This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

**Facts and data about this trust**

Royal Cornwall Hospitals NHS Trust is the main provider of acute hospital and specialist services for most of the population of Cornwall and the Isles of Scilly. The trust serves a population of approximately 450,000 people, although this can more than double during busy holiday periods. The trust employs approximately 5,000 staff and has a budget of around £380 million.

The trust delivers care from three main sites – Royal Cornwall Hospital, Truro; St Michael's Hospital, Hayle; and West Cornwall Hospital, Penzance – as well as providing outpatient, maternity and clinical imaging services at community hospitals and other locations across Cornwall & the Isles of Scilly.

The trust has four clinical divisions: medicine, surgery, clinical support and cancer services, and women, children and sexual health. Clinical services are supported by corporate teams including finance, human resources, and estates and facilities. Payroll and information technology services are hosted by Royal Cornwall Hospitals NHS Trust on behalf of the local NHS community, which includes the provision of IT services to GP surgeries.

The Royal Cornwall Hospitals NHS Trust is a teaching hospitals trust as part of the University of Exeter Medical School and the University of Plymouth (nursing and dental faculties). It also has a strong research, development and innovation portfolio.

(Source: Routine Provider Information Request (RPIR) – Context Acute)

A list of the acute hospitals and units at the trust is below:

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
</tr>
</thead>
</table>
Is this organisation well-led?

Leadership

Managers at all levels in the trust did not always have the right skills and abilities to run a service providing high-quality sustainable care. The board was relatively new and included several interim positions, although appeared to be functioning well. Board development needed a renewed focus, and the leadership structures below the board needed strengthening.

The Chief Executive had been appointed on a 12-month interim basis and was a confident individual with a good grasp of the challenges facing the organisation. Despite the role being interim, they were behaving like a substantive post-holder, leading the organisation through its challenging improvement programme. We were concerned the level of support offered to the interim Chief Executive by other bodies did not seem to respond to the significant challenge being faced in their first Chief Executive position. However, the interim Chief Executive had personally built a good network of support with other Chief Executives and an organisational development consultant.

The Medical Director had been appointed initially on an interim basis in October 2017 but had since become substantive. This was their first executive appointment, but they were engaged and enthusiastic. They had good leadership support available but needed to make more time to access some of this, including their coach.

The Chief Nurse was appointed in May 2017 and was previously the Deputy Chief Nurse at the trust. They were the executive lead for end of life care, the non-medical workforce, safeguarding, education, infection prevention and control, volunteers, chaplaincy, and they were the CQC Nominated Individual.

Historically, both the Chief Nurse and Medical Director had large portfolios with some areas of crossover, for example accountabilities for different parts of the governance system. The appointment of a Director of Integrated Governance was imminent, and deputies were starting to take on more responsibilities. This would release time back into the Chief Nurse and Medical Director portfolios to allow them to focus on the strategic leadership of these staff groups during a period of significant change and improvement work. The Chief Nurse and Medical Director worked very closely together and had a strong, trusting and supportive relationship.

The Chief Operating Officer had very recently resigned, and an interim had been appointed just before our inspection.

A Director of Strategy and Performance had recently been appointed. This was a new role. The post-holder was formerly the Director of Corporate Affairs and had been with the trust since January 2017. They told us their role had previously been quite heavily involved in the sustainability and transformation partnership but was now much more internal, with a focus on “sorting the hospital”. It was recognised by the Chief Executive and by the individual post-holder that strategy was not an area of their expertise. There was a clear plan to support them in this role.
through the appointment of an experienced Head of Strategy and a strong team to lead the strategy work.

The Chief Operating Officer had recently resigned, and an interim had started the week before our inspection. We found they had a good understanding of the issues facing the trust and the work required to make the necessary improvements. They had felt well-supported by the board in their first few days.

There was an experienced Director of Finance who joined the trust’s board in May 2017. This was a joint appointment with another provider, with their time being shared between both organisations. They were confident and had significant knowledge of and experience in the local health economy. The Director of Finance was supported by an experienced deputy and the finance function was held in high regard by everyone we spoke with. Divisional team members were positive about the level of support they received from their finance managers. The interim Chief Executive had been concerned the Director of Finance was not spending sufficient time in the Trust, so positive conversations had taken place with the other employer and more time had been negotiated for the Trust.

The Director of Human Resources and Organisational Development had only been in post for one month but had gained a good understanding of the trust’s current position in relation to human resources issues. This was their first executive appointment and some development was required, particularly around taking a more strategic approach rather than an operational one. However, this had been recognised by the Chief Executive and support and development opportunities were being developed.

The interim Chair had been with the trust for several years and was formerly the Vice Chair. This was the second time they had covered the position on an interim basis in recent years and they were showing strength and courage in helping to address several issues facing the board, including stability and board development. Although the Chair was interim, they told us they were approaching the role as if it were a substantive position. We found this to be the case, with several areas of work being pursued to drive improvements, rather than ‘holding steady’ until a substantive Chair is appointed.

The board had two vacancies for non-executive directors and was actively seeking to recruit to these. In addition to filling the vacancies, the Chair described other steps being taken to improve the overall skill of the board through the appointment of associate non-executive directors. These board members would perform the same function as a non-executive director, but without voting rights.

Members of the board spoke of improved relationships in recent months. The board appeared more cohesive than at previous inspections and board members clearly displayed the trust’s values. However, there was not a structured board development programme. Given the number of relatively new executives, some of who were taking up their first executive positions, this was an area requiring urgent attention to ensure the board operated effectively and were able to support each other during the ongoing improvement programme.

Staff talked positively about the new executive team and held them in high regard. We heard many positive comments about the interim Chief Executive, Medical Director and Chief Nurse, and there was a clear message that staff hoped they would bring the stability required at board level. However, the ‘middle management’ structure was spoken about with mixed feelings. Many staff told us communication from divisional and senior managers was often poor and engagement with staff around programmes of change was limited.
Staff told us the interim Chief Executive, Medical Director and Chief Nurse were more visible than they had been previously, but they felt other members of the board were less so. Staff who were not based at the main hospital site, including those at St Michael’s and West Cornwall hospitals, spoke positively of their engagement with the Chief Executive. However, some smaller groups of staff felt they were “overlooked” by the executive team.

There was a clear policy to ensure directors were ‘fit and proper’, and this was being well-used. We reviewed four personnel files for members of the board, including the interim Chief Executive and Medical Director. We found all files had evidence fit and proper persons checks had been completed, including Disclosure and Barring Service (DBS), references, qualifications and disqualified directors. Each file had a checklist to quickly confirm the relevant checks had been completed, and these were updated annually. Additionally, a central overarching spreadsheet recorded when checks were last completed and next due, and this confirmed all checks were up to date for the whole board.

Leadership capability and capacity below the trust board needed strengthening. The board and other staff told us the divisional leadership did not always function effectively and the governance processes did not help. We were given several examples of communications from the board not being shared in a timely way, or with a different emphasis, or of issues being escalated to divisional leaders but no actions being taken, including further escalation to the board. The trust was undertaking a consultation about a restructure and had moved to an interim structure while this was taking place. The new structure would move the trust from five divisions to seven care groups and was intended to reduce the layers of hierarchy between the board and ward. As part of this restructure, care group leadership positions were going to be advertised and a competency-based assessment process used to ensure the right leaders were in place.

There was strong leadership of the trust’s pharmacy function. The Chief Pharmacist was supported by a deputy who had been in post for four weeks. The deputy was leading on a team restructure in response to difficulties recruiting and a need to respond better to demand.

There were no black and minority ethnic (BME) executive or non-executive members of the board. Of the executive board members at the trust, 35.3% were female. There were 23.5% female non-executive board members.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0%</td>
<td>35.3%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0%</td>
<td>23.5%</td>
</tr>
<tr>
<td>All board members</td>
<td>0%</td>
<td>58.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

Vision and strategy

The trust had a vision for what it wanted to achieve, but there were very limited workable plans to turn it into action.

Board members told us about their vision, but this was not formally adopted in a vision statement and supported by a strategy. Part of the trust’s vision was to change the service focus at the different trust locations to provide increased access to services and a greater ability to respond to increasing demand. It was planned for the Royal Cornwall Hospital to focus on urgent and emergency care, St Michael’s Hospital to focus on planned care and West Cornwall Hospital on urgent care.
There was not a clear organisational strategy. However, both the Chief Executive and Chair recognised this. They told us the appointment of a Director of Strategy and Performance and Head of Strategy would ensure a clear strategy was developed and implemented.

The trust did not have a coherent strategy document which described the vision, indicative timelines and the resource implications, including a clear financial plan. This meant there was no clear direction for leaders to follow across the trust to ensure a coordinated approach to service planning, delivery and innovation. The board members all spoke about what was needed and how some of this would be achieved, but it was recognised most of this had not yet been written down.

There was no strategic framework to support learning and development in the trust, or to link learning and development with organisational development and human resources. Although we were told there was a commitment to learning and development from the board, this appeared to have lost focus because of the recent personnel changes on the board.

There was no documented strategy for infection prevention and control (IPC). It was not clear how specific priorities for the year would be actioned and achieved. Instead, the team worked towards an annual programme of work where assurance was provided to the IPC committee and the quality assurance committee. Following the inspection, the trust informed us there was an annual programme of work with an annual report presented to the trust’s board, although evidence of this was not provided.

The direction of travel for Allied Health Professions was aligned with the sustainability and transformation partnership’s direction of travel. One of the five priorities for Cornwall was to develop community care and support. This included developing the provision of community recovery, reablement and rehabilitation, and community-based care. Work to integrate the allied health professions with community teams to bring care closer to home was in progress. ‘First contact practitioner physiotherapy’ roles had also been introduced, ensuring the right care from the right professional was provided to the patient at the earliest opportunity.

The trust’s pharmacy function had a clear medicines optimisation strategy, which was linked to the overarching hospital pharmacy transformation plan. The department had also developed a medicines optimisation workstream in the sustainability and transformation partnership, which was looking to address issues affecting pharmacy provision across the country. Ideas included central education and training, and a plan to introduce the same electronic prescribing system used by the trust to the community and mental health provider for Cornwall.

The trust had an equality and inclusion strategy and associated delivery action plan, which was being led by the human rights equality and inclusion lead.

The trust had a patient experience strategy covering 2018-2021. Work to implement the strategy had only started in the last couple of months, but progress was being made in all areas of the workplan, including bringing a programme of patient stories to the board, promoting feedback methods and using social media to share positive stories.

There was a voluntary services strategy, which had been developed with the chaplaincy. This supported the recruitment, training, engagement and development of volunteers, as well as developing the areas of work they were able to support, for example friends and family test responses and meal time company. The strategy’s priorities were to enhance patient care, promote the trust’s values, and deliver appropriate training to support the volunteer service.

**Culture**
The trust promoted a positive culture that supported and valued staff, and the impact of this was starting to be seen. However, it was still too early in the trust’s improvement programme for this to be consistently demonstrated and embedded across the trust.

There was a more positive culture among the board. We had previously found some tensions between board members, and we were told of a historical “bullying culture”. However, the culture had since improved, and communication appeared to be more open and inclusive. We were told board members felt supported to challenge each other, and that difficult conversations were managed with greater respect. However, given the interim status of the Chief Executive, Chair and Chief Operating Officer, and several new appointees, there was still some work to do to ensure this positive culture change became truly embedded. Additionally, although we were told there was more challenge at the board, this was not always evidenced in meeting minutes, so we were unable to verify this.

We found there was much more hope for the future among staff at the trust, which we had not seen at previous inspections. They felt better supported by the board and believed there was a real desire to “do the right thing for patient care”. However, it was too early to see any real impact and there continued to be a risk to the culture of the trust in the event of further instability at board level.

Some of the non-executive directors we spoke with assessed the board as being about a five out of 10 for high-performing discussion. They felt this was an improvement from 12 months before, and they were confident this would improve further to around a seven or eight in the next 12 months, subject to the board remaining stable.

The trust had moved to an interim structure of seven care groups, with a formal consultation launching at the same time. There was lots of confusion and anxiety among staff because no clear messages had been received in advance of the changes, however this was quickly responded to by the Chief Executive after we raised some concerns. Much of the anxiety related to staff not knowing who their manager would be and how the roles would be filled. We were told that historically the trust had a culture of filling vacancies without a formal, competitive process, but that this was now changing, and all positions would be advertised and recruited to through a formal process.

There were positive relationships with system partners across the local system. This was an improved position that enabled a culture of joint working, particularly with exploring financial sustainability across the health and social care economy.

The Allied Health Professionals (AHP) felt supported, respected and valued and spoke of supportive and appreciative relationships among staff. They were a focused, dynamic and forward-thinking group who felt supported and able to speak out. They felt there their voice was heard and this was strengthened by the presence of non-executive directors with extensive AHP experience, skills and knowledge being present on the board. However, Clinical Nurse Specialists did not feel valued across the trust, said they did not feel well-represented at board and told us their work was not really celebrated.

The pharmacy department had a Dignity at Work Advisor and staff were aware of the Freedom to Speak-up Guardian.

Pharmacy staff spoke positively about the impact of the new Deputy Chief Pharmacist on the culture in the department. For example, by moving desks around the office teams were able to work together, rather than being separated by grades.
The trust was arranging a conference titled ‘Respecting each other – bullying, harassment and undermining in the NHS’. This was open to all staff and included speakers from a variety of organisations.

Most staff told us they were proud to work for the trust. Although staff recognised there were several issues that needed resolving, they felt the trust was working towards overcoming the issues and it was a positive place to work.

Staff felt there was a positive multidisciplinary culture across the trust, with many examples of the medical, nursing and allied health professional workforces working closely together in a positive and supportive way.

The trust’s team of volunteers were well-engaged, supported, and felt part of the wider hospital team. They told us they were respected and welcomed by staff and patients alike, and several younger volunteers were being supported by the trust to pursue careers in healthcare.

The trust had a Freedom to Speak-up Guardian and 17 champions across the trust. The team had received training to deliver the roles and the guardian was linked into the regional and national speak-up networks. The trust’s policy had been revised in line with national guidance and had been commended by the National Guardian’s Office. We were told the culture was generally more positive than it had been in recent years and staff were starting to feel more supported to raise concerns without fear of reprisal and having some confidence action would be taken. The guardian and champions were supported by the board and regular communications across the trust promoted their work.

There was a positive research culture in the trust. We found staff were motivated by research and received support from a dedicated research team.

Improvements had been made to the trust’s duty of candour processes, including staff training and expectation setting. The trust was now able to track compliance with the regulatory duty of candour, and big improvements were noted, particularly in the medical workforce. The trust’s ‘Being Open’ policy had been updated in April 2018 and we found most staff were aware of their duties and how to record discussions and written communications that met the requirements of the regulation. The duty of candour is a regulatory duty relating to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents' and provide reasonable support to that person.

**Staff Diversity**

The trust provided the following breakdowns of medical and dental staff, qualified nursing and health visiting staff and nursing and midwifery staff by ethnic group:

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Qualified nursing and health visiting staff (%)</th>
<th>Nursing and midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – British</td>
<td>7.5%</td>
<td>20.7%</td>
<td>2.8%</td>
</tr>
<tr>
<td>White – Irish</td>
<td>0.1%</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Any other white background</td>
<td>0.7%</td>
<td>2.1%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Mixed White and Black Caribbean</td>
<td>N/A</td>
<td>0.0%</td>
<td>N/A</td>
</tr>
<tr>
<td>Mixed White and Black African</td>
<td>0.0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mixed White and Asian</td>
<td>0.2%</td>
<td>0.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Any other mixed background</td>
<td>0.1%</td>
<td>0.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Asian or Asian British – Indian</td>
<td>0.8%</td>
<td>0.0%</td>
<td>N/A</td>
</tr>
<tr>
<td>Asian or Asian British – Pakistani</td>
<td>0.1%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td>0.3%</td>
<td>0.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Black or Black British – Caribbean</td>
<td>N/A</td>
<td>0.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>Black or Black British – African</td>
<td>0.1%</td>
<td>0.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Any other Black background</td>
<td>0.0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.1%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>0.1%</td>
<td>0.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Not stated</td>
<td>3.7%</td>
<td>0.9%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

NHS Staff Survey 2017 – results better than average of acute trusts

The trust had five areas that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF20. Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td>KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>KF18. Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure</td>
<td>51%</td>
<td>52%</td>
</tr>
<tr>
<td>KF23. Percentage of staff experiencing physical violence from staff in the last 12 months</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>KF24. Percentage of staff reporting most recent experience of violence</td>
<td>70%</td>
<td>66%</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2017 – results worse than average of acute trusts

The trust has 20 areas that were worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF12. Quality of appraisals</td>
<td>2.90</td>
<td>3.11</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.04</td>
<td>4.05</td>
</tr>
<tr>
<td>KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month</td>
<td>32%</td>
<td>31%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.49</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.52</td>
<td>3.65</td>
</tr>
<tr>
<td>KF19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.46</td>
<td>3.62</td>
</tr>
<tr>
<td>KF15. Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>44%</td>
<td>51%</td>
</tr>
<tr>
<td>KF16. Percentage of staff working extra hours</td>
<td>73%</td>
<td>72%</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.46</td>
<td>3.75</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>3.87</td>
<td>3.92</td>
</tr>
<tr>
<td>KF7. Percentage of staff able to contribute towards improvements at work</td>
<td>68%</td>
<td>70%</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.86</td>
<td>3.91</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.24</td>
<td>3.31</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.37</td>
<td>3.45</td>
</tr>
<tr>
<td>KF6. Percentage of staff reporting food communication between senior management and staff</td>
<td>26%</td>
<td>33%</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.72</td>
<td>3.91</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>3.60</td>
<td>3.71</td>
</tr>
<tr>
<td>KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>27%</td>
<td>25%</td>
</tr>
<tr>
<td>KF27. Percentage of staff reporting most recent experience of harassment, bullying or abuse</td>
<td>42%</td>
<td>45%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

**Workforce race equality standard**

The scores presented below are the un-weighted question level scores, split between white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key finding and question numbers have changed since 2014.

To preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KF25</strong> Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>27%</td>
<td>27%</td>
</tr>
<tr>
<td>White</td>
<td>BME</td>
<td>23%</td>
</tr>
<tr>
<td><strong>KF26</strong> Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>27%</td>
<td>25%</td>
</tr>
<tr>
<td>White</td>
<td>BME</td>
<td>28%</td>
</tr>
<tr>
<td><strong>KF21</strong> Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>85%</td>
<td>87%</td>
</tr>
<tr>
<td>White</td>
<td>BME</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Q17b</strong> In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>White</td>
<td>BME</td>
<td>12%</td>
</tr>
</tbody>
</table>

Of the four questions above, two questions showed a statistically significant difference in score between white and BME staff:

- **KF21**: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. There was a 10% difference between white staff (85% responded positively) and BME staff (75% responded positively). For BME staff, this was 4% higher (better) than the previous year and the same as the national average.

- **Q17b**: In the last 12 months have you personally experienced discrimination at work from manager/ team leader or other colleagues? There was a 6% difference between white staff (6%) and BME staff (12%). For BME staff, this was 5% lower (better) than the previous year and similar to the national average.

(Source: NHS Staff Survey 2017)

The trust had a lead for workforce race equality who felt supported by the board. They told us the board had a good awareness of the workforce race equality standards. Several staff support networks existed, but we were told attendance was often poor and it was difficult to continue...
supporting these as a result. For example, the multi-ethnicity group and disability advisory team had been merged due to reduced attendances. We were also told several actions to address equality in the trust were ongoing, but as some of these did not have any budget allocated to achieve them, progress was very slow.

**Friends and Family test**

The friends and family test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

From July 2017 to June 2018 the trust scored about the same as the England average for recommending the trust as a place to receive care.

(Source: Friends and Family Test)

**Sickness absence rates**

The trust’s sickness absence levels from April 2017 to March 2018 were below the England average for eight months and similar or slightly above for the remaining four months. Sickness absence levels followed a similar pattern to the England average.
General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed as expected for all 13 indicators.

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months:

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>From receipt of complaint:</td>
<td>For formal complaints in the period May 2017 – April 2018:</td>
</tr>
<tr>
<td></td>
<td>• Three working days – first acknowledgement</td>
<td>• First acknowledgement within three working days (93%).</td>
</tr>
<tr>
<td></td>
<td>• Five working days – patient experience officer contacts complainant to introduce self as named case worker and to explain process, and anticipated date for response</td>
<td>• The trust does not monitor when a patient experience officer contacts the complainant to introduce self as case worker; however, internal guidelines state that this should be done when the complaint is actioned (passed to the relevant division for investigation). Therefore, complaints actioned within five working days (82%).</td>
</tr>
<tr>
<td></td>
<td>• Complaint passed to divisional governance team to allocate investigating officer (IO). RCHT complaints policy advises that IO should telephone complainant – vital first step. The divisional governance team set own timescales for response to ensure that final response (signed by associate director) is with the central patient experience team no later than 25 working days after the complaint was first received.</td>
<td></td>
</tr>
</tbody>
</table>
What is your target for completing a complaint

From receipt of complaint:
May 2017 – December 2017 is 25 working days.

From receipt of complaint:
January 2018 – April 2018 is 30 working days for all complaints.

Of complaints closed (as of April 2018):
- 25 Working day process (12%)
- 45 Working day process (28%)
- 30 Working day process (26%)

If you have a slightly longer target for complex complaints, please indicate what that is here

From receipt of complaint:
May 2017 – December 2017 is 45 working days for complex or multi-divisional/organisational complaints investigations.

Extensions approved in extenuating circumstances.

Extensions requested and approved along with statement of declaration that complainant has been advised of delay done via revised DATIX complaints module.

Number of complaints resolved without formal process in the last 12 months?

399 from May 217 to April 2018.

N/A

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

**Number of complaints made to the trust**

The trust received 412 complaints from March 2017 to February 2018, taking an average of 59.6 days to resolve them. Of these complaints, 106 (25.7%) were about clinical treatment and 77 (18.7%) were about communications.

The medical care core service received the most complaints. The top two complaint themes were communications and clinical treatment. Surgery had the second highest number of complaints. The top complaint theme was about clinical treatment.

