappointed to note, that while some progress had been made, this has not been a key priority for the trust. The director of human resources provided assurance that the trust is currently looking to improve the situation by seeking to embed the race equality scheme within the culture of the organisation rather than just leaving it as a policy, and to this end the trust held an equality and diversity conference in November 2008. The trust has identified 20 members of staff to be trained as equality and diversity champions.

Language line and interpreters are available and being used by front line staff and the race and disability schemes are now part of mandatory training for new staff. We were also told that the trust has leaflets in relation to equality and diversity, and multi-language leaflets in maternity. The trust also takes part in a Cornwall-wide forum to promote equality issues.

Governance

Recommendation 9

The trust's board should ensure that plans in place are sufficient to ensure compliance with core standards and that it receives clear information about any lack of progress and action taken in response. In addition, action should be taken to promote awareness of the core standards among all staff. This action should be immediate and ongoing.

The interim chief executive has made the achievement of compliance with core standards one of three main objectives for the trust, along with infection control and financial performance. This follows the qualification by the Commission of five declarations of compliance by the trust against core standards in a follow up

visit undertaken as part of the 2008 annual health check. The executive team meets weekly to review each core standard in turn and to ensure that there is sufficient evidence against each one. In addition, the executive team intends to add governance committee meetings in the final quarter of the year to reinforce the compliance processes with a non-executive director view of assurance, as well as building in further external challenge via the PCT. They will also take part in an SHA-wide assurance programme with other trusts for sharing of knowledge.

There is an undoubted redoubling of efforts by senior managers within the trust to achieve core standard compliance. One member of staff, however, said that, while they felt core standards were about improving patient care and evidencing it, the evidence gathering still seemed to occur “at the last minute” and there was a growing recognition that evidence gathering was a continuous process.

Recommendation 10

The trust’s board should, in the light of this report, review the information presented to them to ensure that it is clear and accurate and enables the board to discharge its functions effectively. This action should be immediate and reviewed in October 2008.

We found evidence of an improvement in the provision of information for use in monitoring the performance of the trust and to engage in more meaningful planning of services. A daily dashboard of key indicators of performance based on quantitative targets is produced. In addition a monthly estates and facilities report goes to the trust’s board. There are also, for example, weekly reports to the executive team on the time from GP referral to treatment performance by clinical specialty as well as other performance indicators, such as A&E targets. This information is provided by the seven newly instituted clinical divisions (plus one non-clinical support division) of the trust via the director of service delivery to the executive team and trust’s board. The divisional teams are much greater in number but smaller, with a wider remit, and are an improvement over the previous structure of three general managers who were too thinly spread to ensure either the necessary improvements or the provision of adequate information to the board.

Following approval by the board, the trust has set itself the ambitious target of fully integrating clinical and corporate governance by April 2009. Each division has already begun to produce a quarterly governance report which is made up of elements including major incidents, levels of compliance with National Institute for Health and Clinical Excellence (NICE) guidance, complaints trends and clinical effectiveness. The first reports varied in terms of accuracy and completeness of information and these issues are being addressed individually by the assistant medical director (governance).

Other governance groups provide similar quarterly reports. These include infection control, research and development, PALS, informatics, finance and cleanliness. The interim chief executive assured us that the quarterly governance report which goes to the trust’s board is a significant improvement.

His view is that this encouraging improvement needs further development with an executive information system providing direct information to the board and executive team.

There are still issues for the trust to consider in relation to both the integrated governance structure and the information which the board receives. For example, there is no trust risk manager, a post that would normally be expected to drive forward many of the fundamentals of governance and risk management within the trust. For example, during our follow-up visit, we undertook a review of serious untoward incidents (SUIs) at the trust recorded between January 2007 and December 2008. We found that, generally, the standard of documentation was inconsistent. There appeared to be no standard system in place apart from the initial report. While there was evidence of action plans to implement learning, there was no record of follow up to confirm that implementation of those actions had taken place.

While we were impressed by the enthusiasm and determination to overhaul the trust's governance system, we feel that it would benefit from external collaboration and validation in conjunction with the SHA, and Cornwall and Isles of Scilly PCT, who are keen to further develop partnership working with the trust.

Organisational and personal development

Recommendation 11

The trust's board should continue to invest in organisational and personal development to ensure that clinician managers and middle managers have the attributes, skills and behaviours to succeed in their roles. A business plan should be submitted to the trust's board by the end of March 2008 and progress reviewed in October 2008.

A triumvirate structure at the head of each of the new divisions, comprising (with the exception of support division) a divisional general manager, a divisional nurse manager and a divisional doctor (clinical director), now reports to the board through the director of service delivery and is the first stage of the organisational development programme. The trust has indicated that the programme of organisational development, which stalled temporarily following the suspension of the chief executive, has been revived and has been devolved to the director of human resources. There is a commitment to complete the divisional structures at a lower level and we were told that a programme of individual development will be re-instated. Senior, middle and front line management roles have been defined by generic job descriptions.

This second stage of organisational development below divisional manager level is at an early stage. The organisational development plan as outlined in the 2008/09 business plan will further drive training plans for individuals within the trust.

Conclusions

Unsurprisingly, the suspensions of the chief executive and acting director of nursing have been unsettling for the trust. Nevertheless, the interim chief executive has minimised the effects of this and has continued to lead a concerted effort, resulting in substantial progress against the recommendations of the intervention report.

The refurbishment of the maternity unit has been successfully achieved and has resulted in high levels of satisfaction expressed by service users, members of maternity staff and elsewhere within the trust. The maternity services liaison committee was due to be re-launched at the time of writing of this report and we have made suggestions, earlier in this report, for its further effectiveness with the support of the trust and the PCT.

The “Lets Respect” programme has had a positive impact on care for older people at the trust, with a reported drop in numbers of complaints in relation to the care of older patients as well as issues of respect and dignity. The trust now has the opportunity to spread the philosophy and practice to all areas of the trust, including those wards not designated for older patients but where older patients and patients with communication difficulties are treated.

There has been progress in infection control practices and standards of hygiene at the hospital. The trust should ensure that this impetus is maintained and that the work of the current team is commensurate with its capacity, concentrating on key risk areas. The trust should seek to fill key posts in order to further develop this area of practice. There are still significant challenges over the long term in relation to the trust’s improved infection control performance.

The trust has reviewed its race equality scheme and has recognised that further work is necessary to ensure that it complies with latest race equality legislation and that race equality is more embedded within the culture of the organisation.

The trust has made a promising start to improving information to the executive team and the board and to achieving an integrated governance structure. There are still areas to be embedded in integrated governance. There is an undoubted willingness and determination at senior level to achieve compliance with core standards and there needs to be continued and increasing effort to ensure that the same level of ownership and understanding of core standards is apparent at all levels within the trust.

The trust has re-instated its organisational development process in order to further develop the structures below divisional lead level. We conclude that this is at an early stage.

Despite the substantial progress that has been made, there are still challenges ahead for the trust in the areas that we reviewed directly. The trust has

demonstrated to the satisfaction of the investigation team that it has shown determination to continue the improvements already achieved against the recommendations of the intervention report. In view of this, we feel that the future formal review of progress should rest with the Strategic Health Authority in conjunction with our operations staff in the south west. The Strategic Health Authority has confirmed that it will actively review further progress against the recommendations of the intervention report.

In reaching this conclusion, we have the following observations:

- The future leadership of the trust needs to demonstrate a high level of commitment, currently evident under the interim chief executive, to allow the progress we saw to further develop into stable and sustainable improvement.
- Over the past few years at least, there has been insufficient strategic vision in relation to this trust to enable a picture to emerge of the shape and extent of health services that the trust should provide to the community it serves over the next 10 to 15 years. This is a process that needs to develop rapidly once the long-term leadership of the trust has been resolved.
- The financial deficit that was allowed to develop in recent years is a clear handicap to future realisation of plans and strategic vision for the trust, involving substantial capital investment and service development. It is not for us to suggest how such a solution to this problem may be achieved. However, we can say that it is a solution that requires the involvement of the whole commissioning, provider and SHA economy working together, and which is an essential prerequisite for the trust to provide high-quality care on a sustainable basis.