The table below shows a breakdown of complaints by core service:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>135</td>
<td>32.8%</td>
</tr>
<tr>
<td>Surgery</td>
<td>98</td>
<td>23.8%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>55</td>
<td>13.4%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>43</td>
<td>10.4%</td>
</tr>
<tr>
<td>Not core service specific</td>
<td>27</td>
<td>6.6%</td>
</tr>
<tr>
<td>Maternity</td>
<td>15</td>
<td>3.6%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>15</td>
<td>3.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>12</td>
<td>2.9%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>9</td>
<td>2.2%</td>
</tr>
<tr>
<td>End of life care</td>
<td>2</td>
<td>0.5%</td>
</tr>
<tr>
<td>Critical care</td>
<td>1</td>
<td>0.2%</td>
</tr>
</tbody>
</table>
**Number of Compliments made to the trust**

From March 2017 to February 2018, the trust received 7,115 compliments. The medical care core service had the highest number of compliments, followed by surgery.

A breakdown of compliments by core service is in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Total number of compliments</th>
<th>Percentage of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>2,532</td>
<td>35.6%</td>
</tr>
<tr>
<td>Surgery</td>
<td>1,531</td>
<td>21.5%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>1,378</td>
<td>19.4%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>531</td>
<td>7.5%</td>
</tr>
<tr>
<td>Maternity</td>
<td>489</td>
<td>6.9%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>255</td>
<td>3.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>236</td>
<td>3.3%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>99</td>
<td>1.4%</td>
</tr>
<tr>
<td>Not core service specific</td>
<td>37</td>
<td>0.5%</td>
</tr>
<tr>
<td>Critical care</td>
<td>27</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,115</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Governance**

The trust did not use a systematic approach to continually improve the quality of its services. It did not always safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.

There was not a clear governance framework that staff and leaders were able to describe. For example, although divisions were able to explain local processes for risk register escalation, very few we spoke with understood how to escalate risks to the board.

The trust was taking steps to strengthen governance arrangements. However, these were at an early stage of implementation, so it was too early to comment on their effectiveness. The trust moved to an interim structure during our inspection. This involved moving from five divisions to seven care groups with the aim of improving governance processes and enabling better oversight of the services being provided. We found that although the Chair and non-executive directors were aware of the planned changes to the trust’s structures, the implementation of these had been a surprise to them. There had not been a paper presented to the board prior to the interim structure being implemented, and we were told by staff and some executive directors that communication about the interim structure had been poor. The trust told us the interim structure had been implemented earlier than planned because it was experiencing significant operational and leadership challenges ahead of winter.

A new associate director of governance had started in post in June 2018 and a director of integrated governance had been appointed, although had not started in post at the time of our inspection. The priorities for these roles were to focus on governance processes and improve the assurance frameworks for the board.

Meeting minutes were often poor. We reviewed minutes from board meetings, sub-board committees and divisional meetings. In most cases we found these lacked detail and did not accurately record discussions, decisions and actions.
The interim Chief Executive and Chair recognised there was a lack of understanding of good governance across the trust and additional work was required to build the competence and confidence of key leaders in this area. This included refreshing the board’s understanding of what good governance looks like. The trust had also agreed to appoint a Director of Integrated Governance to lead and oversee the governance improvement programme.

The trust had recently revised its finance committee to include performance. This was a positive step in bringing together these two key aspects of the organisation.

The finance and performance committee functioned well and had a well-qualified chair. However, the board minutes demonstrated limited discussion regarding finance. This suggested there was an over-reliance on the finance and performance committee and that not all members of the board were challenging and/or gaining assurance regarding the trust’s financial position. Additionally, we heard from the chair of the finance committee that their primary relationship was with the Deputy Director of Finance and that not enough time was available with the Director of Finance.

Governance structures and processes were not standardised across the divisions. Divisional governance leads told us governance within the divisions had only developed properly in the last three to four months. This was due to capacity and time restraints, with governance leads trying to deal with a backlog of issues such as serious incidents. Divisional governance leads were able to talk about governance processes within their division but explained there were a variety ways of sharing learning across the divisions. There was no structured process to ensure learning was shared more widely across the different divisions. Staff told us they had received no formal training around governance.

There had been little guidance for staff about how governance would be managed across the interim care group structure being implemented by the trust. The governance leads told us they had been made aware of the move towards care groups and felt the concept made sense in the context of the trust. However, we were told there had been limited clarity and detail about the new care groups and how structures and processes would change because of this.

There were gaps in the governance around infection, prevention and control (IPC) issues. During our core service inspection, we raised a concern about IPC issues in the mortuary to the trust. Work had then been carried out in the mortuary to resolve the concerns. When we asked how assurance was gained that the work carried out had resolved the issues, we were told a report had been provided by the pathology team. This team had no specialist knowledge of IPC issues and no senior members of the IPC team had gained their own assurance that the maintenance work had been done to an acceptable standard to address the IPC issues.

We were also concerned that despite a joint end of life project with NHSI earlier in 2018 raising urgent work being required to ensure the mortuary was compliant with their Human Tissues Authority license, no work had been undertaken. There had been no risk assessment completed and the board were unaware of the issues, even though staff told us they had been raising concerns through the division.

The trust had recently introduced a Programme Management Office that was starting to work across the clinical divisions to develop and deliver strategic change projects, primarily relating to governance processes. However, senior staff were confused about the roles and responsibilities of this team alongside the transformation and service improvement teams.

A Company Secretary was due to start shortly after the inspection. The role had previously been covered by the Director of Corporate Affairs, but they had recently moved to a new role.
The pharmacy governance group met monthly and reported to the clinical support divisional governance board. This in turn reported to the quality governance committee and through to board. The pharmacy governance group reviewed, among other items, medicines safety, incidents, risks and audits.

The trust had arrangements with the local mental health provider for psychiatric liaison and care of those patients with a mental health condition. However, we found the needs of mental health patients were not always being met under this agreement, particularly in child and adolescent mental health services. These issues were understood by the board with issues being reported through the governance structures into the board. There was work ongoing with partner organisations to improve mental health care, but we were told progress was slow and patients were often cared for in inappropriate environments.

**Board assurance Framework**

The Board Assurance Framework had been revised and was due to undergo further revision, with a draft version being seen during our inspection.

There were 14 risks on the board assurance framework, under four headings: Quality – to provide compassionate, safe, effective care; People – attract, develop and retain excellent staff; Partnership – offer integrated care as close to home as possible; Resources – to make the best use of all our resources.

The most significant risks on the board assurance framework were:

- Strong governance (risk rating 20)
- Tackling delays (risk rating 20)
- Be a financially sustainable organisation (risk rating 20)
- Ensure we recruit and retain staff, who have the right skills and experience to provide safe, effective care (risk rating 16)
- Offer more acute services out of hospital and support locality teams to care for frail and vulnerable people at home (risk rating 16)
- Safety culture (risk rating 15)
- Adopt a “digital first approach” to system wide transformation (risk rating 15)

The draft board assurance framework included descriptions of the risks, key controls in place to manage the risks and any gaps in those controls, sources of assurance and any gaps in those controls, additional actions being taken to address the gaps, and a designated lead executive.

**Management of risk, issues and performance**

The trust did not have effective systems for identifying, removing or reducing risks.

Staff were largely unclear how risks were escalated beyond the division to the board, and we found the board were unaware of some significant risks because these had not been escalated as required. For example, we found significant issues relating to the mortuary that had been raised within the division but not escalated to the board. As a result, when we raised our concerns with the executive team they were unaware of the ongoing issues and the seriousness of these.

Staff felt there was a lack of oversight by the executive team and the board on matters around audit. We were told none of the executive team leading on audit work attended any meetings and an annual audit report had not been presented to the board since 2016.
One of the trust’s most significant risks was the need to replace the existing electronic patient administration system (PAS). The existing PAS could not access the NHS Spine or Personal Demographics Service and required an additional system for staff to access important patient information. This meant there was some duplication of work, and a risk of data not being copied across to other systems correctly. There was a high risk a new PAS would not be in place before the existing PAS contract expired. This meant there was a risk staff would not be able to retrieve records, view appointments, monitor referral to treatment (RTT) status, and locate health records. While this was one of the two highest scoring risks on the trust’s risk register and the trust was seeking an urgent solution, it was not clear when a replacement would be identified and implemented, or how this would be funded given the trust’s financial position. There was a risk patient care could be affected if a solution was not in place before the PAS contract ended.

The trust had not drafted a 2018/19 winter plan. While we were told about many ideas for how the trust would manage over the winter period, these had not been written into a formal plan.

Local and national audit work was ongoing throughout the trust within the different specialities. However, there was limited board oversight of this audit work. There had been challenges around the governance of audit work which was described by staff as being “in a state of flux”. The clinical audit and outcome meeting was stopped in early 2018 because the chair had stepped down but was due to relaunch in October 2018. Audit information would then feed into the clinical effectiveness committee and the quality governance group.

The oversight of complaints and incidents was improving, although further work was required to link complaints and incidents more consistently. The trust was using a single electronic risk system to record and manage complaints and incidents. This had helped cross-referencing of new complaints with ongoing incident reports, but this was not necessarily the case in reverse. We were told work was ongoing to improve the cross-referencing of complaints and incidents, and the increased resource in the patient experience team had helped with this, but it was very much a manual and time-consuming process that did not always work.

There was a possible mismatch between priorities and workforce allocation. For example, sepsis management had been a long-standing challenge in the trust and a lead had been appointed, however they were part time. However, the trust had appointed a full time Workforce Race Equality Standard lead, who often found other areas of work to complete because the role did not require the allocated full-time hours.

The trust’s pharmacy function had been running with 9% vacancies in July 2018 (15% in the pharmacist staff group), but recruitment had recently been completed which had reduced the risk. Three additional pre-registration pharmacists had also been recruited, and a further was due to be recruited in 2019, building greater resilience and capacity within the team.

Pharmacy data was used to target and improve service delivery. This was enabled through the electronic prescribing system, which was well-embedded. Daily reports were produced to identify high-risk patients who may need a clinical pharmacist review, for example patients with diabetes.

Risks relating to pharmacy were regularly reviewed and high-risk items were escalated to the corporate risk register when necessary.

The trust had a medicines safety officer who was responsible for responding to and managing drug alerts, recalls and incidents.

Patient acuity and staffing levels were assessed daily using a safer care tool. This was completed across all areas of the trust and a meeting was held twice a day to review the information. A diagram showing acuity and staffing across the trust was presented at this meeting and an
associate director of nursing used this to make decisions about redeploying staff to safely manage patient care.

**Trust corporate risk register**

The trust provided a document detailing their 13 highest profile risks, which are listed below. Each of these had a risk score of 16 or higher. There were an additional 19 high profile risks with a score of 15 and a further five risks with a score ranging from nine to 12.

<table>
<thead>
<tr>
<th>Risk name</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to replace Patient Administration System</td>
<td>There is a risk the new PAS may not be in place before the existing contract expires - resulting in operational failure affecting patient care. Staff would not have the ability to retrieve records, view appointments, monitor locate the Health Records etc. The existing PAS does not link directly to the Spine/The Personal Demographics Service (PDS).</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>Referral to Treatment Performance</td>
<td>There is a risk the trust will not be able to treat 92% or more of patients on incomplete pathways within 18 weeks. This is caused by a combination of factors including growing waiting lists, waits for outpatients, diagnostics and elective procedures and inefficient pathway management. This risks harm from delay as well as reputational risk for the organisation.</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>Medical equipment maintenance</td>
<td>Lack of or inaccurate data regarding medical equipment servicing. Inability to gain assurance medical equipment is being serviced and maintained appropriately. Potential risk of patient harm and/or service disruption. Caused by: Lack of an accurate and comprehensive medical equipment asset register and insufficient workforce capacity within Medical Physics.</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Business disruption during transition to new PAS</td>
<td>Risk during the transition to new PAS there will be a reduction in the speed and accuracy of data entry. This could lead to delayed booking of appointments, delays to setting new clinics, patients booked to wrong clinic and general reduction in data quality.</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>High Stroke Mortality Rate in comparison to benchmarks</td>
<td>There is a risk stroke patients are at a higher risk of death in comparison to other acute trusts.</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Access control system</td>
<td>The access control system has expanded exponentially since the first installation of four doors in circa 1995. The system is established in two primary networks and both are at capacity and starting to fail due to the size of the network and age of installation. There are also a number of poor quality installations and incompatible</td>
<td>16</td>
<td>8</td>
</tr>
</tbody>
</table>
connections. The current model is no longer available and will cease being supported from circa 2020. Failure to maintain the network will result in compromised security, including the inability to secure wards, departments and high-risk locations, and could result in access being denied to authorised staff in the event of an emergency call.

<table>
<thead>
<tr>
<th>Notes not being available for clinical care due to Health Records Workforce issues</th>
<th>Risk the Health Records Service will not be able to supply patient records for clinicians to treat patients caused by the delay in implementing electronic notes, delivering transformation of the workforce and increase in workload. Currently have 14% vacancy rate.</th>
<th>16</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polkerris Ward Environment including Paediatric HDU</td>
<td>Risk Polkerris Ward does not meet the needs of those patients using the service, including those on the High Dependency Unit. Caused by poor ward environment that does not meet current HTM and HBN requirements. Could lead to poor patient outcome, patient harm, CQC intervention, adverse media interest and litigation.</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>MRI capacity (particularly inpatients) - ageing MRI 1+2 scanners, increased demand</td>
<td>Lack of MR scanning capacity, particularly for inpatients caused by terminal failure of a critical part in the 14 and 16 year old MRI 1 + 2 systems, and increased demand. Risks significantly reduced MR scanning capacity in the event of terminal failure. Inability to scan inpatients using MRI. Could result in delayed diagnosis and treatment for patients, and loss of trust reputation.</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Equipment not fit for purpose (ED CT dual slice head scanner)</td>
<td>Risk that brain pathologies will be missed e.g. small infarcts caused by the old technology of the CT head scanner. The dual slice CT scanner is not technologically capable of producing images required. Could lead to missed pathologies, incorrect diagnoses and treatments.</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Insufficient Workforce Capacity for Medical Equipment Maintenance &amp; Servicing</td>
<td>Risk that equipment is not serviced and maintained on time caused by insufficient workforce capacity. Could lead to: increased risk of device failures, resulting in increased risk of patient harm and/or impact on service continuity, increased risk of regulatory action. There are currently insufficient technicians to conduct the maintenance work required as a result of growth in the asset base over many years coupled with the lack of an effective mechanism to identify the revenue costs associated with on-going maintenance of devices.</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Failure to comply with Duty of</td>
<td>Failure to comply with Duty of Candour regulations as a result of low staff awareness. This could potentially</td>
<td>16</td>
<td>4</td>
</tr>
</tbody>
</table>
Candour regulations because of low staff awareness. have a negative impact on patient experience of care and engagement. May also result in fines and impact on trust's corporate reputation.

Serious Incident Administration and non-compliance with CQC Regulation 12 Risk the trust will fail to take timely and appropriate action to safeguard patients after the reporting of an incident or Serious Incident (SI) due to weaknesses in the current system for reporting, grading, investigating and management of actions following an incident. This could lead to further avoidable harm to patients and non-compliance with CQC Regulation 12.

(Source: Trust Corporate Risk Register – P113)

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£378.1m</td>
<td>£404.9m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£0.9m)</td>
<td>(£2.5m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£379.0m</td>
<td>£407.5m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£375.3m</td>
<td>£399.8m</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

The trust’s Cost Improvement Programme (CIP) was focused on existing business activity rather than transformational change. There was a risk short-term gains could impact on the longer-term position of the trust or cause other unintended consequences. Additionally, the trust was reporting only about 40% of their overall CIP target was forecast to be delivered on a recurrent basis, which meant the cost pressures in 2019/20 would be greater. A high proportion of the non-recurrent CIP savings were being achieved through the ongoing holding of vacancies. It was not clear how the decisions had been made not to fill these vacancies from a safety, quality or financial perspective. This issue was not clearly visible to the board and the Chair had only recently been made aware of it. Equality impact assessments did not appear to have been systematically completed and reviewed, which meant the board’s reporting structures and assurance processes had not picked up the issue and reported to board.

The finance and performance committee provided a summary report to the board. This was not sufficiently detailed to make sure the board was fully aware of the financial issues and able to seek the necessary assurances.

The trust had worked with its local health partners to develop a financial framework that allowed it to work more effectively across organisational boundaries. Improved relationships with these partners had seen a combined approach to the proposed 2018/19 ‘control total’ for the trust. Each partner had provided financial support to enable the trust to reduce their control total. A control total is a financial target set by NHS Improvement that must be achieved for additional funding to be released.
The Chief Executive and Chair told us aspects of reporting to the board, including the current integrated performance report, required development.

Senior leaders were able to describe the trust’s financial position. They said they believed there was good awareness of the financial challenges facing the organisation, which was covered in team briefings.

The annual internal audit plan was developed on a risk basis and included financial matters.

**Information management**

*Although the trust collected, analysed and managed information to support its activities, this was not always done well or presented in a coherent, easy-to-use way. Secure electronic systems with security safeguards were used.*

We were told the key risks to the trust’s information systems were a lack of a shared IT vision across the trust, the aging patient administration system, IT infrastructure and cyber-security. Given the trust’s IT strategy was out of date, it was unclear how these risks were being prioritised, mitigated and ultimately how they would be overcome. The trust did have a draft standard operating procedure for cyber-security threat notifications, but this had been circulated in July 2018 and was not approved and published.

The trust had an aging IT infrastructure and had 92 electronic systems in use across the trust, not all of which communicated with other systems. The trust’s IT strategy was out of date and a new strategy had not been drafted. The interim Chief Executive had a strong understanding of the risks and issues associated with information technology and its impact on information management throughout the trust. The board were aware of the risks and had agreed to appoint a joint non-voting board-level Director of Information Management and Technology and Chief Information Officer with another NHS provider in the county to enhance board level capacity in this area. Staff told us they had to log into multiple systems and they hoped a single log-on solution could be introduced to reduce the need for this.

The trust’s integrated performance report was a collection of individual reports, rather than being a single report pulling all the necessary information together in a single, easy to use format. The report lacked key performance measures and actions and did not identify key responsibilities for delivery.

The storage of completed investigations following a patient death was unclear. We were told there was a requirement for completed investigations to be sent and stored centrally in the governance department, however this was not always happening. We were told some investigations were still stored with the investigating officer and not in the division where the incident occurred. There was no clear process to ensure completed investigations were held centrally. The trust’s policies for mortality review and incident management did not define the storage arrangements for completed investigations.

Mandatory training information was held centrally, although there was some confusion around the accuracy of this. During our inspections of the core services we identified poor compliance with mandatory training in several areas and raised this with the trust. We were initially told there was some doubt about the accuracy of this data, but subsequently were informed it was correct. Actions had been identified to improve mandatory training compliance, including bespoke medical training sessions and introducing clear communications to managers about available dates and deadlines for completion, and this information was now being reported through the board governance processes. We found that previously the board had limited assurance of mandatory training completion.
Live ward data was used in the pharmacy dispensary to allocate work and prioritise patient who could benefit from a pharmacist review, for example those requiring antibiotics, insulin or medicines for Parkinson’s disease.

There was a programme of internal clinical audit to monitor medicines optimisation processes, including medicines reconciliation, omitted doses, pharmacist interventions, storage temperatures and controlled drugs.

**Engagement**

The trust engaged with patients, staff, the public and local organisations to plan and manage services and collaborated with partner organisations. There were some good examples of this working well, and other areas that needed strengthening.

Senior managers and staff were positive about the recent engagement initiatives and increased executive visibility, particularly from the Chief Executive, Medical Director and Director of Nursing.

Important updates were communicated to staff by email, for example information about changes to the senior leadership team and interim structure. There was an expectation these important communications would then be discussed in individual teams, but this did not always happen. Staff were therefore not always aware of important messages, especially if they were too busy to access their emails.

A consultation document about a restructure to seven care groups was due to be published shortly after our inspection. In the meantime, staff had received some limited information from the interim Chief Executive by email and had been encouraged to participate in the consultation and share their ideas, thoughts and concerns with their managers. Not all staff felt this was clear and had come as a bit of surprise, causing confusion and leaving some staff feeling disengaged and unvalued.

Staff were kept up-to-date with pharmacy issues and plans through monthly face-to-face meetings, newsletter and bulletins.

The trust had a newly-formed patient and family experience team who produced a regular team newsletter to highlight their work, including successes, trials and priority areas needing additional attention. Items included NHS Friends and Family Test responses, updates on volunteers and patient feedback. Their work was underpinned by a new strategy, introduced in August 2018, which recognised the importance of staff engagement in creating a patient experience-focused improvement environment.

A large team of over 500 volunteers helped the trust engage with patients and visitors across the trust. These dedicated and enthusiastic volunteers promoted the friends and family test, aided people wishing to raise a concern, and spent social time with patients, for example by playing cards or joining them for lunch.

The trust had signed up to the Care Opinion website, allowing patients to share their feedback and have their stories published and responded to by the trust.

Several ‘wonder walls’ had been placed around the hospital site. Staff, patients and visitors were encouraged to write messages of thanks and attach them to the wonder wall. These positive comments were regularly collated and shared with individuals and teams as a means of providing feedback and improving morale.

Consultants told us they were heavily involved in the development and upgrading of clinical IT systems. They told us they felt listened to and suggestions were taken forward to improve the systems they worked with.
The Chief Nurse had introduced a weekly ‘breakfast with the Chief Nurse’ initiative. Staff were invited to spend time over breakfast with the Chief Nurse and discuss any issues, concerns or ideas they had. There was no agenda and the discussions were led by the staff in attendance.

The Director of Estates was engaged with the sustainability and transformation partnership. As part of this system-wide partnership, a group was looking at all the available estate with a view to consolidating services to improve access for patients, as well as potentially releasing some money into the system.

There was no forum for consultants to come together and engage as a group with the leadership team. We were told there had previously been monthly meetings, but these had stopped some time ago. The consultants we met believed the Medical Director was trying to get the meetings started again, but they were not aware of when this would happen, although the trust informed us they had been reinstated since August 2018.

There was poor engagement from the board with staff side (union) representatives. Although there was a monthly joint negotiation and consultation committee to which directors were invited, we were told these were poorly attended. The Deputy Director of HR was supportive of the group and regularly chaired the meeting, but we were told the former Director of HR and other executives did not attend. The meeting was not jointly chaired by management and staff side and important action plans, for example in response to the staff survey, were not discussed at the committee. Additionally, we were told there had not been a local negotiating committee since February 2017, which staff believed was due to the high turnover of executive staff in the last 18 months.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. However, action was sometimes limited to a single area where wider application would have a more significant impact.

The trust was engaging in the ‘Getting It Right First Time’ initiative. This was influencing procurement of clinical products with relevant experts and was being included in the trust’s continuous improvement plan.

The trust had a small, yet strong research team who promoted and supported research across the trust. Overall, the trust had 93 staff involved with research, including both registered and unregistered staff. The trust’s research function performed well nationally, being ranked 10 out of 52 organisations for recruitment into oncology research by the National Institute for Health Research (NIHR) and being in the top 20 for most other specialties. The research function was mostly reliant on a grant from NIHR and commercial research opportunities as a source of funding, receiving only a small amount of money from the trust. The trust was also involved with international research and had three ‘global firsts’ (being the first organisation to start an international research programme). Research opportunities were used to help with recruitment and we were told about a researcher of the year being recruited to a consultant post in the trust because an element of research had been built into their job plan. We were also told of challenges recruiting nurses into trauma and orthopaedics, so an agreement had been reached to offer a 50/50 split between research and trauma and orthopaedics to attract applicants. The trust also worked with two universities on research, including having a joint strategy to establish scholarships.

The quality improvement and innovation team was undergoing a restructure. The trust was working with the Academic Health Science Network to develop the quality improvement strategy and to define the concept of a quality improvement hub. It had been recognised there was a
requirement for staff to be trained in quality improvement to drive service improvement. Staff were undergoing training to become quality ambassadors in conjunction with the Institute for Healthcare Improvement. The trust aimed to have 80 staff trained over the course of the year. The interim Chief Executive chaired a fortnightly quality improvement board, which was currently focused on priorities drawn from our previous inspection findings.

The pharmacy department was one of the first teams in the trust to run a quality improvement project and were working to raise awareness of this across the trust. The department also led the Cornwall antimicrobial resistance group across the sustainability and transformation partnership.

The pharmacy department had introduced an electronic portal for ordering medicines and following a successful pilot was being rolled out across the trust.

There were early plans for medicines dispensing to be decentralised, particularly for discharge medicines. When introduced, this would allow staff to provide patients with medicines much faster, therefore helping to improve patient experience and flow.

Leaders were able to demonstrate improvements that had been made in response to feedback. However, there was little evidence that feedback was looked at in a wider area. For example, following our inspection in June 2017 we raised safety concerns about the environment in the fracture clinic. During this inspection we found the trust had made improvements to the environment in the fracture clinic but had not taken the opportunity to review and address other environmental issues in the rest of the outpatient department.

We found improvements in shared learning from complaints. The trust’s patient and family experience team produced short shared learning briefings, which highlighted themes and learning opportunities across the trust and not just in the area where the complaint related to.

Although complaint responses were not often completed within the target timescales, improvements to the process had been made and the team size increased, which was starting to reduce the backlog of complaints.

There were plans to move to six localities across the county, with a flexible workforce that could work across the different services in that locality. This was intended to move care closer to patients’ homes but was in the early stages of development and needed testing.

The interim Chair told us of a plan to start a non-executive director academy and, although it had not yet been established, two people had been recruited to join. It was unclear, however, how this academy would link with the resources already available through other NHS initiatives, which risked causing confusion.

There was no strategic framework to provide clear direction for the education, training or development functions. There was no obvious link between education, training or development and organisational risk or development needs.

There was no means for the effectiveness of training to be evaluated. Additionally, findings from incidents, complaints and audits did not feed into the training programme.

**Accreditations**

NHS trusts can participate in several accreditation schemes. A service can be accredited if they can demonstrate they meet certain standards of best practice in the given area. An accreditation usually carries an end date (or review date) when the service will need to be re-assessed to continue to be accredited.

The table below shows which of the trust’s services had been awarded an accreditation:
<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy at RCHT and West Cornwall Hospital site</td>
</tr>
<tr>
<td>Individual GI JAG accreditation in order to be involved with the bowel screening programme</td>
<td>Individual gastroenterologists</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation (CPA) and its successor Medical Laboratories ISO 15189</td>
<td>All pathology departments have CPA accreditation currently, until September 2018. All pathology departments are recommended for accreditation to ISO 15189:2012, subject to closure of mandatory findings, and with the exception of automated platforms in chemistry.</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>ISO 9001:2015 radiotherapy service certificate renewal received on 10.03.2018</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>MQEM achieved at Level 5 in Nov 2017</td>
</tr>
<tr>
<td>Bowel Cancer Screening Programme</td>
<td>This was a Quality Assurance Visit for the Bowel Cancer Screening Programme held from the 12th to the 14th January 2016. This review applies to RCHT and West Cornwall Hospital.</td>
</tr>
<tr>
<td>Stroke Pathway Peer Review</td>
<td>This was a joint stroke peer review carried out by the Royal College of Physicians, British Association of Stroke Physicians and the Stroke Association Joint Stroke Services on the 9th March 2018. This review applies to the stroke pathway in RCHT and Community Services.</td>
</tr>
<tr>
<td>Cardiology External Peer Review</td>
<td>This was an external peer review led by the Royal College of Physicians on the 7th &amp; 8th February 2018. Awaiting final report.</td>
</tr>
<tr>
<td>ISO 13485:2016</td>
<td>Sterile services department</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)

The trust had also introduced a ‘ward accreditation scheme’, which the Director of Nursing led. Wards received accreditation if they met certain criteria. We found there had been a positive impact on noise reduction at night and better management of beds to avoid mixed sex breaches, with a reduction in complaints with these themes.

Learning from deaths

While the trust had started to implement new processes to support learning from deaths, further work was required to ensure all the recommendations were implemented and embedded.

The trust had responded to the 2017 NHS National Quality Board guidance on learning from deaths and the 2016 CQC report ‘Learning, candour and accountability.’ The learning from deaths guidance required NHS trusts to produce and publish an updated policy on learning from death. The policy was to include the recommendations from the guidance, which included the trust’s review processes, response to different categories of deaths, procedures to determine deaths to be investigated under the serious incident framework and how the trust intended to engage with and support bereaved families.

The trust’s policy covered all the detail recommended by the national guidance. The policy included information about how the trust planned to respond to different categories of deaths, such as learning disabilities, infant deaths and stillbirths and the process for review. It was the role of the divisional management teams and the bereavement team to engage with and include families.
in the investigation process and support bereaved families. However, it was unclear how the trust planned to share learning from deaths more widely across the organisation. The policy identified how the reviews would be fed back to divisional governance leads, but there was no detail behind how this would be disseminated through the divisions or more widely across the trust.

Of the 11 investigations we reviewed, we saw limited evidence of any contact being made with the family of the deceased person and how there were supported. We saw no evidence about how the trust involved relatives in setting the terms of reference for the investigation. We did see examples of letters sent to families introducing the investigating officer and providing an explanation of why the case was going to be investigated. However, there was no evidence of further correspondence or engagement with relatives following this. There was no evidence that a final report was sent to the relatives.

We were not assured learning from deaths was being used to drive service improvement. There was no evidence actions from investigations had been implemented and embedded because action plans not being completed. In the investigations we reviewed we found there was no detail to explain how the required actions would be addressed. There was no evidence to demonstrate whether actions had been implemented or how assurance had been gained that actions had been implemented and were embedding into practice. Investigations had been signed off and closed by senior members of staff, despite clear action plans not being present.

The national guidance also recommends a mortality report is presented quarterly to the board. While this was taking place, the quality and depth of the report did not provide sufficient oversight and assurance to the board. We reviewed two reports which had been presented to the board in February and May 2018. In one of these reports, none of the identified learning from deaths had been presented in the report to the board. The other report included the learning identified, however neither of the reports provided assurance about how actions would be implemented and embedded to drive service improvement.

It was unclear whether the trust was compliant with its policy of subjecting all deaths to a screening tool mortality review. We reviewed data provided in mortality review papers presented to the board in February and May 2018. Data presented in February 2018 showed out of 541 deaths, 48% (262) had been subject to a screening review. In May 2018, out of 459 deaths, 54% (250) were subject to a screening review. The data was unclear as it did not provide reasons why some deaths were not subject to the screening review and whether the omitted screening reviews were exempt under the speciality of care of the elderly (where only 10% of cases would be reviewed) as stated in their policy.

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**Acute services**

**Urgent and emergency care**

**Facts and data about this service**

**Details of Emergency Departments and other Urgent and Emergency Care services**

The Urgent and Emergency Care Service for Royal Cornwall Hospitals NHS Trust is provided from two locations. This includes the emergency department (ED), the same day emergency care unit (SDEC) and the Clinical Decisions Unit (CDU) at Royal Cornwall Hospital and the Urgent Care Centre (UCC) at West Cornwall Hospital.
The Urgent and Emergency Care Service also provides care on the Acute Medical Unit (AMU), but this was inspected under the Medical Care core service.

The Royal Cornwall Hospital ED is open 24 hours a day, seven days a week. It treats patients with serious and life-threatening emergencies and those with minor injuries that need prompt treatment, such as lacerations and suspected broken bones.

Between April 2017 and April 2018, the ED had 74,971 attendances. This was an increase of 3,397 from 2016/17.

Between April 2017 and April 2018, the UCC at West Cornwall Hospital had 20,422 attendances. This was an increase of 1,056 from 2016/2017.

The ED has 22 cubicles for majors, a dedicated paediatric area and minor injuries area as well as triage facility, an eight-bedded clinical decision unit and a three-bay resuscitation room. It is staffed by a multi-disciplinary team led by ED consultants, advanced nurse practitioners (ANPs), specialty doctors, therapists, and specialist nursing teams with input from psychiatric liaison service and adult social care.

The Royal Cornwall Hospital NHS Trust ED is an accredited trauma unit and part of the Peninsula Trauma Network. The Peninsula Trauma Network brings together all those responsible for treating patients who have undergone major trauma incidents across Devon and Cornwall, including the Isles of Scilly ensuring that patients receive the most appropriate care in their region. Depending on journey time and injury, patients can be transported directly to the most local major trauma center following on scene assessment, or may be taken to a trauma unit, such as that at The Royal Cornwall NHS Trust for initial care and stabilisation. Because of the travel times involved within this region this is frequently the case. They will then often be transferred to the appropriate Major Trauma Centre.

West Cornwall Hospital’s Urgent Care Centre (UCC) is led by an acute GP team supported by emergency care middle grade doctors and nurse practitioners operating 24 hours a day seven day a week. This is open for patients needing urgent medical care for injuries and conditions such as minor burns and scalds, simple fractures to the arms and legs, cuts, urinary infections and minor falls. It has direct admitting rights to two onsite medical wards and daily acute GP clinics.

The SDEC operates seven days per week, with a multi-disciplinary team of acute GP’s, acute medical consultants, ED consultants and nurse practitioners, with input from specialty services, psychiatric liaison service and adult social care. The service is in the process of further developing its model of operation. Primary care streaming from ED to GP is co-located in SDEC.

Non-elective admissions, from either ED or primary care, are generally admitted through the acute medical unit (AMU) which consists of 47 beds across two wards and a medical assessment area. The AMU aims to discharge or transfer to speciality wards within 24-48 hours.

(Source: Routine Provider Information Request (RPIR) – Context Acute)

Additionally, the ED consultant team provide clinical support and advice to the minor injury units across Cornwall, which are run by another provider.

Activity and patient throughput
From July 2017 to June 2018 there were 184,500 attendances at the trust’s urgent and emergency care services as indicated in the chart below.

Total number of urgent and emergency care attendances at Royal Cornwall Hospitals NHS Trust compared to all acute trusts in England, July 2017 to June 2018
Urgent and Emergency Care attendances resulting in an admission

The percentage of ED attendances at this trust that resulted in an admission fell from 2016/17 to 2017/18. In 2017/18, the rate at the trust was like the England average.

Urgent and Emergency Care attendances by disposal method
Is the service safe?

Mandatory training

Safety systems and processes relating to mandatory training were implemented and communicated through a mandatory training policy. This meant there was clarity as to what training was essential. This policy explained what individual responsibilities were, the trusts approach to mandatory training and reporting processes. Updates to mandatory training and reminders were cascaded through the Emergency Department (ED) staff meetings, governance meetings and through notices and newsletters.

Although all medical and registered nursing staff had received initial mandatory training, not all had received refresher training. This meant that staff were not all up to date with the latest guidance and practices to ensure patients and staff were kept safe. The trust set a target of 95% for completion of mandatory training. However, medical staff failed to meet this target for eight of 12 modules and registered nursing staff failed to meet this target for seven of 12 modules.

A breakdown of compliance for mandatory training courses from May 2017 to April 2018 for medical and registered nursing staff in the ED at Royal Cornwall Hospital is shown below:

Medical staff in the ED:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>100.0%</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>100.0%</td>
</tr>
<tr>
<td>Manual handling – handling objects</td>
<td>98.0%</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>95.9%</td>
</tr>
<tr>
<td>Fire safety</td>
<td>93.9%</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>93.9%</td>
</tr>
<tr>
<td>Information governance</td>
<td>93.9%</td>
</tr>
<tr>
<td>Health and safety (including slips, trips and falls)</td>
<td>93.9%</td>
</tr>
<tr>
<td>Manual handling – handling people</td>
<td>83.7%</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>75.5%</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>57.1%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>24.5%</td>
</tr>
</tbody>
</table>
Resuscitation training had the lowest completion rate with 24.5%. However, 100% of medical staff had completed medicine management training and dementia awareness training.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided for medical staff at Royal Cornwall Hospital had a completion rate of 69.8% for April to August 2018. Medical staff met the 95% target for two modules and improved their compliance rate for one module when compared to the previous time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>42</td>
<td>44</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>42</td>
<td>44</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>40</td>
<td>44</td>
<td>90.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>38</td>
<td>44</td>
<td>86.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>35</td>
<td>44</td>
<td>79.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>31</td>
<td>44</td>
<td>70.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>29</td>
<td>44</td>
<td>65.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>29</td>
<td>44</td>
<td>65.9%</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>24</td>
<td>44</td>
<td>54.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>24</td>
<td>44</td>
<td>54.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>24</td>
<td>44</td>
<td>54.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year</td>
<td>5</td>
<td>36</td>
<td>13.9%</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Registered nursing staff in the ED, from May 2017 to April 2018:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>100.0%</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>98.0%</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>96.9%</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>96.9%</td>
</tr>
<tr>
<td>Manual handling – handling objects</td>
<td>95.9%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>92.4%</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>89.8%</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>88.8%</td>
</tr>
<tr>
<td>Information governance</td>
<td>87.8%</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>86.7%</td>
</tr>
<tr>
<td>Infection prevention</td>
<td>79.6%</td>
</tr>
<tr>
<td>Manual handling – handling people</td>
<td>77.6%</td>
</tr>
</tbody>
</table>

Manual handling (people) had the lowest completion rate with 77.6%. However, 100% registered nursing staff at Royal Cornwall Hospital had completed medicine management training.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)
Updated training data provided for nursing staff at Royal Cornwall Hospital had a completion rate of 90.8% for April to August 2018. Qualified nursing staff met the 95% target for five modules and improved their compliance rate for six modules out of the 12 applicable modules. Thirteen members of nursing staff had completed the adult immediate life support module although none were indicated to have been eligible during this reporting period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>73</td>
<td>73</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>77</td>
<td>79</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>76</td>
<td>79</td>
<td>96.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>76</td>
<td>79</td>
<td>96.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>76</td>
<td>79</td>
<td>96.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>71</td>
<td>79</td>
<td>89.9%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>69</td>
<td>79</td>
<td>87.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>69</td>
<td>79</td>
<td>87.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>68</td>
<td>79</td>
<td>86.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>68</td>
<td>79</td>
<td>86.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year</td>
<td>55</td>
<td>73</td>
<td>75.3%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>59</td>
<td>79</td>
<td>74.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Immediate Life Support</td>
<td>13</td>
<td>-</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

The trust did not provide any mandatory training data for medical staff working in the urgent care centre at West Cornwall Hospital from May 2017 to April 2018. 

(Source: Routine Provider Information Request (RPIR) –Mandatory and Statutory Training tab)

Updated training data provided for medical staff at the West Cornwall Hospital UCC had a completion rate of 90.2% for April to August 2018. Medical staff met the 95% target for nine modules and improved their compliance rate for one (Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year).

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Mandatory training rates for nursing staff at West Cornwall Hospital UCC from May 2017 to April 2018 were also mixed. The 95% target was met for three of the 12 mandatory training modules. The resuscitation training module had the lowest completion rate with 25%. The three modules with 100% compliance were dementia awareness, medicine management and equality and diversity.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (including Privacy &amp; Dignity standards)</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>100.0%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>100.0%</td>
</tr>
<tr>
<td>Manual Handling – handling object</td>
<td>93.8%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>93.8%</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>81.3%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>81.3%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>81.3%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>81.3%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>81.3%</td>
</tr>
<tr>
<td>Manual Handling – handling people</td>
<td>37.5%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>25.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training provided for nursing staff at the West Cornwall Hospital UCC had a completion rate of 85.8% for April to August 2018. Qualified nursing staff met the 95% target for five modules and improved their compliance rate for eight modules out of the 12.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)
The ED had an in-house system for training to give staff the ability to attend. The mandatory training policy stated that training could be accessed through the trusts electronic staff record system and workshops were available through weekly newsletters. However, to improve attendance rates, the emergency department had developed a three-day training system where annually staff would attend and undertake all their mandatory training over several days. However, not all staff had gone through this programme at the time of the inspection. Some training was delivered as face-to-face training sessions, and some was completed by e-learning.

Staff received training to make them aware of the potential needs of patients with mental health conditions, learning disability, autism and dementia through various elements of their safeguarding training, dementia training and regular update sessions with the service leads on these topics.

Training on sepsis (the body’s overwhelming and life-threatening response to infection) management kept patients safe. All staff had received training in the identification and management of sepsis in adult patients. Most staff had a good understanding and could explain processes they would follow as part of the clinical protocol for the management of sepsis. This protocol was in line with the National Institute of Clinical Guideline National Guidance 51: Sepsis recognition, diagnosis and early management. Staff in the emergency department had received training in the use of the automatic sepsis screening tools embedded in the trusts triage system and were able to explain the use of sepsis six care bundles.

Staff working with children had additional training to ensure they were kept safe. All nursing staff working in the paediatric emergency department had received paediatric basic life support and there was an additional set of paediatric competencies to keep children and young people safe. The nurse in charge of the paediatric ED was also trained in advanced paediatric life support and additional support was available from the paediatric ward if required.

All Emergency Nurse Practitioners and GP’s working at West Cornwall Hospital Urgent Care Centre had, additionally to mandatory training, advanced life support training, intermediate life support training, and advance paediatric life support training.

**Safeguarding**

There was an adult safeguarding policy and a child protection policy and procedure. This meant there was clarity as to the safeguarding processes in the trust. This policy explained what individual responsibilities were, the trusts approach to safeguarding and reporting processes. Updates to mandatory training and reminders were cascaded through ED staff meetings, governance meetings and through notices and newsletters.
Safety was promoted in the recruitment processes using Disclosure and Baring Service checks. The trusts Disclosure and Baring (DBS) Policy identified processes to follow on a conditional employment offer being made. Following this process, the offer of employment would either be withdrawn (if new information increased risks to staff and patients) or added to the electronic staff record for information.

Although all medical and registered nursing staff had received initial safeguarding training, not all had received refresher training. This meant that staff were not all up to date with the latest guidance and practices to ensure patients and staff were kept safe. Safeguarding training included sections on mental capacity act and deprivation of liberty safeguards and female genital mutilation and preventing radicalisation.

The trust set a target of 95% for completion of safeguarding training. However, medical staff failed to meet this target for three of five modules and registered nursing staff failed to meet this target for two of five modules.

A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for medical staff in urgent and emergency care at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 1)</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>98.0%</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>67.3%</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>65.2%</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>49.0%</td>
</tr>
</tbody>
</table>

Safeguarding children (level 2) had the lowest completion rate with 49.0%. However, safeguarding children level one had 100% compliance.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated medical staff in urgent and emergency care at Royal Cornwall Hospital only met the 95% target for one of the five modules, with a compliance rate of 76.2% overall. Compliance improved for two modules when compared to the earlier time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 1)</td>
<td>42</td>
<td>44</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>40</td>
<td>44</td>
<td>90.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>30</td>
<td>44</td>
<td>68.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>24</td>
<td>44</td>
<td>54.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>2</td>
<td>5</td>
<td>40.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for registered nursing staff in urgent and emergency care at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>97.6%</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>91.5%</td>
</tr>
</tbody>
</table>
Safeguarding children (level 3) had the lowest completion rate with 81.3%. However, both safeguarding adults and children’s level one had 100% compliance.

(Source: Routine Provider Information Request (RPIR) –Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicates nursing staff in urgent and emergency care at Royal Cornwall Hospital met the target for two of the five safeguarding modules, with a compliance rate of 94.3% overall. Performance improved for one module when compared to the previous time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>78</td>
<td>79</td>
<td>98.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>78</td>
<td>79</td>
<td>98.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>75</td>
<td>79</td>
<td>94.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>71</td>
<td>79</td>
<td>89.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>30</td>
<td>36</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

The trust did not provide any safeguarding training data for medical staff working in the urgent care centre at West Cornwall Hospital from May 2017 to April 2018.

(Source: Routine Provider Information Request (RPIR) –Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicates that medical staff at West Cornwall Hospital UCC met the target for three of the five safeguarding modules, with a compliance rate of 90.9% overall.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>9</td>
<td>11</td>
<td>81.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>8</td>
<td>11</td>
<td>72.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for registered nursing staff in urgent and emergency care at West Cornwall Hospital UCC is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>93.8%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>81.3%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>75.0%</td>
</tr>
</tbody>
</table>

Safeguarding compliance for level one for both children and adults was 100%. Compliance for level two and level three training was below the trust target.

(Source: Routine Provider Information Request (RPIR) –Mandatory and Statutory Training tab)
Updated training provided for registered nursing staff at the West Cornwall Hospital UCC had a completion rate of 91.8% for April to August 2018. The hospital met the 95% target for two modules and improved their compliance rate for two modules out of the five.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>16</td>
<td>17</td>
<td>94.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>16</td>
<td>17</td>
<td>94.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>12</td>
<td>17</td>
<td>70.6%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

With regards to safeguarding children, there was low compliance for level two and level three training for medical staff and level three training for nursing staff. This was not compliant with the Royal College of Emergency Medicine (RCEM): Emergency Department Care quality standard 42 – evidencing safeguarding of children.

Despite training concerns, staff understood their responsibilities to protect patients from abuse and the service worked well with other agencies to do so. Staff could recognise, and report abuse and they knew where to seek advice. Staff gave us examples of when and how they had raised safeguarding concerns and could identify who the safeguarding team were and how to contact them.

There were processes in place to allow alerts to flag up on the computer system from community and primary care providers for patients who were at risk. This was used to identify patients who had been alerted as at risk of abuse, such as at risk of domestic violence. Staff had a good awareness of this process and told inspectors examples where they had alerted the trusts safeguarding team because of different alerts being flagged.

Once the trust safeguarding team had been alerted they were able to attend the department quickly. The safeguarding team were made up of nurses and doctors who could provide advice and support staff in managing patients with safeguarding alerts.

The safeguarding children standards produced by the RCEM clinical effectiveness committee were met. All medical and nursing staff working in the paediatric emergency department were trained to children’s safeguarding level three, this included when staff from the children’s ward worked in the ED. Additionally, staff in the emergency department could describe the processes to access a senior paediatric doctor on call who was available 24 hours a day seven day a week.

**Cleanliness, infection control and hygiene**

The service managed infection risk well. In most instances, staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. This included policies such as the hand hygiene policy, and the clostridium difficile policy. Updates to cleanliness, infection control and hygiene policies and updates were cascaded through ED staff meetings, governance meetings and through notices and newsletters.

Standards of cleanliness were found to be mostly maintained during the inspection. Staff were observed decontaminating their hands (either by washing or gelling) before and after every episode of direct contact or care. This was in line with National Institute for Health and Care Excellence quality statement three – Hand Decontamination. Staff were also bare below the
elbows. The department audited staff compliance for the five moments of hand hygiene. Results showed that in September 2018 90% of staff followed these principles.

However, on all three days of the inspection we occasionally found equipment which was not clean. We occasionally found blood pressure cuffs on the floor which had not been cleaned ready for use on the next patient. We also found an echocardiogram monitor which was dirty. On some occasions it was unclear if trolleys had been cleaned and if blankets and linen were clean or used.

On one occasion in a sluice room a used urine test strip on the left worktop was not cleaned away. And on another occasion, pots of urine were left in the sluice and were there for several hours before they were disposed of. We also found a sharps bin in the minor’s area which had blood splatters on it and had not been cleaned or taken out of use.

**Environmental and equipment infection control audits**

Audits showed that the environment was clean. We reviewed the results of environmental cleanliness audits conducted by an external contractor who provided cleaning services to the trust for the emergency department, the Same Day Emergency Care (SDEC) and the Clinical Decisions Unit (CDU). The results of these were positive against a trust target of 95% (although some results were missing) and can be seen below for areas within the emergency department between August 2017 and July 2018:

<table>
<thead>
<tr>
<th></th>
<th>Jul 18</th>
<th>Jun 18</th>
<th>May 18</th>
<th>Apr 18</th>
<th>Mar 18</th>
<th>Feb 18</th>
<th>Jan 18</th>
<th>Dec 17</th>
<th>Nov 17</th>
<th>Oct 17</th>
<th>Sep 17</th>
<th>Aug 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>97%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>95%</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>99%</td>
<td>98%</td>
</tr>
<tr>
<td>SDEC</td>
<td>97%</td>
<td></td>
<td>97%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>94%</td>
<td>95%</td>
</tr>
<tr>
<td>CDU</td>
<td>96%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>96%</td>
<td>97%</td>
<td>95%</td>
<td>97%</td>
<td>96%</td>
<td>98%</td>
<td>98%</td>
<td>96%</td>
</tr>
</tbody>
</table>

Audits showed that the equipment was mostly clean, but standards had dropped in the last few months before the inspection. We reviewed the results of equipment cleanliness audits conducted by an external contractor who provided cleaning services to the trust. The results of these were mostly positive. However, there were some months where data was not collected. Results can be seen below for areas within the emergency department between August 2017 and July 2018:

<table>
<thead>
<tr>
<th></th>
<th>Jul 18</th>
<th>Jun 18</th>
<th>May 18</th>
<th>Apr 18</th>
<th>Mar 18</th>
<th>Feb 18</th>
<th>Jan 18</th>
<th>Dec 17</th>
<th>Nov 17</th>
<th>Oct 17</th>
<th>Sep 17</th>
<th>Aug 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>93%</td>
<td>74%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
<td>95%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
</tr>
<tr>
<td>SDEC</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>CDU</td>
<td>93%</td>
<td>74%</td>
<td>74%</td>
<td>85%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
<td></td>
<td>98%</td>
<td></td>
<td></td>
<td>98%</td>
</tr>
</tbody>
</table>

Where data was submitted, audits showed that the environments and equipment at West Cornwall Hospital were clean. We reviewed environmental and equipment audits and found submission of data to be inconsistent. Out of a 12-month period only seven submissions were made for both the environmental and the equipment audits. The data for the environmental audit can be found below:

<table>
<thead>
<tr>
<th></th>
<th>Jul 18</th>
<th>Jun 18</th>
<th>May 18</th>
<th>Apr 18</th>
<th>Mar 18</th>
<th>Feb 18</th>
<th>Jan 18</th>
<th>Dec 17</th>
<th>Nov 17</th>
<th>Oct 17</th>
<th>Sep 17</th>
<th>Aug 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>100%</td>
<td>98%</td>
</tr>
</tbody>
</table>

The data for the equipment audit can be found below:
The department audited records associated with the care of patients requiring vascular line care. 80% of patient’s records were completed. This meant most patients were cared for in line with NICE QS61 Statement 5: which states that patients who need a vascular access device have their risk of infection minimised.

The department audited records associated with care of patients requiring urinary catheter care. This showed that 100% of patients had completed paperwork. This was in line with NICE QS61 Statement 4: Patients who need a urinary catheter have their risk of infection minimised.

Cleanliness within the resuscitation room at Royal Cornwall hospital did not promote, infection prevention and control. There were multiple pieces of equipment stored on the top of cupboards which were physically dusty. Windowsills and the tops of curtain poles were also dusty. Clinical waste bins were placed in direct proximity to drug fridges.

Some curtains in majors and the clinical decisions unit did not have replacement dates on them. This meant the department did not know when they required washing.

Due to the location of the dirty utility, ambulance crews were required to walk through the department with dirty linen.

The emergency department was well equipped, and all equipment checked was well maintained. We found that “I am clean stickers” were used for trolleys and wheelchairs when they had been cleaned.

**Environment and equipment**

The design and layout of the emergency department did not always keep patients safe.

There were two major’s areas on either side of a corridor. However, one of the major’s area did not have access to a sluice room. On several occasions during the inspection some nursing staff walking corridors to the clinical decision unit with pots of urine which posed an environmental risk.

The emergency department was frequently crowded. Patients were queued in a corridor between the two major’s units, the clinical decisions unit and the ambulance entrance. This was a confined space which frequently became congested with no call bells or piped oxygen and unless a member of staff was assigned to that area, was un-observed. During our visits on one occasion there were 11 patients queueing in the corridor which made it difficult for the nurse to observe all patients.

We observed practice in the corridor between 18:00 and 19:00 on 5 August. During this time there were 11 patients in the corridor with only one nurse caring for them. Due to the length of the corridor it was not possible to observe all patients effectively at one time. There was a patient in this area who absconded without nursing staff knowing they had done so. During this time several patients also went outside and were unsupervised, one of which presented with chest pain, and one which had taken an overdose of alcohol and drugs. One of the CQC specialist advisors was asked to observe these patients while they managed the care of other patients in this area.

The layout of the resuscitation room was not fit for purpose. Although it had all required equipment within it, it was cluttered and disorganised. There was no standard layout for cubicles which meant equipment was in a different place in all three cubicles making it difficult for staff to find equipment and consumables.
The environment of the paediatric emergency department kept patients safe. The children’s department was co-located but physically separate, providing a secure area, which was not overlooked by adult patients and visitors. The waiting area was also observed by the nurse’s station.

The emergency department mental health assessment room did not meet all the quality standards described by the Psychiatric Liaison Accreditation Network in 2017. The room was equipped with an emergency alarm, but there were ligature points. The design did not protect patients’ privacy and dignity as there was a window in the door which could not be covered to provide a private environment. However, it did contain two doors which opened outwards. This was raised with trust management at the time of the inspection.

Throughout the department sharps bins were consistently left open, with some being overfilled. Some which were in use which were undated. This corroborated with a sharps audit conducted in September 2017 which stated that only 50% of bins were closed properly when audited.

The environment at West Cornwall Hospital met the needs of the staff and patients.

**Assessing and responding to patient risk**

Systems to assess risks to patients did not always keep them safe.

**Ambulance handover**

NHS England recognises that handover delays between the ambulance service and the emergency department can result in increased risk to patients due to delays in diagnosis and treatment, increased risk in the community due to fewer ambulances being available to respond, the ability for the healthcare system to respond to a serious or major incident, and a reduced ambulance response performance.

The median time from arrival to initial assessment was similar the overall England median over the 12-month period from June 2017 to May 2018.

In the latest period, May 2018, the median time to initial assessment was better than the England average. Average handover times were seven minutes compared to the England average of eight minutes. Time of handover compared to the England average can be seen below:

(Source: NHS Digital - A&E quality indicators)

From July 2017 to June 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal Cornwall Hospital with performance ranging from 38-50%. In the latest month, June 2018, 40% of ambulance journeys had turnaround times over 30 minutes. The average number of turnaround times can be see below:
We observed several handovers with ambulance crews and found them to be safe. Ambulance crews were asked when they arrived if their patient was “fit to sit” to see if they were more suitable for the major’s department or for the Same Day Emergency Care (SDEC) unit. However, with one air ambulance handover there were no hospital staff (either nursing or medical) to receive them on arrival which meant the crew had to escort the patient to the CT scanner unaided.

**Number of black breaches for this trust**

From April 2017 to March 2018 the trust reported 309 “black breaches”, with particularly numbers in September 2017 (84), December 2017 (81), February 2018 (61) and March 2018 (34).

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. This increases the delay for the patient in receiving initial diagnosis and treatment.

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)

**Time to initial assessment**

There were streaming and triage systems in place for both ambulance-borne and self-presenting patients. Streaming is a recognised system to allocate patients to the most appropriate location and the correct person to manage their needs. Triage is a process of initial assessment which is described by RCEM as a system which sorts patients according to a combination of their presenting complaint and measured physiological parameters at the time of arrival in the emergency department.

Processes for streaming and assessing patients on arrival in the emergency department were in line with guidance issued by the Royal College of Emergency Medicine (RCEM); however, at times of surge, they were not operating efficiently, and assessments were sometimes delayed. RCEM recommends that systems identify the most time-critical patients for treatment and prioritise the rest.
The department utilised a system called ‘Rapid Assessment and Treatment’ (RAT) for patients arriving by ambulance to triage patients quickly and safely. The department ran a pilot of a doctor led RAT process but found this demanded too much of the senior medical team and meant that doctor availability was reduced. Therefore, nurse led RAT was established. It involved an early assessment of patients attending for ‘majors’; led by a team of nurses to initiate investigations and early treatment significantly reducing triage time and delays to diagnosis and treatment. However, at times, there was no one in the RAT-room to receive the patients and paramedics were waiting for a member of staff to start the process.

The Royal College of Emergency Medicine recommends that patients should be assessed by a healthcare professional within 15 minutes of arrival. This standard was consistently not met between January 2018 and July 2018. In this period the monthly average percentage of patients arriving by ambulance and assessed within 15 minutes was as follows:

<table>
<thead>
<tr>
<th>Month</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>70.4%</td>
</tr>
<tr>
<td>Feb</td>
<td>68.1%</td>
</tr>
<tr>
<td>Mar</td>
<td>68.5%</td>
</tr>
<tr>
<td>Apr</td>
<td>76.6%</td>
</tr>
<tr>
<td>May</td>
<td>69.7%</td>
</tr>
<tr>
<td>Jun</td>
<td>65.9%</td>
</tr>
<tr>
<td>Jul</td>
<td>62.2%</td>
</tr>
</tbody>
</table>

Triage times at West Cornwall Hospital were not monitored. This meant that the unit had no way of identifying if patients were being seen in a timely way.

**Emergency Department Survey 2016**

The trust’s scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*(Source: Emergency Department Survey – September 2016)*

**Ongoing monitoring of risks to patients and identification of deteriorating patients**

There were systems in place for the ongoing monitoring of risks to patients in the emergency department so that staff could identify seriously ill and deteriorating patients. However, the department was failing to ensure that processes were followed consistently.

Some patients were not having observations monitored in a timely way. Two patients, one of whom presented with chest pain and one with advanced liver disease should have had observations undertaken hourly. Both went for three hours before having their observations repeated.

In addition, risk assessments were not carried out in a way that kept people safe. One patient had been identified as having a risk of pressure damage. No actions had been identified or documented and as a result, no preventative actions had been initiated. The same patient had also been identified as a high falls risk, but no action was put in place to reduce this risk. Another patient had been prescribed fluids, but we had found they had not been given in a timely way.
Additionally, this patient, for whom hourly neurological observations had been requested had a seven-hour gap between them being done. This meant that deterioration may not have been identified.

Records for another patient showed observations were incomplete. It was also not possible to identify when they were done. Additionally, there was also no national early warning score observations completed. There was another patient who required a repeat echocardiograph 30 minutes after initial assessment which was not done for several hours.

Another patient who was documented as having sepsis didn’t have all indicators ticked. This meant the diagnosis may have been inaccurate and interventions not appropriate. This patient also had not had fluids for a two-hour period despite them being recognised as requiring this. There was another patient who was identified as having sepsis who didn’t have their checklist completed in a timely way. Although antibiotics were given within an hour, there was no documentation made on the fluid balance chart. Additionally, observations were only being taken every three hours following this which meant that deterioration may not have been identified.

On multiple occasions that there was not suitable observation of patients who were either confused, or at a risk of falls. On one occasion a patient was wondering around Majors who was confused and distressed but there was no one with them. Additionally, there was one occasion where a patient who was a high falls risk tried to get out of bed without anyone observing them.

At West Cornwall Hospital managing risk was good. There was a patient who was identified as requiring transfer to Royal Cornwall Hospital. This was managed well, and the patient was kept safe and well supported until the ambulance arrived.

At West Cornwall Hospital reception staff in the urgent care centre were trained for recognising an unwell patient who needed alerting to the nurses. This was supported by written criteria on the reception wall. Reception staff showed understanding of time critical illnesses and said, “if they look unwell then I alert a nurse, if in doubt I still alert a nurse”.

**Nurse staffing**

The service had enough 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, as there were a significant number of registered nurse vacancies, there was a heavy reliance on temporary staff to ensure that assessed and planned staff to patient ratios were consistently met.

The trust reported their staffing numbers below for qualified nursing staff and support staff as of September 2018 in terms of whole time equivalents (WTE).

<table>
<thead>
<tr>
<th></th>
<th>Planned WTE staff</th>
<th>Actual WTE in post</th>
<th>Vacant posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurses</td>
<td>155.59</td>
<td>115.23</td>
<td>40.36</td>
</tr>
<tr>
<td>Support staff</td>
<td>116.59</td>
<td>99.69</td>
<td>16.90</td>
</tr>
<tr>
<td>West Cornwall Hospital</td>
<td>17.3</td>
<td>16.7</td>
<td>0.5</td>
</tr>
</tbody>
</table>

The service had been employing significant numbers of temporary staff to meet the required (assessed) nurse to patient ratios. In September 2018 the service had employed 37.62 WTE temporary staff including agency and those working on bank contracts.

*(Source: Core Service Information Pack – Urgent and Emergency Services – P4)*

From May 2017 to April 2018, Royal Cornwall Hospital reported 352 shifts filled by bank staff and nine shifts filled by agency staff for nursing assistants. There were 57 shifts that were left unfilled.
Over the same period, there were 733 qualified nurse shifts filled by bank staff and 2,278 shifts filled by agency staff in urgent and emergency care. There were 277 shifts not filled by bank or agency staff.

Staffing at West Cornwall Hospital was good, which meant consistent care was provided. From May 2017 to April 2018, the trust reported no bank or agency shifts were filled by qualified nurses or nursing assistants at the urgent care centre at West Cornwall Hospital.

Turnover rates were better than the trust average at Royal Cornwall Hospital, but was higher than the trust average at West Cornwall Hospital. From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 7.6% in urgent and emergency care trust wide, compared to the trust level target range of 10-14%. West Cornwall Hospital reported a turnover of 16.1%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates were better than the trust average. From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 2.5% in urgent and emergency care trust wide, compared to the trust target of 3.8%. West Cornwall Hospital reported a sickness rate of 1.1%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Medical staffing

There was sufficient medical cover to meet Royal College of Emergency Medicine standards. Consultants were available 24 hours a day seven day a week. Medical staff were positive about the introduction of two middle grade doctors on duty overnight which had improved the quality of care and availability of medical staff.

Medical staffing numbers had improved since the last inspection. Additional emergency department consultants had been employed with additional advertising for posts ongoing both in the UK and in Australia for senior and middle grade doctors. Additionally, five clinical fellow posts (a senior house officer/junior specialist registrar with research interests) had been recruited from a field of over 40 applicants, to develop the service.

Some doctors we spoke with described how they were stretched as they had to manage patients in both the emergency department and the clinical decisions unit. These patients ideally would have been admitted onto a ward, but due to capacity remained in ED adding to the workload of doctors. Doctors said these patients took a lot of their time when they should have been managed by the in-patient medical or speciality teams. However, medical staff felt better supported in the clinical decisions unit by medical staff at times of surge.

Medical cover at West Cornwall Hospital was provided by GP’s.

Planned vs actual

The trust has reported their staffing numbers below as at April 2018 for medical staff in urgent and emergency care at Royal Cornwall Hospital, with an over-established staffing rate of 8.6%.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Planned WTE Staff</th>
<th>Number in post as at April 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>92.9</td>
<td>100.9</td>
<td>Over-establishment of 8.6%</td>
</tr>
</tbody>
</table>

The trust did not provide any medical staffing data for the urgent care centre at West Cornwall Hospital.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)
Vacancy rates
Vacancies were worse than the trust average. From May 2017 to April 2018, Royal Cornwall Hospital reported a vacancy rate of 16.4% in urgent and emergency care, compared to the trust target of 10% at March 2018 and 6% at March 2019.

The trust did not provide any vacancy data for medical staff in the urgent care centre at West Cornwall Hospital.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates
Turnover was better than the trust average. From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 8.0% in urgent and emergency care, compared to the trust level target range of 10-14%:

The trust did not provide any turnover data for medical staff in the urgent care centre at West Cornwall Hospital.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
Sickness rates were better than the trust average. From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 0.1% in urgent and emergency care, compared to the trust target of 3.8%:

The trust did not provide any sickness data for medical staff in the urgent care centre at West Cornwall Hospital.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage
From May 2017 to April 2018, the trust reported 141 shifts filled by locum staff (junior doctors) in urgent and emergency care. There were six shifts not filled by locum staff.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix
In March 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher. However, junior doctors did not find it difficult to access consultant advice, support or opportunities to learn.

Staffing skill mix for the 38-whole time equivalent staff working in urgent and emergency care at Royal Cornwall Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Staffing Level</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>22%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>28%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>24%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>26%</td>
<td>23%</td>
</tr>
</tbody>
</table>
Records

Records, such as safety checklists, were not completed in a way that kept people safe at Royal Cornwall Hospital. The emergency department used an ‘emergency department patient safety checklist’ as a resource to maintain patient safety in a crowded department. NHS improvement has highlighted that the use of a safety checklist has been proved to improve clinical processes and reduce incidents from unrecognised patient deterioration.

In the morning of 4 September, we checked 12 checklists in major’s one and six checklists in major’s two and found none of them to be completed past the initial assessment. We found that the initial assessment (filled in during triage) was used as a tick box exercise and was not completed properly. The way in which the initial assessments were completed meant that it was impossible to identify if individual activities (such as bloods being taken or imaging) had been completed.

We escalated our concerns to the executive team in the evening of 4 September.

In the morning of 5 September, five checklists out of eight patients were incomplete. Although some had had initial assessments and the first few hours of the checklist completed.

However, audit results contradicted our findings. Audit results showed good compliance to the National Institute of Health and Care Excellence Quality Standard 15 Statement 12 which states that there should be accurate and clear information on patient care. We reviewed documentation audits conducted by the trust. In September 2018 100% of records checked had a nursing assessment and discharge plan completed, 90% of records had an up to date care plan for each problem identified, 100% of records checked had legible handwriting and 90% of records had entries which included a signature, name and job title.

All staff we asked had secure access to relevant electronic information. Staff secured computers when not in use and these were password protected to prevent unauthorised access.

We checked 11 patient records at West Cornwall Hospital. We found they were all completed, accurate and were legible.

Medicines
There were processes and practices (through a management and administration of medicines policy, controlled drugs policy, and standard operating procedures) meant that medicines were prescribed and administered in line with best practice and national guidelines.

Medicines were stored safely. Rooms where medicines were stored had thermometers in situ which were monitored remotely by the pharmacy department. Fridges where medicines were stored had their temperatures monitored in the same way. This ensured oversight of when a medicine may be spoiled due to excessive high or low temperatures. All medicines were stored in locked rooms with medicines in the clinical decisions unit being stored in an automated medication dispensing system which required a staff members thumb print for access.

Patients own medicines (excluding controlled drugs) which they brought in with them were kept with the patient until they were either discharged or transferred to a ward. Patient's controlled drugs were locked away, in the controlled drugs cupboard a record was made in the departments ’Patients Own Controlled Drug' register.

Processes for managing controlled drugs kept patients safe. All orders for controlled drugs were signed by a nurse and there was awareness from staff of who the controlled drugs accountable officer was. Controlled drugs were checked twice a day by two trained nurses. Additionally, controlled drugs for disposal were kept separate to those in use.

Most controlled drugs were stored securely and locked away in the controlled drugs cupboard. However, there were controlled drugs which were kept in an unlocked draw in the resuscitation room. This meant that staff and patients could have unauthorised access to these drugs. We raised this with department leaders during the inspection.

Stock medicines were ordered by the pharmacy team but there were processes in place for a nurse to order these medicines if necessary. Medicines required following patient discharge from the emergency department were dispensed by the on-site outpatient pharmacy with specific prescription forms which were printed using an electronic system. ‘To Take Home’ packs (packs of pre-prepared medicines to supply the patient with enough medicines until they could get to their own pharmacy) were available when the pharmacy was closed.

If the outpatient pharmacy was closed, and medicines were unavailable for the ‘To Take Home’ pack FP10 forms could be used to allow the patient to go directly to a pharmacy and retrieve medinas. The use of these forms was monitored by the pharmacy service in hospital.

We checked a selection of medicines and controlled drugs and they were all found to be in date.

In the emergency department there were ‘Patient Group Directions’ (PGD) in place. PGD’s are written instructions to allow nurses to supply or administer medicines to patients, in planned circumstances. We checked a selection of these and found them all to be in date, and appropriately authorised. There were processes in place for the department to apply to the medicines committee if further PGD’s were required.

**Incidents**

Staff described an open culture for reporting incidents, including medicine incidents. There was a computerised system used to report which sent notifications to the emergency department (ED) matrons to investigate incidents. There were processes in place to escalate incidents further to the divisional leadership team if necessary. Once a medicine incident had been reported a summary report was sent to the medicines safety committee and following investigation learning was fed back to the ED and disseminated across the trust.
Staff we spoke with were aware of their statutory obligation to observe the duty of candour when a patient has come to harm because of a clinical error. The culture to be transparent when something went wrong, and apologising extended to incidents where a patient had not come to harm, and when experiences for patients were poor. We were shown a duty of candour letter which was given to a patient if something went wrong, this highlighted the fact that the trust would investigate it and how they would contact the patient regarding the error.

We reviewed four serious incidents and found them all to follow the serious incidents framework 2015. All incidents had an associated report quality assurance checklist which identified that all investigations had been conducted by an appropriately trained member of staff, that enough evidence was gathered, that information was analysed well, and that solutions were compressive. They also included checks on the clarity of reports, and if the duty of candour had been applied.

Lessons from incidents were shared in different ways. Serious incident action plans were created which had disseminating and sharing of information as a core action from incidents that occurred. Additionally, lessons learnt were shared through the ED newsletter, and in the department’s monthly governance meeting.

External safety alerts were shared with the department from the trusts governance team. They set expectations and the department were required to provide evidence when action had been taken. Safety alerts were shared through the staff notice boards and at daily safety briefings.

Mortality and morbidity reviews fed into service improvement. Emergency department reviews and governance reviews were held monthly. There was a multidisciplinary approach to managing mortality and morbidity and an action plan was produced following findings.

**Never Events**

From June 2017 to May 2018, the trust reported no incidents classified as never events for urgent and emergency care.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 14 serious incidents in urgent and emergency care which met the reporting criteria set by NHS England from June 2017 to May 2018. The site at which the incident occurred was not specified in most cases.

The breakdown of the types of incident reported is:

- Treatment delay meeting SI criteria with six (42.9% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with three (21.4% of total incidents)
- Abuse/alleged abuse of adult patient by staff with one (7.1% of total incidents)
- Abuse/alleged abuse of child patient by staff with one (7.1% of total incidents)
- VTE meeting SI criteria with one (7.1% of total incidents)
- Major incident/ emergency preparedness, resilience and response/ suspension of services with one (7.1% of total incidents)
- Medication incident meeting SI criteria with one (7.1% of total incidents)

(Source: Strategic Executive Information System (STEIS))

Is the service effective?
Evidence-based care and treatment

The emergency department (ED) at Royal Cornwall Hospital and the urgent care centre at West Cornwall Hospital provided care and treatment in accordance with evidence-based guidance, including Royal College of Emergency Medicine (RCEM) and National Institute for Health and Care Excellence (NICE) guidelines. There was a suite of clinical guidelines, which were well organised and easily accessible on the intranet. Each speciality had a lead consultant who was responsible for ensuring these were up to date.

All clinical protocols and pathways were readily available on the computer systems to guide treatments and pathways. These were ‘owned’ by the emergency department so they could easily be changed based on learning from incidents, or updates to pathways and processes.

At West Cornwall Hospital, in addition to computerised protocols, there was information displayed in the resuscitation room regarding the management of critical conditions. Such as the H’s and T’s of advanced cardiac life support. This is a mnemonic used to aid the diagnosis of the possible causes of a cardiac arrest. The chest pain pathway was also displayed on the wall directing staff on the best practice for managing patients with this condition.

Nutrition and hydration

Most patients we spoke with said they had been offered food or drink while they had been waiting. However, when the department was busy more patients were asking for drinks and did not get them in a timely way. We spoke with one patient who said they had been waiting several hours in the department and didn’t know if they could get a drink. We raised this with the nurse on duty who got the patient a drink.

The Royal Cornwall Hospital department performed well in nutrition and hydration audits. In August 2018 the audit results showed that 100% of patients who were not nil by mouth had been offered food or drink in the clinical decisions unit and in majors one. In majors two 86% of patients had been offered food or drink. In September 2018 100% of patients audited in the clinical decisions unit and majors two had been offered food or drink. Of the patients in majors one, 86% had been offered food or drink.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.1 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as than other trusts.

(Source: Emergency Department Survey – September 2016)

Pain relief

The Royal Cornwall Hospital department audited the management of pain and results required improvement. The audit identified that almost all patients had their pain assessed when they arrived in the department, the administration of analgesia within 20 minutes and re-assessment within 60 minutes was poor. Between September 2017 and September 2018 96% of patients had pain assessed on arrival. In the same time only 76% of patients had received any analgesia within 20 minutes and only 82% of patients had had pain reassessed within 60 minutes. This meant that patients did not have their pain management optimised for their changing pain.

At West Cornwall Hospital we checked 11 records and found that all patients had a pain score completed. However, on six of these that repeat pain scores were not assessed. This meant that patients did not have their pain management optimised for their changing pain.

Emergency Department Survey 2016
In the CQC Emergency Department Survey, the trust scored 4.8 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7.4 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey – September 2016)

Patient outcomes

The trust had in place a corporate record of all clinical audit activity, which was aligned and informed by the annual clinical audit plan. The ED plan was agreed annually at a sub-board meeting of the quality assurance committee. Clinical audit leads were appointed in the ED at specialty level and provided leadership in their clinical area. This work was supported by the central team to ensure projects were well designed to maximise positive impact and learning obtained from audit work.

We were given a list of internal audits conducted by the emergency department which were held on the corporate clinical audit record and examples of where learning had been taken to improve compliance. For example, a fractured neck of femur consent audit was conducted which identified that there were not enough appropriate consent forms in the emergency department and identified that junior doctors needed further education in the correct processes for consenting fractured neck of femur patients.

Information about clinical outcomes was collected and monitored. The trust participated in national Royal College of Emergency Medicine (RCEM) audits, so they could benchmark performance against best practice and other emergency departments. Performance was mixed. However, there were action plans in place to resolve concerns.

RCEM Audit: Moderate and Acute Severe Asthma 2016/17

In the 2016/17 Moderate and Acute Severe Asthma report, Royal Cornwall Hospital failed to meet any of the standards (which were all 100%), although few trusts achieve these standards.

The hospital was in the upper UK quartile for one standard:

Standard 1a: O2 should be given on arrival to maintain oxygen saturation 94-98%. This site: 31.6%; UK: 19%.

The hospital was in the lower UK quartile for one standard:

Standard 5a: If not already given before arrival to the ED, steroids should be given within one hour of arrival (acute severe). This site: 3.3%; UK: 19%.

The hospital’s results for the remaining five metrics were all between the upper and lower UK quartiles.

West Cornwall Hospital did not participate in this audit.

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, Royal Cornwall Hospital failed to meet any of the standards (which were all 100%), although few trusts achieve these standards.

The hospital was in the upper UK quartile for two standards:

- Standard 3: Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge – 52.3% compared to the national aggregate of 12%.
• Standard 4: Consultant reviewed – abdominal pain in patients aged 70 years and over – 26.3% compared to the national aggregate of 10%.

The hospital's results for the remaining two standards were both between the upper and lower UK quartiles.

West Cornwall Hospital did not participate in this audit.

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, Royal Cornwall Hospital failed to meet any of the standards (which were all 100%), although few trusts achieve these standards.

The hospital was in the upper UK quartile for two standards:

• Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. This site: 64.6%; UK: 30.4%.

• Standard 5: Blood cultures obtained within one hour of arrival. This site: 63.6%; UK: 44.9%.

The hospital was in the lower UK quartile for two standards:

• Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This site: 26.0%; UK: 69.1%.

• Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This site: 31.0%; UK: 64.6%.

The hospital's results for the remaining four metrics were all between the upper and lower UK quartiles.

West Cornwall Hospital did not participate in this audit.

Unplanned re-attendance rate within 7 days

From June 2017 to November 2017, the trust’s unplanned re-attendance rate to A&E within seven days was worse the national standard of 5% but about the same as the England average.

However, in the winter months, December 2017 to February 2018, the unplanned re-attendance rate within seven days improved and was better than the national standard. From March 2018 to May 2018, performance declined once more and in the latest period, May 2018, the rate at the trust was 10.7% compared to an England average of 7.9%.

Unplanned re-attendance rate within 7 days - Royal Cornwall Hospitals NHS Trust
Competent staff

The service provided appropriate training and support to ensure staff were competent for their roles.

The ED had a team of emergency nurse practitioners (ENP’s) throughout the service. ENP’s are senior emergency department nurses who are qualified to assess, diagnose, and treat patients without having to refer to a doctor. During the inspection, the department had employed an additional seven ENP’s in training roles to develop their skills to build the confidence and competence of this staff group.

Staff were positive about the use of simulations in the ED. There was a regular programme of simulations conducted and all staff we spoke with about this were aware of recent examples and what practice changed as a result. There were three simulation training sessions per month, conducted in a multidisciplinary approach to involve all elements of a patient’s pathway. There was a recent example in the children’s ED where they simulated the management of a collapsed child which led to some learning.

New starters in the emergency department had a comprehensive induction pack which prepare them for their role. The pack included a structured programme of learning and development over six months and discussed processes in the different areas of the department and what to do when different patients present, for example, how to call the psychosis team in the trust. Additionally, the department had a ‘back to basics’ leaflet for all nurses to follow when looking after a patient presenting in the ED.

Medical staff described how they had received training to enhance their understanding and application of ultrasound and echocardiography skills during resuscitation. Staff were positive about this and felt the programme was well structured and informative.

New staff working at West Cornwall Hospital were required to be supernumerary for three weeks to ensure they were fully informed of protocols and processes.

Competency assessments at West Cornwall Hospital included a one-day triage course which was delivered at Royal Cornwall Hospital and an online Ionising Radiation (Medical Exposure) Regulations course to allow the nursing staff to refer patients for X-ray. Additionally, staff would need to be competency assessed to be able to read and interpret X-rays.

Appraisal rates
Up to August 2018, 77.4% of staff within urgent and emergency care at Royal Cornwall Hospital had received an appraisal compared to a trust target of 95%. Nursing staff had a completion rate of 76.6% and medical staff had a 58.1% completion rate. This meant that not all staff had opportunities to discuss development or career progression.

Up to August 2018, 75% of staff within the urgent care centre at West Cornwall Hospital had received an appraisal compared to a trust target of 95%. Nursing staff had a completion rate of 75%. No data was provided for medical staff. This meant that not all staff had opportunities to discuss development or career progression.

Appraisal rates at Royal Cornwall Hospital by staff group are below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to scientific, therapeutic and technical staff</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>85.5%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>79.3%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>76.6%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>66.7%</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>58.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>77.4%</strong></td>
</tr>
</tbody>
</table>

Appraisal rates at West Cornwall Hospital by staff group are below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>75.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>75.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>75.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Appraisals at West Cornwall Hospital were displayed in the staff room. Appraisals were linked to both Nursing and Midwifery Council re-validation and with the trust values. The process went through objectives, career aspirations and personal development plans.

**Multidisciplinary working**

Staff, teams and services worked well to deliver effective care and treatment. However, some staff in the emergency department felt more could be done by the specialities to support flow out of the department. Most referrals from the emergency department were to the acute medical or surgical speciality teams. Medical admissions were usually via the Acute Medical Unit (AMU) or through the Same Day Emergency Care (SDEC) service. Medical teams were regularly seen in the emergency department and were available to review patients. The surgical speciality teams were available, but this was not consistently available during times of pressure. We were told that Trauma and Orthoptic surgical teams were most difficult to get support from. Although, there were plans in place to improve availability.

Leaders told inspectors that teamwork between the department and the medical teams had improved since the last inspection. We were told that they worked pre-emptively to escalate when they would be busy and are clear and to what actions would be most effective at times of surge.

There were various pathways to stream patients to different parts of the hospital and away from the emergency department which involved multi-disciplinary working. The SDEC service had a team of acute GP’s, acute medical consultants, ED consultants and nurse practitioners, with input...
from specialty services, psychiatric liaison service and adult social care to prevent admission to
the hospital. Patients who were likely not to need an admission were seen in this area. An out of
hours a GP’s worked overnight in a primary care capacity working with the staff in the ED to
stream patients away from the department.
We observed several staff handovers. During these meetings, staff routinely referred to the
psychological and emotional needs of patients, their relatives and carers.
A team, called the Acute Early Intervention Therapy Team (AEITT) had been introduced in the
emergency department which had reduced the length of stay and improved outcomes for patients
referred. The service included occupational therapists, dieticians, physiotherapists and speech
and language therapists who provided an early assessment and intervention for patients
presenting at the emergency department. Between April and June 2018, the service saw 551
patients a month for those patients had reduced length of stay by an average of 5.2 days per
patient. Additionally, patients could be discharged by the team and referred to direct access
outpatient clinics preventing admission. For example, a patient presenting with difficulty
swallowing could be referred for a video-fluoroscopy clinic held collaboratively between the AEITT
team and a consultant radiographer.

Seven-day services
The emergency department had a full range of services seven days a week at both Royal
Cornwall Hospital and West Cornwall Hospital.
The emergency department was co-located next to the diagnostic imaging department who
provided a 24 hours 7 day a week service which included rapid access to CT scanner facilities.
Occupational health services were available seven days a week, with a ‘twilight’ evening service
available between Monday and Friday. Dietetic services were available five days a week. Speech
and language therapists provided a five day a week service and physiotherapists were available
six days a week.
The trust had an agreement with a local community trust who provided mental health liaison
service 24 hours a day, seven days a week.

Health promotion
The emergency department supported patients to maintain their independence by encouraging
patients to get dressed and get moving in the emergency department if it was safe to do so. This
has been proven to decrease dependency on staff and increase motivation and confidence.
The trust also had an addiction Hospital Outreach Team (HOT) who were working with the alcohol
liaison team, psychiatric team and safeguarding team to focus on regular attenders at the
emergency department to identify and address reasons behind multiple attendances. This
included patients attending with severe alcohol and drug problems and provide support and care
packages to minimise attendance to hospital.
The trust had a frailty team who could provide assessments in the emergency department for
patients at risk of falls. This team was made up of consultants and nurses who worked across the
hospital and community hospitals.
At West Cornwall Hospital there were management plans for frequent attenders which meant that
staff working could facilitate the holistic care of patients, even if they didn’t require medical
attention.
At the urgent care centre, the service ran an acute frailty service to provide assessments for
patients at risk of falls. This was with the aim to reduce the risks to these patients and to reduce
the likelihood of them being admitted to hospital. This service was led by GP’s employed by the trust with support from a middle grade doctor.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance including the Mental Capacity Act, 2005. During the inspection we spoke with various staff regarding the need for capacity assessments and found that understanding was inconsistent. Staff recognised that there was an increase in patients attending the emergency department with mental health conditions but felt that there wasn’t enough specific training to allow them to support patients.

One patient had been given intra-muscular rapid tranquiliser medication, but it was not clear what was documented to assess capacity or to record a best interest decision.

From May 2017 to April 2018 Mental Capacity Act (MCA) level 1 training had been completed by 98.7% of staff within urgent and emergency care at Royal Cornwall Hospital. Nursing staff had a completion rate of 96.3% and medical staff had a 100% completion rate.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level one training had been completed by 98.8% of staff within urgent and emergency care at Royal Cornwall Hospital. Nursing staff had a completion rate of 97.5% and medical staff had a 95.5% completion rate.

*(Source: Updated data provided by the trust)*

From May 2017 to April 2018 MCA level 1 training had been completed by 100% of staff within urgent care centre at West Cornwall Hospital. Nursing staff had a completion rate of 100%.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level one training had been completed by all staff within the urgent care centre at West Cornwall Hospital. Both nursing and medical staff had 100% completion rates.

*(Source: Updated data provided by the trust)*

**Is the service caring?**

**Compassionate care**

All patients we spoke to told us they received care and treatment from attentive and caring staff. One patient told us that the “nurses are lovely” and that “nothing was too much trouble”. Another patient said, “the nurses are polite and friendly”.

Most staff introduced themselves when they approached a patient and were made aware of roles and responsibilities of the healthcare team. This was in line with National Institute of Health and Care Excellence quality standard 15 – statement three.

Receptionists greeted patients who self-presented to the emergency department politely and were welcoming patients in a compassionate way. We observed cleaning staff having conversations with patients and chatting with them to put them at ease. We also saw that the booking staff working at the ambulance entrance provided a warm welcome to patients.
It was clear that the camaraderie between the ambulance staff and the nursing staff was having a positive impact on the anxieties of patients attending the emergency department. Patients were included in jokes. One patient said, “it’s been fun being able to wind up the nurses with the ambulance team”.

Patients privacy and dignity were not always respected. Patients were triaged through rapid assessment treatment (RAT) in a corridor. We were consistently able to hear private conversations between nurses and patients. When the department was crowded, on multiple occasions nursing staff were performing assessments in the corridor. There was also a patient in the corridor who was vomiting. They were not offered a cubicle or privacy screen. One nurse was observed cannulating a patient and administering fluids in the corridor. There were no screens to protect privacy and dignity.

In West Cornwall Hospital privacy and dignity was not always maintained. During triage, on multiple occasions, the door was not closed. This meant that conversations could be overheard, and privacy was compromised.

On one occasion we observed a nurse failing to respond to multiple requests for help from the relative of a patient who needed to use the toilet. It took unnecessary discussion from the relative to stop the nurse looking at paperwork and help them. We also found there was a patient who was asking for help as they were cold but were unable to get the attention of nurses.

On regular occasions call bells were sounding for long periods of time which were being ignored. One call bell sounded for five minutes with multiple staff walking by and ignoring it. We found some examples where call bells were left for up to ten minutes before a member of staff would respond. On one occasion a frail patient, whose call bell was ringing for five minutes, was seen by inspectors trying to get out of their bed without support. CQC inspectors alerted staff to this situation and no harm came to the patient.

Call bell audits were mixed. We reviewed audit results for call bell’s in the emergency department in August 2018. The audit results showed that 25% of patients in the clinical decisions unit did not have a call bell in reach. In Majors one, 12% of patients did not have a call bell in reach and in majors two 9% of patients did not have a call bell in reach. In September 2018 results had improved. In the clinical decisions unit all patients had a call bell in reach, and in majors one only 10% of patients did not have a call bell in reach and 17% of patients in majors two didn’t have a call bell in reach. This meant that patients were not always able to ask for help when they needed too.

**Friends and Family test performance**

From July 2017 to June 2018 the trust’s urgent and emergency care friends and family test performance (% recommended) was consistently better than the England average.

In the latest period, June 2018, performance was 96.1% compared to the England average of 87.4%. This showed that more patients than the England average responded to the questionnaire making the data more reliable.

**A&E Friends and Family Test Performance - Royal Cornwall Hospitals NHS Trust**
Emotional support

We saw good examples of staff giving emotional support to patients at West Cornwall Hospital. Nurses were frequently reassuring patients if they were distressed or upset and could give clear information to alleviate anxieties before, during and after procedures.

Staff spoke with children in a way they could relate too which engaged them and relieved them of anxieties or worries of being in hospital.

One patient we spoke with said they were angry that they had to attend the hospital but said that the nursing staff spoke with her and calmed her down. The patient said that they were understanding and the “lovely nurses helped me with my stress”.

Understanding and involvement of patients and those close to them

Staff communicated with patient in a way, so they understood their care, treatment and condition. One example of this was in the rapid assessment and treatment room where we saw a confused patient having their treatment explained to them in a way they understood. The nurse also included the patients relative in this conversation to ensure they were also aware of what was going to happen.

Another example was with a nurse bringing a patient through from the main waiting room. This patient was asking questions about their care and the answers were explained in a caring and compassionate way to put the patient at ease.

We spoke with the relative of a patient who attended the emergency department. We were told that they were involved in the planning of the treatment and the decisions around admitting them to a ward. The relative felt listened too and had their views considered by the doctors.

Emergency Department Survey 2016

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in all 24 questions relevant to caring.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a manner you could understand?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing, and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey – September 2016)

Is the service responsive?
Service delivery to meet the needs of local people

The department was part of system wide processes aimed at reflecting the needs of the population served in a flexible way to try and promote continuity of care.

The Operational Pressures Escalation Framework (OPEL) detailed how the trust identified and responded to pressures within its system daily as well as times of extra-ordinary pressure. This framework related to adult beds and includes the emergency department flow. Each day bed meetings took place at 8am, 12 mid-day and 4pm to review the flow of patients through the hospital.

Those meetings were attended by the site management team, bed managers, ward senior staff, transport staff and the emergency department leadership team. It was clear that the focus of the meetings was based on safety, and staff worked cohesively and persistently to drive flow through the hospital.

In between those meetings board rounds were held. These were held every four hours and included the ED team and the site management team. These meetings detailed the current state of the department, and actions regarding flow which were ongoing, including discharges and ward transfers.

The emergency department had a ‘full capacity protocol’ which set out the steps to be taken to address crowding in the emergency department. When the department was full, the protocol was activated to promote flow out of the department. Managers in the department felt that the actions between OPEL 3 and OPEL 4 were not felt in the department. An example was given when the hospital was in OPEL 3 the emergency department would commonly be meeting the criteria for OPEL 4 but not get the support required to manage the situation.

A system of bronze, silver and gold command meetings were used to escalate any developing issues around bed management and flow of patients. An 11:30 call each day was made between the trust and external stakeholders. This was a bronze command meeting. A silver command meeting was called during inspection to review delayed transfer of care patients and in April 2018 a gold command meeting had been called to address a crisis in the flow of patients. At that time an extra 60 beds had been made available in the community to enable the flow of patients out of the hospital.

Facilities and premises were not wholly appropriate for the services delivered at Royal Cornwall Hospital. Demand for services frequently outstripped the availability of appropriate clinical spaces to assess, treat and care for patients.

Patients frequently queued in the corridor in the emergency department, where it was difficult to maintain their comfort, privacy and dignity. The department were unable to show how many patients had waited in the corridor, or for how long they had been in there. This meant the department were unable to identify waiting times for patients in this inappropriate area.

The department had patient pathways in place to stream patients to primary care services to reduce the burden on the emergency department. This included an onsite GP service, an acute GP service, and access to the Same Day Emergency Care service, for patients who were likely not to need an admission. The use of these service has greatly increased between January and August 2018. In January 523 patients were streamed away from the emergency department. In August 808 patients were streamed away from the emergency department. This had been increasing steadily throughout the year.

There was enough seating and space in the reception and waiting areas. The reception desk was adequate distance away from seating areas to ensure conversations could not be overheard.
The reception area had a screen which showed the live waiting times for the department, the urgent care centre and minor injury units throughout Cornwall.

Patients had access to information leaflets which staff could print off if required. Staff told inspectors of the different leaflets available for managing treatments, wellbeing, and information leaflets about charities and other services available.

At West Cornwall Hospital the facilities were not wholly appropriate for care provided. The department was not well signposted, which meant it was difficult for patients to find it. Also, the waiting room was small, there was no separate children’s waiting area and there were no refreshments available.

**Meeting people’s individual needs**

The department identified the needs of patients with communication needs, a disability or sensory loss through a flagging process on their computer system. For example, if a patient with a learning disability or autism presented at the ED with a flag, it could alert the disability liaison team to come and see the patient.

Staff working in the paediatric ED could refer patients with learning disabilities or mental health issues to other support services. This included access to charities which funded surf therapy sessions and beach therapy sessions which aimed to reduce a child's anxiety and increase confidence.

Additionally, staff could refer to a charity which offered a community alcohol and drug treatment service for young people in Cornwall. They could provide specialist substance misuse treatment to children and young people aged between 11 and 18 including assessment, treatment and advice.

Housekeeping staff performed refreshment rounds of the department during the day and offered patients drinks. However, staff commented that there were insufficient housekeepers to run this service consistently. Although all patients had access to water fountains, some patients didn’t know where they were or that they were available for patients to use.

Access to the adult mental health liaison service was positive. The service was staffed by 11.4 whole time equivalent band six nurses, one band seven clinical lea and a full-time consultant with a minimum of two staff rostered at any one time. If a patient required, an emergency referral the mental health liaison team planned to have a face to face contract with the patient within an hour with a care plan in place within four hours. However, this service was spread geographically across the county which meant responding to referrals in a timely way was difficult.

There were also processes in place to gain access to children and adolescent mental health services (CAHMS). However, CAHMS was only available until 5pm each day. To ensure the safety of patient’s staff working in the paediatric ED had received training to allow them to discharge patients home if they needed too. Also, if a patient was going to be spending more than four hours awaiting an assessment, they would be admitted to the children’s assessment unit.

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>condition with the receptionist?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>department last?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or</td>
<td>8.7</td>
<td>About the same</td>
</tr>
<tr>
<td>or examined?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Access and flow

There were systems used to promote flow, but these were not always effective, as increasing demand in the emergency department outweighed the trust ability to admit or discharge patients in a timely manner. Patients were not always able to access care and treatment in a timely way and in the right setting. The trust was consistently failing to meet national standards in relation to the time patients spent in the emergency department, the time they waited for treatment to begin and the time they waited for an inpatient bed.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust set an internal target of 50% of patients receiving treatment within one hour and this was met between January 2018 and July 2018 in three months. Average percentage of patients treated within one hour can be seen below:

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.8%</td>
<td>45.4%</td>
<td>48.7%</td>
<td>59.5%</td>
<td>52.7%</td>
<td>41.5%</td>
<td>38.6%</td>
</tr>
</tbody>
</table>

Despite meeting internal targets, in April and May 2018, performance was worse than the standard and the England average.

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED.

From January 2018 to July 2018, the trust met the standard once and breached the standard six times. In majors the four-hour target was breached for all seven months and the four-hour target in minors was met for all seven months. Performance improved from March 2018 and was above the national standard in April and May 2018. In June 2018, performance dropped below the standard, but was higher than the England average.

The month of worse overall compliance was February 2018 where overall compliance was 65.2% (with only 39.6% compliance in majors). A breakdown of percentage compliance can be seen below:

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>71%</td>
<td>65.2%</td>
<td>78.7%</td>
<td>95.2%</td>
<td>92.6%</td>
<td>85.4%</td>
<td>83.4%</td>
</tr>
<tr>
<td>Majors</td>
<td>46.8%</td>
<td>39.6%</td>
<td>56.4%</td>
<td>89.2%</td>
<td>84.7%</td>
<td>69.5%</td>
<td>66.6%</td>
</tr>
<tr>
<td>Minors</td>
<td>99.4%</td>
<td>97.8%</td>
<td>99.0%</td>
<td>99.3%</td>
<td>98.1%</td>
<td>96.3%</td>
<td>94.4%</td>
</tr>
</tbody>
</table>

Percentage of patients waiting more than four or 12 hours from the decision to admit until being admitted

From January 2018 to June 2018, Royal Cornwall Hospitals NHS Trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse
than the England average for all six months. A breakdown of percentage compliance can be seen below:

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent compliance</td>
<td>62.5%</td>
<td>56.7%</td>
<td>62.9%</td>
<td>72.6%</td>
<td>69.1%</td>
<td>62.1%</td>
<td>61.5%</td>
</tr>
</tbody>
</table>

Between January 2018 and July 2018 there were a total of 8295 breaches. There were considerably less breaches in April 2018 and May 2018. A monthly breakdown of breaches can be seen below:

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breaches</td>
<td>1887</td>
<td>1909</td>
<td>1366</td>
<td>300</td>
<td>510</td>
<td>1063</td>
<td>1260</td>
</tr>
</tbody>
</table>

A large proportion of patients were delayed in the emergency department because of pressures elsewhere in the hospital. The average percentage of patients delayed between decision to admit being because of the emergency department between January 2018 and July 2018 was 38%. The average percentage of patients delayed due to factors outside of the control of the emergency department was 62%. The biggest delays because of delayed ED was during April and May 2018. The reason for the four-hour breaches between decision to admit and being admitted is broken down below:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed ED process</td>
<td>20%</td>
<td>38%</td>
<td>33%</td>
<td>45%</td>
<td>46%</td>
<td>41%</td>
<td>42%</td>
</tr>
<tr>
<td>Waiting for a bed</td>
<td>67%</td>
<td>52%</td>
<td>53%</td>
<td>25%</td>
<td>37%</td>
<td>44%</td>
<td>42%</td>
</tr>
<tr>
<td>Waiting for speciality review</td>
<td>10%</td>
<td>7%</td>
<td>9%</td>
<td>14%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical exception</td>
<td>3%</td>
<td>3%</td>
<td>5%</td>
<td>16%</td>
<td>7%</td>
<td>5%</td>
<td>6%</td>
</tr>
</tbody>
</table>

**Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment**

From June 2017 to May 2018 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was better than or like the England average for eight of the 12 months. Performance was worse than the England average between December 2017 and March 2018. In the latest period, May 2018, the percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 0.3%, compared to the England average of 2.4%.

**Percentage of patient that left the trust without being seen - Royal Cornwall Hospitals NHS Trust**
Median total time in A&E per patient (all patients)

From July 2017 to June 2018 the trust’s monthly median total time in ED for all patients was consistently lower than the England average. In the latest period, June 2018, the trust’s monthly median total time in A&E for all patients was 96 minutes compared to the England average of 148 minutes.

Median total time in A&E per patient - Royal Cornwall Hospitals NHS Trust

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Patients were encouraged to report concerns about their care and treatment. We found leaflets in the reception area in both hospitals, which directed patients and visitors to the trust’s Patient and Family Experience (Complaints) Team. If a patient wished to raise a complaint, they would encourage them to speak with senior staff in the emergency department to see if concerns could be addressed.
It was easy for patients to raise complaints and concerns. There were multiple ways to contact the Patient and Family Experience (Complaints) Team. They could be contacted by staff on internal phones, via external phones, text message, email and had an office both at Royal Cornwall Hospital and at West Cornwall Hospital (by appointment).

Complaints were handled effectively. We reviewed five complaint letters and found them all to be open and transparent. We reviewed associated reports and found the final letters to patients and their relatives were signed by someone from the trust executive team.

Complaints were used as an opportunity to learn by the department. Learning was regularly shared through newsletters and were discussed at department governance meetings.

Following a complaint being made, the complainant would be offered a ‘local resolution meeting’ to go through the investigation and give the complaint an opportunity to ask questions.

**Summary of complaints**

From May 2017 to April 2018 there were 55 complaints about urgent and emergency care services. The trust took an average of 52.3 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 25 days.

Of the 55 complaints, 96.4% (53 complaints) occurred at Royal Cornwall Hospital and two (3.6%) at West Cornwall Hospital.

The most prevalent types of complaints were those relating to clinical treatment (29.1%), patient care (18.2%) and communication (14.5%).

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

**Number of compliments made to the trust**

From June 2017 to May 2018 there were 255 compliments within urgent and emergency care. There were 180 compliments for Royal Cornwall Hospital and the remaining 75 were for West Cornwall Hospital.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

The medicine division management team was comprised of three directorates, each led by a clinical director, an associate director of nursing, and an associate director supported by divisional finance, governance and human resources teams. The acute and emergency department was one of the three directorates and was led by a clinical director, a speciality and a governance lead for each of the specialities (emergency medicine and acute medicine) with a deputy associate director (for medicine) and two clinical matrons. Staff told us that all the local management team were visible and accessible and were frequently seen on the floor, providing help.

Leaders understood the challenges to quality and sustainability within the department and were enthusiastic and energetic about the actions identified to address them. They were knowledgeable about risks to the service.

The leadership team in the emergency department felt a clinical director structure was “invaluable for moving forward”. They described how the teams working together meant they had the senior support to make big differences in the department. Examples were given regarding interactions with the local clinical commissioning group and other providers to have a joined-up approach to urgent and emergency care.

Nursing leadership at the West Cornwall Hospital Urgent Care Centre was provided by a band seven Sister who was an experienced emergency nurse and had been in post for two years. She reported to the matron at West Cornwall Hospital, who liaised with the matron at the ED at Royal Cornwall Hospital. Both the Sister and the matron were well regarded by the nursing staff. Several nurses told us that they were approachable and that “you could discuss anything with them”. They were visible, professional and respected by all the staff that we spoke with.

There was a clinical lead who provided medical leadership at West Cornwall Hospital UCC. We were told they had strong grip on medical practice and was respected by all staff.

Vision and strategy

Royal Cornwall Hospitals Trust vision and values were clear and easily accessible on the trusts website. Staff we spoke with were aware of the trust vision and values and were clear of the important role they play in being part of that. Staff mostly described the strategy for the department to be good management of flow and keeping patients safe during crowding.

All nursing and allied healthcare professional staff were given pocket cards with detailed the trusts vision and values between 2018 and 2020. This linked the trust vision and values to behaviours and processes which could be actioned in the emergency department. Additionally, this was linked with the Royal Cornwall Hospital Trust Clinical School to encourage innovation and improvement.

The service did not have a mental health strategy appropriate for patients with mental illness that the trust board approved and reviewed annually. However, staff told us this was being developed. The trust had a Service Level Agreement with a mental health trust for mental health liaison and Mental Health Act management.

Staff at West Cornwall Hospital were clear about the vision and strategy for the urgent care centre. All staff we spoke with were focused on admission avoidance and their role to play in that. We were told that this was linked in with the clinical commissioning group plans for a joined up urgent care service for Cornwall.

Culture
Historically there had been a negative culture in the emergency department where staff were not engaged in governance. However, there had been a dramatic improvement with the introduction of team governance meetings and the appointment of two matrons. We were told that this had “engaged the whole team to progress the department and to support ideas”. Staff described projects which were initiated by staff regarding the management of sepsis and the introduction of ‘Greatix’. Greatix involved positive incident reporting when staff saw something that showed themselves going “above and beyond” what was expected of them. The results of these were shared at monthly safety briefings. We were given an example where an orthopaedic senior house officer went above and beyond for a patient’s care.

Junior doctors described a strong culture of support from the senior doctors and by the leadership team. They said they received good training in-house and felt that seniors were always approachable and candid with feedback.

Staff said there had been good engagement when the safety checklist was started. However, some staff we spoke with were not engaged or enthusiastic about using it. Some we spoke with saw it as additional paperwork which they did not feel supported the care of their patient. Some managers told inspectors that “we have not been able to keep that focus and drive” when talking about the checklist. One nurse we spoke with described the checklist as “an audit for you guys” rather than a tool to keep patients safe.

There was a positive culture amongst all staff at the Urgent Care Centre. Strong, supportive relationships were demonstrated and there was an open and honest approach when things went wrong. There was an emphasis on development which staff appreciated. Medical staff in West Cornwall Hospital felt supported by the leadership team in the main ED and could describe situation where they had had support during times of high demand.

**Governance**

The department identified its biggest risks to be flow, population size increase and staffing. These were identified on various risk registers escalating from local risk registers to the corporate risk register. The department was effective at managing and actioning risks. There was effective engagement between the emergency department team and with the rest of the trust to manage and mitigate the risks associated with hospital flow.

There was a structure of governance which ensured accountability for the delivery of the safety and quality of the service. Meetings such as the governance update meetings and divisional meetings were used effectively to escalate information and concerns to divisional leadership and disseminate information from divisional leadership. We were told how information in these meetings is escalated if necessary.

There was a governance framework in place which allowed leaders to prioritise different risks over others. Additionally, the incident reporting processes allowed leaders to identify immediate risks to safety and quality. A 24-hour report was produced following a moderate or severe incident which meant action could be taken immediately.

In addition to the governance meetings there were incident theme reviews every six months. This identified themes from complaints, incidents and is attended by the clinical directors. However, this could have been done more frequently to identify themes sooner.

There were effective processes to disseminate information to staff. The leadership team engaged the department in governance through ‘governance meetings’ and newsletters. We attended a governance meeting where patient safety, clinical effectiveness and performance was reviewed.
This forum allowed discussion and learning to be shared in a meaningful way. It was clear that staff attending this were engaged and enthusiastic about what was being discussed.

During this meeting there were presentations on current issues and concerns as well as an update on projects to improve safety and quality in the department. Other specialities in the hospital were involved in the development and facilitation of some of these projects.

Although medical attendance to the governance meeting was good, there were limited nursing staff available to attend. Senior managers said that this was partly due to workload, and partly due to the inability to hold the meeting in the department. However, funding had been agreed prior to the inspection to build a resource room in the department to hold these meetings in.

There was a lead consultant for governance who worked with both the medical and nursing team on quality and safety matters. All consultants working in the department had a responsibility for governance due to being in link roles to improve outcomes, processes and systems based on audit and quality improvement work. This was engaging the medics in constructive way. One medic we spoke with said they feel as if they “now recognise the part they play in governance and quality improvement”.

Medical staff were engaged with governance and had access to governance reports and were given time to read them. Some described how they learnt and improved their practice based on the ‘message of the week’ sent by the trust.

The Medication Safety Committee met every two months. It reviewed medicine incidents and adverse events and looks at learning themes and trends. This was fed back to the emergency department team. The Drug and Therapeutics Committee (including a medicines practice committee and joint formulary committee with Cornwall Clinical Commissioning Group) which met every two months. It reviewed formulary issues, prescribing trends, Patient Group Directions and safe medication practices.

The medicines management optimisation group published a monthly newsletter which was circulated via e-mail. Safety bulletins were also circulated following medicine incidents.

The Accountable officer for Controlled Drugs was aware of their responsibilities. All incidents involving controlled drugs were investigated. Three monthly reports were made to the NHS England controlled drugs officer and the Controlled Drug Local Intelligence Network (CDLIN) meetings were attended.

Management of risk, issues and performance

There was evidence of managerial oversight of risks and performance. The service maintained a risk register which recorded known risks and rated them according to their potential impact. Risks documented aligned with the “worry list” of staff and showed that the leadership team understood their department well.

It was clear from the risk registers that the emergency department were managing their biggest risks as effectively as they could within their remit. For example, the risk around hospital flow and crowding. The department had introduced action cards for staff to manage crowding based on the level escalation and work had been undertaken to identify how reconfiguring the space they had could be better used to provide optimal care for patients.

The leadership team performed a weekly walk around the department to look for any concerns or risks which may not have been identified through incidents or through escalation from staff. For example, during one walk around managers noticed a door which was not closing properly, so raised it as a risk for their next senior team meeting.
The pharmacy team managed risks associated with medicines well. In addition to clinical pharmacist services there was support from the chief pharmacist and other senior pharmacists who had an overview of medicine optimisation/safety issues. There was a medicines management policy/strategy and business plan. The chief pharmacist also reviewed incidents involving medicines (including controlled drugs), adverse events, non-medical prescribing and the prescribing of medicines on external prescription forms. They were also involved in the development of medicine policies and procedures.

There was risk register for all aspects of the pharmacy service which is updated monthly.

**Information management**

The trust collected, analysed, managed and used information to support all its activities. There was real time information available to show departmental activity and operational performance and there was a regular review of metrics and breach analysis by the senior management team. There was good oversight of performance but there was limited analysis done to compare safety and quality with activity.

There was a pharmacy dashboard which compiles performance information monthly, this includes time for dispensing discharge medicines, the rate of reconciliation of patient’s medicines on admission, the number of missed doses and monitoring of the emergency department pharmacy service.

Notice boards at entrances to majors which showed information for patients, for example, results from hand hygiene audits, level of falls and a cleaning analysis. There was a screen in the reception which showed waiting times for the emergency department, West Cornwall Hospital Urgent Care Centre and the minor injury units run by another provider.

**Engagement**

A month prior to the inspection the service had redesigned a newsletter which was sent to all staff working in the emergency department. It was an engaging and glossy document which covered recent mortality reviews, 24-hour reports from incidents of note, serious incidents and learning identified from these. Additionally, the newsletter included learning from safety alerts, complaints, and a summary of changes in the risk register.

Managers found it difficult to engage staff. One manager we spoke with described how a feedback post-box was in place for ideas to be shared but found that very few responses were received.

**Learning, continuous improvement and innovation**

The department at Royal Cornwall Hospital worked well to encourage learning, continuous improvement and innovation. The ED had a ‘Turbo 10’ project where ideas where shared to improve the department. To improve the effectiveness of these projects quizzes were created to embed learning and engage staff.

The governance meeting described various quality improvement projects ongoing in the emergency department. These included with processes around the management of sepsis, acting on results from Royal College of Emergency Medicine audits and learning from simulation training.

**Medical care (including older people’s care)**

**Facts and data about this service**

The medical care service at Royal Cornwall Hospitals NHS Trust provides care and treatment for seven specialties. There are 378 medical inpatient beds located across three sites with 54
medical inpatient beds located at West Cornwall hospital, and 12 at St Michael's hospital:

**Royal Cornwall Hospital:**

<table>
<thead>
<tr>
<th>Ward/unit name</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute medical unit 1 (AMU1)</td>
<td>21</td>
</tr>
<tr>
<td>Acute medical unit 2 (AMU2)</td>
<td>26</td>
</tr>
<tr>
<td>Cardiac investigations unit (CIU)</td>
<td>19</td>
</tr>
<tr>
<td>Coronary care unit</td>
<td>10</td>
</tr>
<tr>
<td>Gastroenterology and liver unit</td>
<td>29</td>
</tr>
<tr>
<td>Grenville ward</td>
<td>24</td>
</tr>
<tr>
<td>Kerensa ward</td>
<td>25</td>
</tr>
<tr>
<td>Kynance independence unit</td>
<td>18</td>
</tr>
<tr>
<td>Lowen ward</td>
<td>18</td>
</tr>
<tr>
<td>Phoenix ward</td>
<td>27</td>
</tr>
<tr>
<td>Roskear ward</td>
<td>28</td>
</tr>
<tr>
<td>Tintagel ward</td>
<td>29</td>
</tr>
<tr>
<td>Wellington ward</td>
<td>26</td>
</tr>
<tr>
<td>Wheal Prosper ward</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>312</strong></td>
</tr>
</tbody>
</table>

**St Michael’s Hospital:**

<table>
<thead>
<tr>
<th>Department name</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marie Therese House</td>
<td>12</td>
</tr>
</tbody>
</table>

**West Cornwall Hospital:**

<table>
<thead>
<tr>
<th>Unit name</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical unit 1</td>
<td>26</td>
</tr>
<tr>
<td>Medical unit 2</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>54</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request - Sites)

Medical services provide both inpatient and outpatients services with clinics at the main hospital sites and peripheral clinics.

**Royal Cornwall Hospital (Treliske)**

The trust is registered with CQC at this location for the following regulated activities: 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, and Treatment of disease, disorder or injury.

There are 312 medical inpatient beds. The medicine department within the trust is divided into three areas. Emergency medicine to include the emergency department, ambulatory care and the medical assessment unit. Cardio respiratory departments and speciality medicines which include, neurology, renal services, gastroenterology, endocrinology. All have a directorate manager, a matron and a clinical lead.

**St Michael's Hospital (Hayle)**
Departments and services offered include: breast surgery, children's and adolescent services, ear, nose and throat services, geriatric medicine services, gastroenterology and hepatology services, general surgery, oral and maxillo-facial services, orthopaedic services, rehabilitation services and vascular surgery services.

The trust is registered with CQC at this location for the following regulated activities: Treatment of disease, disorder or injury, Diagnostic or screening procedures, and Surgical procedures.

Marie Therese House is situated in the grounds of St Michaels hospital. It provides 12 specialist rehabilitation inpatient beds for adult patients suffering from neurological disorders such as acquired brain injury, brain tumours, Multiple Sclerosis and Motor Neurone disease.

**West Cornwall Hospital (Penzance)**

Departments and services offered include: MIU services, cardiology services, children’s and adolescent services, dermatology services, diagnostic services, diabetic medicine services, endocrinology and metabolic medicine services, gastroenterology and hepatology services, general surgery, gynaecology services and geriatric medicine services.

The trust is registered with CQC at this location for the following regulated activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983, Diagnostic and screening procedures, Family planning, Surgical procedures, Termination of pregnancies, and Treatment of disease, disorder or injury.

West Cornwall Hospital has two medical wards with 54 medical inpatient beds.

The trust had 58,954 medical admissions from April 2017 to March 2018. Emergency admissions accounted for 20,046 (34%), 1,541 (2.6%) were elective, and the remaining 37,367 (63.4%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 18,970
- Gastroenterology: 15,358
- Clinical oncology: 8,980

Inpatient care at the Royal Cornwall Hospital is provided as follows:

- Phoenix ward: stroke medicine
- Wheal Prosper ward: infectious diseases
- Roskear ward: cardiology
- Wellington ward: respiratory medicine with a six-bedded higher-level care bay for patients who require additional care and support which may include non-invasive ventilation
- Kerensa ward: care of the elderly
- Grenville ward: renal medicine and endocrinology
- Gastro & Liver Unit: gastroenterology and care of the elderly
- Tintagel ward: Care of the elderly and neurology
- Coronary care unit: Cardiology
- Cardiac investigation unit: Inpatient and day case cardiology
- Acute Medical Unit (AMU)
In-patient services include cardiology and a coronary care unit (level 2), with an elective and inpatient ward shared with respiratory. There is the provision of 24/7 primary percutaneous coronary intervention (PCI) and two catheterisation laboratories. Cardiac surgery is referred to two other trusts in the Southwest.

There are two elderly care wards, one of which, Tintagel ward, is shared with neurology. There is an independence rehabilitation unit for patients prior to discharge. There is a dedicated stroke ward with two ‘hyper acute stroke’ beds.

There is one respiratory ward, Wellington Ward, including six higher care beds providing non-invasive ventilation (NIV) to these patients. Endocrinology and nephrology jointly cover two wards to provide specialist in patient service. There is one ward for gastroenterology and hepatology patients. The service provides a seven-day gastrointestinal (GI) bleed on call service.

Complex neurology rehabilitation is provided at Marie Therese House, located at St Michaels Hospital. The Eldercare team provide ortho-geriatric service and input to West Cornwall Hospital and the community hospitals.

There is a discharge lounge which operates Monday to Friday, from 7.30 am to 10pm, excluding bank holidays. The unit can accommodate up to eight seated patients and six patients requiring a bed and aims to improve patient flow in the hospital by freeing up beds once a patient is ready to be discharged. There was also an intermediate care ward which had been opened for patients who were clinically stable who were awaiting discharge.

Medical care was provided on Lowen Ward which is an oncology ward. Although this ward does not fit within the medical services structure at the trust, it was visited as part of this inspection as it sits within the CQC framework of medical care.

Day case activity includes endoscopy at Royal Cornwall Hospital (RCH) and West Cornwall Hospital (WCH). Renal dialysis is at RCH, WCH and Bodmin and cardiac procedures and diagnostics are at RCH. There is a medical day unit at RCH, providing infusions and pre/post recovery for interventional radiology.

During this announced inspection of Royal Cornwall Hospital between 4 September and 6 September 2018, we visited all the medical wards. This included the Gastro & Liver Unit, Grenville ward, Phoenix ward, Roskear ward, Wellington ward, Kerensa ward, Wheal Prosper ward and Tintagel ward. We also visited the Medical Admissions Unit, the ambulatory care department, the medical day unit, the discharge lounge, the cardiac unit and the intermediate care ward. We also visited outlier patients on Eden Ward and Wheal Coates ward. During this inspection a team of six inspectors, pharmacy and mental health inspectors and specialist advisors visited all the three locations. We spoke with 61 members of staff, nine patients and five relatives and looked at 15 sets of patient notes which included medical, nursing and observation records.

During the announced inspection of West Cornwall Hospital between 4 September and 6 September 2018, we visited the two inpatient wards. We spoke with five patients, 21 staff including a matron, doctors, nurses, healthcare assistants, ward clerk and allied health care professionals. We observed interactions between staff and patients. We reviewed 15 patient records, attended board rounds (a daily multidisciplinary meeting) and observed ward rounds.

During the announced inspection of St Michaels Hospital, we visited Marie Therese House. We spoke with six patients and two relatives. We spoke with seven members of staff of various seniorities including the consultant, ward manager, nurses, healthcare assistants and allied health care professionals. We observed interactions between staff and patients. We reviewed four sets of patient records.
Is the service safe?

Mandatory training

Mandatory training completion rates
The trust set a target of 95% for completion of mandatory training.

Trust wide
A breakdown of compliance for mandatory courses from May 2017 to April 2018 for medical/dental and nursing staff in medicine trust wide is shown below:

Mandatory training completion by module – medical and dental staff – Trust wide

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation</td>
<td>25</td>
<td>8</td>
<td>312.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>190</td>
<td>201</td>
<td>94.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>189</td>
<td>201</td>
<td>94.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>186</td>
<td>199</td>
<td>93.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>181</td>
<td>202</td>
<td>89.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>175</td>
<td>204</td>
<td>85.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>161</td>
<td>205</td>
<td>78.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>161</td>
<td>205</td>
<td>78.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>155</td>
<td>202</td>
<td>76.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>157</td>
<td>205</td>
<td>76.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>138</td>
<td>205</td>
<td>67.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>99</td>
<td>205</td>
<td>48.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The conflict resolution training module had the lowest completion rate with 48.3%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in medical care trust wide had a completion rate of 76.9% for mandatory training. Medical staff met the target of 95% for one of the 12 modules.
The 95% target was met for five of the 12 mandatory training modules shown above for nursing staff in medical care trust wide, including the resuscitation training module which had a completion rate of 678.9%, based on 129 staff having completed the training compared to only 19 being eligible. Staff told us that they were all enabled to attend resuscitation training of some level.

The manual handling (people) training module had the lowest completion rate with 67.9%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in medical care trust wide had a completion rate of 90.4% for mandatory training. Qualified nursing staff met the target of 95% for five of the 12 applicable modules. Thirty-one members of nursing staff had completed the adult immediate life support module although none were indicated to have been eligible during this reporting period.
Royal Cornwall Hospital

The trust did not meet their target for mandatory training in all areas. This meant that not all staff had received the mandatory training and while not seen at this inspection, this may impact on patient safety. The trust set a target of 95% for completion of mandatory training. Staff received regular statutory and mandatory training updates in a range of different subjects, but training compliance did not meet the trust's 95% completion target.

The 95% target was met for five of the 12 mandatory training modules shown above for nursing staff at Royal Cornwall Hospital, including the resuscitation training module which had a completion rate of 600%, based on 114 staff having completed the training compared to only 19 being eligible. All staff spoken with told us that they had received resuscitation and basic life support training as part of their mandatory training.

The trust's mandatory training included moving and handling, conflict resolution, fire safety, infection prevention and control and basic life support. Staff also received regular updates in safeguarding adults (including mental capacity act and deprivation of liberty safeguards and female genital mutilation), preventing radicalisation, safeguarding children and information governance. Staff had training days delivered as a block of two or more days to ensure all mandatory training was completed. Some training was delivered as face-to-face training sessions, and some was completed by e-learning.

Training compliance was recorded and monitored through electronic staff records, which were available to managers. Staff confirmed that they were alerted by email when training was due and would approach the managers to book a convenient time to attend. Training was completed in blocks, so staff would undertake several topics in one day. Some of this training was delivered in face-to-face training sessions and some was completed by e-learning.

The manual handling training module had the lowest completion rate with 70.2%. Staff told us that some training was not attended due to staffing constraints. Staff confirmed that sometimes, when the hospital was under pressure, training was missed. We observed staff moving and handling patients safely and noted that no incidents were reported of poor outcomes for patients because of moving and handling.

Clinical staff received mandatory training for mental health, learning disabilities, autism and dementia. Staff did not feel this training was sufficient to provide them with the knowledge and skills required to care for these patients. Staff felt they learned on the job and relied on teams (such as psychiatric liaison) for specialist skills and support.

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for medical/dental and nursing staff in medicine at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>331</td>
<td>379</td>
<td>87.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>330</td>
<td>379</td>
<td>87.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>283</td>
<td>379</td>
<td>74.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>253</td>
<td>379</td>
<td>66.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Immediate Life Support</td>
<td>31</td>
<td>-</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)
The 95% target was met for one of the 12 mandatory training modules shown above for medical staff at Royal Cornwall Hospital. This was the resuscitation training module which had a completion rate of 300%, based on 24 staff having completed the training compared to only eight being eligible. All staff spoken with told us that they had received resuscitation and basic life support training as part of their mandatory training.

The conflict resolution training module had the lowest completion rate with 49.5%.

(Source: Routine Provider Information Request (RPIR) –Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in medical care at Royal Cornwall Hospital had a completion rate of 76.4% for mandatory training. Medical staff did not meet the target of 95% for any of the 12 modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia awareness (inc Privacy &amp; Dignity standards)</td>
<td>187</td>
<td>197</td>
<td>94.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>185</td>
<td>196</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>184</td>
<td>197</td>
<td>93.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>173</td>
<td>197</td>
<td>87.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>157</td>
<td>197</td>
<td>79.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>142</td>
<td>197</td>
<td>72.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>132</td>
<td>197</td>
<td>67.0%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>129</td>
<td>197</td>
<td>65.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>125</td>
<td>197</td>
<td>63.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>123</td>
<td>197</td>
<td>62.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>120</td>
<td>197</td>
<td>60.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Mandatory training completion by module – nursing staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation</td>
<td>24</td>
<td>8</td>
<td>300.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>184</td>
<td>194</td>
<td>94.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>183</td>
<td>194</td>
<td>94.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>180</td>
<td>192</td>
<td>93.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>175</td>
<td>195</td>
<td>89.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>169</td>
<td>197</td>
<td>85.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>155</td>
<td>198</td>
<td>78.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>155</td>
<td>198</td>
<td>78.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>150</td>
<td>195</td>
<td>76.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>151</td>
<td>198</td>
<td>76.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>133</td>
<td>198</td>
<td>67.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>98</td>
<td>198</td>
<td>49.5%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in medical care at Royal Cornwall Hospital had a completion rate of 91.0% for mandatory training. Qualified nursing staff met the target of 95% for five of the 12 applicable modules. Thirty members of nursing staff had completed the adult immediate life support module although none were indicated to have been eligible during this reporting period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>332</td>
<td>332</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>331</td>
<td>332</td>
<td>99.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>286</td>
<td>287</td>
<td>99.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>320</td>
<td>332</td>
<td>98.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>304</td>
<td>332</td>
<td>91.6%</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year</td>
<td>16</td>
<td>18</td>
<td>88.9%</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>292</td>
<td>332</td>
<td>88.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>292</td>
<td>332</td>
<td>88.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>291</td>
<td>332</td>
<td>87.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>253</td>
<td>332</td>
<td>76.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>225</td>
<td>332</td>
<td>67.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Immediate Life Support</td>
<td>30</td>
<td>-</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

St Michael’s Hospital

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for nursing staff in medicine at St Michael’s Hospital is shown below:

Mandatory training completion by module – nursing staff – St Michael’s Hospital

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
</table>

Page 74
The 95% target was not met for any of the mandatory training modules shown above for nursing staff at St Michael's Hospital. Manual Handling (people) had the lowest completion rate with 60%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in medical care at St Michael's Hospital had a completion rate of 82.5% for mandatory training. Qualified nursing staff did not meet the target of 95% for any of the 11 modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>11</td>
<td>14</td>
<td>78.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>11</td>
<td>14</td>
<td>78.6%</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>11</td>
<td>14</td>
<td>78.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>11</td>
<td>14</td>
<td>78.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>9</td>
<td>14</td>
<td>64.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>9</td>
<td>14</td>
<td>64.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

St Michael’s Hospital, Marie Therese House - Mandatory training completion by module – medical staff

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for medical staff in medicine at Marie Therese house is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>78.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
The 95% target was met for five of the mandatory training modules shown above for medical staff at Marie Therese house. Compliance, due to the small number of medical staff at Marie Therese House, was skewed by a doctor not completing training.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

The trust did not provide any updated training data for medical staff in medical care at St Michael’s Hospital for the period April to August 2018.

(Source: Updated data provided by the trust)

West Cornwall Hospital

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for medical/dental and nursing staff in medicine at West Cornwall Hospital is shown below:

Mandatory training completion by module – medical and dental staff – West Cornwall Hospital

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>1</td>
<td>7</td>
<td>14.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>1</td>
<td>0</td>
<td>n/a</td>
<td>95%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

The 95% target was not met for any of the 11 mandatory training modules shown above for medical staff at West Cornwall Hospital. Conflict resolution had the lowest completion rate with 14.3%. There was an additional staff member that completed the resuscitation training module although none were indicated to have been eligible during this reporting period.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in medical care at West Cornwall Hospital had a completion rate of 88.6% for mandatory training. Medical staff met the target of 95% for five of the 11 modules.
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>4</td>
<td>8</td>
<td>50.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

**Mandatory training completion by module – nursing staff – West Cornwall Hospital**

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>34</td>
<td>34</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>34</td>
<td>34</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>34</td>
<td>34</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>34</td>
<td>34</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>33</td>
<td>34</td>
<td>97.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>32</td>
<td>34</td>
<td>94.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>31</td>
<td>34</td>
<td>91.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>27</td>
<td>34</td>
<td>79.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>27</td>
<td>34</td>
<td>79.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>27</td>
<td>34</td>
<td>79.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>17</td>
<td>34</td>
<td>50.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>15</td>
<td>0</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The 95% target was met for five of the 12 mandatory training modules shown above for nursing staff at West Cornwall Hospital. Manual Handling (people) had the lowest completion rate at 50%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in medical care at West Cornwall Hospital had a completion rate of 87.6% for mandatory training. Qualified nursing staff met the target of 95% for four of the 11 applicable modules. One member of nursing staff had completed the adult immediate life support module although none were indicated to have been eligible during this reporting period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>33</td>
<td>33</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.

Trust wide

A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for medical/dental and nursing staff in medicine trust wide is shown below:

### Safeguarding training completion by module – medical and dental staff – Trust wide

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>188</td>
<td>202</td>
<td>93.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>184</td>
<td>201</td>
<td>91.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>115</td>
<td>205</td>
<td>56.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>75</td>
<td>203</td>
<td>36.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was not met for any of the four safeguarding training modules for which medical staff in medicine were eligible. Safeguarding children (level 2) had the lowest completion rate with 36.9%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that medical staff in medical care trust wide had a completion rate of 72.1% for safeguarding training. Medical staff did not meet the 95% target for any of the four modules. Compliance improved for two modules when compared to the earlier time period.

### Name of course

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>190</td>
<td>205</td>
<td>92.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>187</td>
<td>205</td>
<td>91.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>134</td>
<td>205</td>
<td>65.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>80</td>
<td>205</td>
<td>39.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)
Safeguarding training completion by module – nursing staff – Trust wide

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>365</td>
<td>368</td>
<td>99.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>364</td>
<td>368</td>
<td>98.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>324</td>
<td>368</td>
<td>88.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>318</td>
<td>368</td>
<td>86.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for two of the four safeguarding training modules for which nursing staff in medicine were eligible. Safeguarding adults (level 2) had the lowest completion rate with 86.4%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in medical care trust wide had a completion rate of 93.8% for safeguarding training. Qualified nursing staff met the 95% target for two of the four modules. Compliance improved for all four modules when compared to the earlier time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 1)</td>
<td>377</td>
<td>379</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>377</td>
<td>379</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>335</td>
<td>379</td>
<td>88.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>333</td>
<td>379</td>
<td>87.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Royal Cornwall Hospital

A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for medical/dental and nursing staff in medicine at Royal Cornwall Hospital is shown below:

Safeguarding training completion by module – medical and dental staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>182</td>
<td>195</td>
<td>93.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>178</td>
<td>194</td>
<td>91.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>112</td>
<td>198</td>
<td>56.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>75</td>
<td>196</td>
<td>38.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Royal Cornwall Hospital, the 95% target was not met for any of the four safeguarding training modules for which medical staff in medicine were eligible. Safeguarding children (level 2) had the lowest completion rate with 38.3%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that medical staff in medical care at Royal Cornwall Hospital had a completion rate of 71.8% for safeguarding training. Medical staff did not meet the 95% target for any of the four modules. Compliance improved for two modules when compared to the earlier time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 1)</td>
<td>75</td>
<td>196</td>
<td>38.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Safeguarding training completion by module – nursing staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 1)</td>
<td>317</td>
<td>319</td>
<td>99.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>317</td>
<td>319</td>
<td>99.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>284</td>
<td>319</td>
<td>89.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>278</td>
<td>319</td>
<td>87.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Royal Cornwall Hospital, the 95% target was met for two of the four safeguarding training modules for which nursing staff in medicine were eligible. Safeguarding adults (level 2) had the lowest completion rate with 87.1%. The trust set a target of 95% for completion of safeguarding training. The 95% training target was not met for any of the four safeguarding training modules for medical staff. For nursing staff this had a better completion rate for level two of 87%. Nursing staff met two of the four safeguarding training modules for which nursing staff in medicine were eligible.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in medical care at Royal Cornwall Hospital had a completion rate of 94.1%. Qualified nursing staff met the 95% target for two of the four modules. Compliance improved for three modules when compared to the earlier time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 1)</td>
<td>331</td>
<td>332</td>
<td>99.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>331</td>
<td>332</td>
<td>99.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>295</td>
<td>332</td>
<td>88.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>293</td>
<td>332</td>
<td>88.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Some staff told us they had access to level three training, this was because their units had young people from 16 to 18 years attending. This included the Acute Medical Unit (AMU) and the medical day unit.

There were safeguarding systems, processes and policies available, they were understood by staff and used to ensure patients safety. The trust safeguarding policies described abuse and who might be at risk. These policies were accessible on the trusts intranet and included contact details for the trusts safeguarding team to enable further support for staff if needed.

Staff understood their responsibilities to raise concerns and report abuse and the trust had seen a significant increase in safeguarding incidents reported. There had been 1,293 safeguarding alerts to the trust safeguarding team made by the medical directorate in the last year (April 2017 to September 2018). There were 212 safeguarding alerts to Cornwall Council in direct response to RCHT safeguarding referrals made by the medical directorate in the last year (April 2017 to
September 2018). Staff told us this was because they were encouraged and supported to raise these incidents. Staff used electronic systems to alert safeguarding risks to the safeguarding team and the local authority. Where safeguarding concerns had been identified and a referral alert had been made, this was noted clearly in the patients’ medical records. Staff could give us examples of when safeguarding concerns and alerts had been raised and the actions taken.

Staff we spoke with on all wards and units were aware of signs to identify adults and children at risk of or suffering from significant harm and they knew how to escalate their concerns.

Patients were protected from discrimination in accordance with the Equality Act. Staff demonstrated an understanding of anti-discrimination. They told us how discrimination which may be related to abuse or physical harm was observed for and how they strived to ensure that any discrimination was highlighted, and appropriate action taken to prevent any further discrimination and provide person-centred care.

**St Michael’s Hospital**

A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for nursing staff in medicine at St Michael’s Hospital is shown below:

**Safeguarding training completion by module – nursing staff – St Michael’s Hospital, Marie Therese House.**

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 1)</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>12</td>
<td>15</td>
<td>80.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>12</td>
<td>15</td>
<td>80.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Marie Therese house, the 95% target was not met any of the safeguarding training modules for which nursing staff in medicine were eligible. Safeguarding adults (level 2) and safeguarding children (level 2) both had the lowest completion rates with 80% each. However, most staff had been trained in safeguarding adults and children at level one with only one member of staff not completing it.

*(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)*

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all nursing staff had completed training on how to recognise and report abuse.

Staff told us they had a good working relationship with the safeguarding team and could call on them for advice. No current patients had a safeguarding alert raised for them.

Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in medical care at St Michael's Hospital had a completion rate of 85.7% for safeguarding training. Qualified nursing staff did not meet the 95% target for any of the four modules. Compliance deteriorated slightly for all modules when compared to the earlier time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 1)</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Safeguarding training completion by module – medical staff – Marie Therese house

<table>
<thead>
<tr>
<th>Course name</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>0</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Marie Therese house, the 95% target was met for three of the four safeguarding training modules for which medical staff in medicine were eligible. Of the eligible staff for safeguarding children (level 2) training, none had completed the course.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

The trust did not provide any updated training data for medical staff in medical care at St Michael’s Hospital for the period April to August 2018.

(Source: Updated data provided by the trust)

West Cornwall Hospital

A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for medical/dental and nursing staff in medicine at West Cornwall Hospital is shown below:

Safeguarding training completion by module – medical and dental staff – West Cornwall Hospital

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>3</td>
<td>7</td>
<td>42.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>0</td>
<td>7</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At West Cornwall Hospital, the 95% target was not met for any of the four safeguarding training modules for which medical staff in medicine were eligible. Of the seven-eligible staff for safeguarding children (level 2) training, none had completed the course.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Staff used electronic systems to alert safeguarding risks to the safeguarding team and the local authority. Where safeguarding concerns had been identified and a referral alert had been made, this was noted clearly in the patients’ medical records. Staff could give us examples of when safeguarding concerns and alerts had been raised and the actions taken. This meant that staff were clear of their role to protect patients.

Updated data provided by the trust for the period April to August 2018 indicated that medical staff in medical care at West Cornwall Hospital had a completion rate of 78.1%. Medical staff met the 95% target for two of the four modules. Compliance improved for all four modules when compared to the earlier time period.
### Safeguarding training completion by module – nursing staff – West Cornwall Hospital

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>34</td>
<td>34</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>33</td>
<td>34</td>
<td>97.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>28</td>
<td>34</td>
<td>82.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>28</td>
<td>34</td>
<td>82.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At West Cornwall Hospital, the 95% target was met for two of the four safeguarding training modules for which nursing staff in medicine were eligible. Safeguarding adults (level 2) and safeguarding children (level 2) both had the lowest completion rates with 82.4% each.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in medical care at West Cornwall Hospital had a completion rate of 93.9%. Qualified nursing staff met the 95% target for two of the four modules. Compliance improved for three modules when compared to the earlier time period.

### Cleanliness, infection control and hygiene

#### Royal Cornwall Hospital

The trust had systems and processes to ensure standards of cleanliness and hygiene were maintained. The trust employed an outside cleaning contract service. All units and wards we visited were visibly clean and free from offensive odours.

The cleaning services staff lacked knowledge about cleaning expectations and the correct checklists to follow but all areas were seen to be clean. There was a lack of consistency in approach with some ward staff having a checklist and clear schedule to follow and other staff not following any schedule.

The ward staff completed audits around infection prevention and control as part of a key performance indicators report. Cleanliness was audited, and results demonstrated compliance above 97% for the medical care group at Royal Cornwall Hospital between October 2017 and March 2018.

The implementation of safety systems, processes and practices was monitored using a hand hygiene audit. Hand hygiene audits were displayed on all the wards and departments we visited and results for most areas were positive with most being 100% compliant.
Staff adhered to recommended infection prevention and control measures. We observed doctors and nursing staff washing their hands and using anti-bacterial gel in line with infection prevention and control guidelines. All staff were bare below the elbow in line with trust policy. Areas for hand washing were clearly identified and patients and visitors were reminded of the importance of hand hygiene. Staff used personal protective equipment such as gloves and aprons when required and disposed of these correctly in clinical waste bags.

Single use items of equipment were disposed of correctly, either in clinical waste bins or sharps instrument containers. The disposal bins were seen to be closed when possible and clinical waste bins clearly identified. Staff separated waste including soiled linen in accordance with national guidance.

Staff cleaned equipment between patient use. Commodes had been cleaned and labelled with ‘I am clean’ stickers to indicate they were ready for use.

All wards and departments had single rooms, as well as shared bays, to ensure they could treat and care for patients with confirmed or suspected infectious diseases. This system was used to reduce risks of cross infection. We saw notices on wards on single room doors advising staff and visitors of the precautions they were to take when entering the room. Protective personal equipment (PPE) was available outside of the single rooms. Patients admitted through the emergency department with known infections were transferred when room became available. Should a room not be available the patient would have to remain in the emergency department.

Several staff expressed concerns about being moved from ward to ward to manage staff shortages mid shift, after working with infected patients. Staff told us that this risk did not appear to be considered and placed patients at risk. We observed at safer staffing meetings and bed management meetings discussion about staff being moved from ward to ward. No consideration was heard about this issue of infection control management.

The trust was required to report on all MRSA bacteraemia (the presence of bacteria in the blood causing a serious infection) to ensure they did not exceed national threshold targets. The trust did not exceed these national targets with no recorded cases of MRSA bacteraemia in the previous year and four cases of Clostridium difficile.

The endoscopy unit minimised the risk of spread of infection whilst ensuring treatment procedures were carried out safely. Staff used processes to identify clean and dirty scopes, with systems of cleaning which prevented any risks of cross contamination. Staff planned for patients with possible or confirmed communicable infections to be treated at the end of the list.

**West Cornwall Hospital**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Hand hygiene results were displayed on the ward and showed 100% for August 2018. The hospital scored 99.2% for cleanliness against a national average of 98.5% (Health and Social Care Information Centre. 2018). All staff we saw were bare below the elbow which is in line with trust policy, washed hands or used gel between patient care and used the personal protective equipment such as gloves and aprons provided.

The sluice was clean and uncluttered. Commodes were clean and had a clean green sticker on them. There were no chemicals left unsecured, these, were in a locked cupboard to ensure patient safety and in line with national guidance. There was plenty of personal protective equipment such as aprons and gloves on the ward and we saw staff using them correctly. Waste bins were not overfull and there was secure storage for waste and dirty linen. It was collected three times daily.
The wards were due to have new plastic re-cycling containers. Toilets and bathrooms were clean and had up to date and completed cleaning regimes.

Most equipment had a green sticker on it to denote that it was clean and ready for use. We observed staff cleaning blood pressure cuffs between each patient use.

We asked four healthcare assistants about the signs and symptoms of urinary sepsis and they responded accurately. However, there was some confusion about how often to change a catheter bag. There were no instructions in the care plans and this may cause a risk to patients.

**St. Michaels Hospital, Marie Therese House**

The service monitored infection risks and took appropriate action to prevent cross infection. The environment, equipment and the premises were seen to be clean and well monitored.

Staff followed trust policies on infection prevention and control. For example, all staff we saw were bare below the elbow, used antibacterial gel between patient care, washed their hands, wore personal protective equipment and disposed of waste correctly. This ensured all patients were cared for as safely as possible.

Hand hygiene results were displayed on the ward, which showed 100% compliance for August 2018. The unit scored 100% for cleanliness against a national average of 98.5%. *(Health and Social Care Information Centre. 2018).*

Cleaning chemicals were stored securely and not accessible to the public or patients. There was an adequate supply of personal protective equipment such as aprons and gloves on the ward and we saw staff using them correctly. Waste bins were not overfull and there was secure storage for waste and dirty linen.

All equipment when used was cleaned and labelled as ready for use. Commodes and wheelchairs were stored in the bathrooms when not in use. Each commode and wheelchair had a green ‘I am clean’ sticker on it.

**Environment and equipment**

The maintenance and use of facilities, premises, and equipment generally kept people safe, however, a small number of wards and unit areas were not fully equipped, and the appropriate emergency equipment checks were not consistently undertaken.

Some wards were not fully equipped with oxygen and suction for each bed space. In those areas a business plan was submitted to add these facilities but was not yet actioned. The risks for these areas were mitigated by using shared portable equipment.

Escalation areas used at times of high operational pressures were not always suitable and safe for patients and staff. We observed that when six bedded bays were used for seven patients, there was no oxygen, suction, call bell or curtains available for the extra person.

The environment and facilities were not all appropriate for the patients waiting for a bed. The wards did not always have capacity in the hospital for all the patients requiring medical beds and for those patients being admitted to surgical wards instead of medical beds did not ensure all needs could be met.

Emergency equipment checks were not consistently completed on all wards. Equipment for urgent and emergency situations was kept in tamper evident trolleys and was to be checked daily by staff. Records of these checks were signed and dated daily, however, in some instances the checks were not recorded and there was no rationale as to why they had not had been undertaken. This included wards Roskear, Tintagel, Grenville and Acute Medical Unit (AMU).
Some specialist medicine areas had identified risks related to equipment. These risks were recorded and reviewed through the speciality risk registers. The risks related to lack of training in the equipment needed for example in gastroenterology and for paracentesis (the perforation of a cavity of the body to remove fluid or gas) for liver disease. These risks remained ongoing.

We saw that ward areas had been risk assessed to identify and minimise ligature risks. A gap analysis had been undertaken to ensure that all areas were considered. A policy was in place to support and advise staff to minimise any risks. Six ligature incidents had taken place in the previous 12 months. Patients at risk of self-harm would need continued monitoring to ensure they were safe.

We noted that a risk was recorded on the medicine risk register for Tintagel ward due to a lack of visibility of patients. This was caused by a lack of a nursing station at the female end of the ward. The ward was originally planned to have desk areas within bays for nursing staff to work or for patients to use; however, additional patients had been placed in these spaces. This carried the risk that patients could not be safely observed and potential greater risk of falls or safety incidents. This risk remains ongoing.

Staff had access to equipment for pressure relief and moving and handling equipment on the wards. They told us that when they requested equipment it arrived in a timely way. If the request was at weekends or out of hours they could access the equipment needed from the emergency store. They told us that after use this equipment was cleaned, checked and returned to the store.

Staff knew how to report faulty equipment and devices and the requests were dealt with in a timely manner. We saw some equipment in the Grenville ward store room with no equipment check date.

Ward equipment store rooms were locked to ensure their safety and security and prevent theft, damage or misuse.

The Medical Day Unit had recently moved to a new, more central location and staff were settling in to their new accommodation. The location was considered by staff and patients to be a bonus as it was nearer the hospital entrance and so better accessible for patients.

We observed fire safety equipment and signage for emergency exits. Fire exits were kept clear to ensure free escape routes for patients and staff.

**West Cornwall Hospital**

The service had suitable premises and equipment and they were maintained well. Some pressure relieving equipment was not used correctly.

The wards were light, spacious, uncluttered and visibly clean. There were adequate storage facilities for consumables and equipment. Pressure relieving equipment was readily available. We checked expiry dates on various consumables such as gauze, needles, urinary catheters and dressing packs and found they were in date. However, we found some skin disinfectant that was out of date. The ward manager removed it immediately.

The use of some pressure relieving equipment did not ensure patient safety. The pressure relieving mattresses on beds were not set for the correct weight of several patients. This meant the patient did not have the full benefit of the pressure relieving properties of the mattress. Correct settings for patient’s weight was displayed on the side of the bed. There were no information booklets available about how to use the beds correctly. This was brought to the attention of the nurse in charge.
Areas of safety and security on the ward were well managed. Resuscitation trolleys were tamper-proof and locked. They were checked daily with a full check weekly. This was completed according to trust policy.

Medical equipment had labels denoting their last service and that they had been safety tested. Medical Physics kept the asset registers for equipment and arranged servicing with the equipment loan library.

Fire exits were clearly marked and were not blocked.

Laptop computers were used for electronic prescribing and dispensing of medicines. All laptops we saw on the wards were locked.

**St. Michaels Hospital, Marie Therese House**

The service had suitable premises and equipment, but they did not appear to be maintained effectively and there was a lack of storage for equipment.

The unit was suitable for purpose and appeared light, spacious, uncluttered and visibly clean. It had wide corridors and doors to accommodate larger wheelchairs.

The day room and dining room had carpet on the floor. The ward manager told us that although this was not a clinical area, the carpets were due to be replaced with more suitable flooring. Some of the dining room chairs were not in a good state of repair as the seats had ripped coverings.

There were inadequate storage facilities for equipment. The bathrooms were spacious and equipped for disabled patients but contained stored equipment and wheelchairs.

Most patients had a custom-made wheelchair which was larger than average. The patient rooms were too small to store the wheelchairs when the patient was not in them. Therefore, they were stored in the bathrooms and therapy areas and so they had to be removed for the bathrooms and therapy areas to be used. This meant they cluttered more areas.

Maintenance of the environment was not well managed. In an assisted bathroom we found a rusty radiator and pipes, mould on the sealant between tiles, chipped and discoloured tiles, mould on the ceiling and air extraction unit and peeling paint on the light fitting. In another bathroom we found chipped tiles, and a hole in the wall where something had been removed and not repaired. We noted in the sluice the urine bottle holder was rusty. These areas would be difficult to keep clean and posed a risk of cross infection.

Consideration was given to ligature risks for patients living with mental illness. Nurse call cords in both bathrooms were made to reduce any ligature risks and gave way if any weight was put on them.

Maintenance of equipment was not consistently well managed. Most of the equipment had service dated stickers on them, were safety tested and in date. However, we found a battery charger last serviced in 2012. This meant that there had been no monitoring of the equipment’s suitability for use and may place patients at risk of harm.

Resuscitation trolleys were tamper-proof and locked. They were checked daily with a full check weekly. This was completed according to trust policy. However, we found a bag/value oxygen mask that had a deflated seal and the valve had been snapped off preventing re-inflation. This could impact on the efficiency of the mask when used in an emergency. This was brought to the attention of the ward manager who immediately ordered a replacement.
Access to pressure relieving equipment was efficient. Pressure relieving equipment was readily available from the trust equipment library, usually by the next day. All equipment had a green sticker on it to denote that it was clean and ready for use.

The use of pressure relieving equipment was not well managed and may place patients at risk of pressure damage. We found pressure relieving mattresses on beds were not set for the correct weight of several patients. This meant the patient did not have the full benefit of the pressure relieving properties of the mattress. There were no information booklets available about how to use the beds correctly. This was brought to the attention of the nurse in charge.

Disposable equipment was available and monitored for its safe usage. We checked expiry dates on various consumables such as gauze, needles, urinary catheters and dressing packs and found they were in date.

All patients were nursed in individual rooms containing a sink, wardrobe and television. Six of the 12 rooms had their own fire door. These were not blocked despite the rooms being small. General fire exits were clearly marked and were not blocked. Rooms could not easily accommodate a bariatric patient as the large bed would not fit in unless everything else was removed from the room. However, this had not yet caused a problem for the unit. Four of the rooms had a built-in ceiling track hoist with a maximum weight use of 35 stones to enable safe moving and handling of patients.

Assessing and responding to patient risk
Royal Cornwall Hospital

Staff assessed and responded to patient risks, however, there were issues with connectivity for the electronic observation tools. The management of risk also lacked a focus on mental health.

Written records were used by doctors, nurses and therapists as a contemporaneous record of treatment and care planned and provided. The records showed when the patient had been assessed and admitted they were reviewed by a consultant within 14 hours of their admission.

Risk assessments were carried out for patients and care plans were developed to meet any identified area of need. Records seen showed risk assessments were completed, evaluated and updated as the patients’ needs changed. These assessments included pressure ulcer risk assessment, falls risk assessment and a nutrition risk assessment. Certain risks such as falls and nutritional risks were highlighted on the patients’ headboards. Staff updated information about patient risks and any changes at handovers and safety briefings. We observed staff regularly checking on patient wellbeing and responding to any questions.

Staff completed a holistic assessment of patients, however there was no focus on the mental health needs of patients. If mental health/learning disability/dementia needs were identified there was not a corresponding care plan.

Medical staff completed risk assessments for venous thromboembolism (VTE) (formation of blood clots) in line with the National institute for Health and Care Excellence NG89 (2018). This recommends all medical patients have a risk assessment as soon as possible after admission, or by the first consultant review and are re-assessed within 24 hours of admission. Each patient had a VTE assessment, some specialist nurses could also undertake the VTE assessment for example the stroke nurse can assess and prescribe intermittent pneumatic compression. (This is a therapeutic technique used that can include an air pump and inflatable auxiliary sleeves, gloves or boots in a system designed to improve venous circulation in the limbs of patients who suffer from venous thrombosis). We reviewed 25 patient notes and found the initial risk assessment was consistently completed.
There were processes for staff to follow to identify when patients’ conditions deteriorated, however staff experienced some difficulties with the electronic systems used. The use of an electronic observation system was not consistently safe. The electronic system being used had connectivity problems in some areas of the hospital and had to be supported by paper systems. This was problematic for some staff and created a risk of patients not having consistently reviewed observations.

Staff used a modified early warning scoring (EWS) as part of an electronic observation system to identify patients who had deteriorated. The Acute Medicine Quality Standards (2013) and the Royal College of Physicians (2012) recommend the use of a numeric scoring system of patients’ vital observation to identify deteriorating patients and advise staff of actions to take. Staff knew how to escalate concerns about patients’ vital observations and stated they would always inform the doctors if they were concerned about a patient.

Sepsis is a life-threatening condition in which the body is fighting a severe infection that has spread via the bloodstream. Sepsis recognition and treatment time is critical and requires prompt action. In the previous year August 2017 to August 2018 there were between 169 and 234 reported cases of sepsis every month. The deteriorating patient suffering from sepsis was identified through the electronic observation sepsis bundle as well as through the training and experience of staff. Staff followed a standard instruction called BUFALO to ensure appropriate steps were completed.

One of the most common types of incident reported by the trust were, sub-optimal care of the deteriorating patient meeting serious incident criteria with 11 (14.7% of total incidents).

Simulation training had been provided in July 2018 to ensure staff knew how to use the electronic equipment. The electronic application would signpost when the patient’s observations had indicated an increased risk or potential for sepsis, but ward staff told us it would not replace staff skills in observing sepsis risk. When the score reached a level three any unregistered staff would inform a registered member of staff, when the score reached level five, the system would automatically trigger an alert to the on-call doctor.

Monitoring or evaluation of a patient’s deterioration may be missed or incomplete because of the use of multiple systems. Should the equipment fail, a paper copy of the assessment was completed and then the result was transferred to the electronic equipment later. Staff recognised the risks in this practice as the observations may be missed, later transfer of paper records on the electronic system may not take place or may be input incorrectly and risks be missed.

On Lowen ward the electronic observation escalation trigger had been disabled, this meant that when the trigger scored five an alert should be sent to the doctor on duty – but now wasn’t. This may be a risk for patients if staff who do not know this. The risk was also further heightened if staff were moved between wards regularly to meet staffing needs.

We observed one patient who had higher than normal observations which may indicate sepsis triggers on the electronic monitoring device held by staff. The device indicated a red alert but there was no action seen to address the observations trigger. The nurse in charge was alerted to this.

Staff in the medical care group felt well supported by the outreach care team (an on-call team of nurses with enhanced skills to provide support and advice to staff to look after any acutely unwell patients). Staff contacted the outreach care team for advice, support and assistance when patients deteriorated. The team assisted with escalation of treatment such as managing sepsis, starting non-invasive ventilation and pain relief.
When the hospital was under pressure with surges in demand for inpatient beds, the trust used a system whereby patients were placed in the centre of ward bays pending an admission bed. They did not have access to equipment or facilities to protect their privacy and dignity. This practice was called Safer Placement for Patients.

The practice and policy of Safer Placement for Patients did not ensure a safe and dignified admission for patients. At times of high capacity pressure, some ward patients were identified for potential discharge but may be waiting to leave. In these instances, a patient could be identified as waiting for that bed in the emergency department. The waiting patient was seen to be transferred to the ward and placed in the centre of the patient bay. Staff referred to these patients as boarders. Patients were placed at risk because the environment and staffing levels were not suitable for their placement.

Should a patient in this situation deteriorate they did not have access to equipment or a suitable environment for their care. The patient did not have any curtains, call bell, oxygen or suction. We saw one instance when an elderly lady was placed in the centre of a six-bedded bay so making the bay a seven-bedded space, she was in a bed, had an intravenous infusion and was very frail. She was not able to summon assistance and was overlooked by all the other patients in the bay. There was no facility for her to access the toilet and this location was undignified and inappropriate. Staff told us this happened regularly, and wards could have up to three of these ‘boarder patients’ at any given time.

We reviewed incident reports which also confirmed this situation happened with regularity. We were assured that this was only supposed to happen when a discharge was identified and was a short-term solution. However, we were told that at times of pressure these criteria were overruled, and the patients could be placed in this situation without a potential discharge being identified or planned.

Staff told us that they were not always aware of the patient arriving and handovers of patient details were not consistent. We saw one boarder patient arrive and the nurse in charge of the bay was unaware of the patient’s arrival. We were told of another patient who arrived and was left unattended because staff had not received a handover. The patient then sustained an injury because they had walked unescorted.

There was no medical high dependency unit. There was no step-up area between the wards and the critical care unit. This meant that patients with higher dependency needs, except for respiratory higher dependency and the coronary care unit, were nursed in the medical ward bed base. The ward medical and nursing teams were supported by the outreach team for specialist advice.

The service included round the clock access to mental health liaison (covering the age range of the ward/clinic) and/or other specialist mental health support if staff were concerned about risks associated with a patient’s mental health.

Staff completed a holistic assessment of patients; however, this was not focused on mental health. If mental health/learning disability/dementia needs were identified there was no corresponding care plan. Staff did not routinely complete risk assessments for these patients. There was no risk assessment form for staff to complete and staff explained that they would consider risks for patients based on patient presentation and experience. This should be documented in a patient’s clinical notes; however, we found no examples of this.

Not all staff had completed mandatory conflict resolution training. Those staff who had completed the training felt it equipped them well. However, when needed, staff could call two security staff who had completed restraint training and would support staff to ensure patient and staff safety.
The trust tried to avoid bed moves so as not to inconvenience patients, however there was evidence that bed moves were taking place both during the day and night time. These discharges included patients with dementia or who lived alone.

Staff told us that they usually occurred at night time between 8pm and 6am which placed vulnerable patients at a higher risk. We visited Wheal Coates ward which had 21 beds and of those eight were used by outlying patients. Staff told us up to eight patients could be admitted in a short period of time including overnight, making a thorough admission process challenging.

Delays were seen in the response time to answering patient call bells. On Tintagel, Grenville and Wheal Coates wards bells were noted to be ringing unanswered for up to five minutes, leaving patients waiting for care.

**West Cornwall Hospital**

Staff assessed and responded to patient risks, however, these were not always recorded correctly. All patients required risk assessments on admission for pressure ulcers, moving and handling and malnutrition. In the 15 records we reviewed, five had not had all had their risk assessments completed. One patient did not have a falls risk assessment completed despite fitting the criteria. This placed patients at risk of a lack of identification of risks and appropriate action being implemented.

We found the trusts’ policy for prevention and management of falls in hospital and the safe use of bedrails with adult patients was out of date but under review. Therefore, the policy did not reflect the latest NICE guidance and meant that patients were not being cared for under the latest guidance.

**St. Michaels Hospital, Marie Therese House**

Staff assessed and responded to patient risks and these were usually recorded correctly. Patients required risk assessments on admission for pressure ulcers, moving and handling and malnutrition. Risk assessments were carried out for the four patients whose notes we reviewed within 12 hours of admission in compliance with trust policy.

Staff knew about the trusts’ sepsis policy and explained the process of escalating a sick patient. They could assess and respond to patients who were deteriorating using an early warning score. This was based on the patient’s observations of pulse, blood pressure and breathing rate and documented on the electronic system. If a patient deteriorated in the daytime, medical staff were on hand to review the patient. Out of hours medical cover was provided by the doctor on call for St Michael’s hospital. In a medical emergency, nursing staff could call 999.

Staff could call on a wide variety of specialist nurses for advice. For example, the tissue viability nurse provided advice on treatment and care for wounds and pressure ulcers.

**Nurse staffing**

**Planned vs actual**

There was a chronic staffing shortage which resulted in low morale of staff. There were high vacancy rates on the wards which were covered by agency and bank staff. There were not always sufficient nurses to ensure patients received safe care and treatment. To mitigate staff shortages, senior managers redeployed staff from other wards or booked temporary staff to cover. The staffing establishment had not been increased despite the wards sometimes having to take extra patients.

The divisional risk register noted as a risk the failure to maintain safe staffing levels on medical wards caused by unfilled vacancies of registered nurses which may result in compromised patient
care and safety. The trust has reported their staffing numbers below as at April 2018 for nursing staff in medicine, with an overall staffing rate of 83%.

Staff vacancies in April 2018 included:

- AMU 22
- Grenville 12
- Kerenza 16
- Kynance 18
- Phoenix 10
- Roskear 12
- Tintagel 14
- Wellington 14

Staffing levels were monitored three times a day and staff moved to the areas with reduced staffing. Agency and bank staff were used to make up for permanent staffing shortfalls.

A Safer Staffing system had been implemented to review levels of patient need to staffing levels.

Audit data provided by the trust showed that actual staffing and planned staffing levels were comparable in almost all wards. The trust used an electronic system to measure patient’s dependency to ensure those needs were met. The ‘safe care’ acuity tool which used the Association of UK University Hospitals (AUKUH) dependency tool was introduced on all wards. This required staff to input the patients level of need three times a day. This information fed into the Safer Staffing meetings so that staff could be redeployed to areas where there were patients with a higher need. The safer staffing meetings were held twice a day and used to plan for the evening and following day. We reviewed incidents of risk caused by staff shortages and saw that staff reported concerns.

Staff were moved between wards to cover shifts. The decision to move staff was made at a daily staffing trust wide meeting, prioritising the wards with highest demand but the staff did not always have the skills appropriate for the change. Redeployment of staff to other wards and areas was considered normal and some staff we spoke with were reluctant to be redeployed to other wards.

On the Coronary Care Unit there were ten high care beds. Patients in these beds required more detailed observation and required advanced support and care. National standards recommend level two care patients need one nurse to two patients, which meant there should be four registered nurses on duty. Staff confirmed that they were staffed for these levels. They usually had one bed designated for primary PCI (Percutaneous Coronary Intervention) to open an artery during an acute myocardial infarction (heart attack). The staffing levels on this unit had been increased and were based around having enough staff to support the level of patient need. The level included additional cover for a percutaneous coronary intervention between 8am and 6pm during the week. Out of those times should an urgent PCI patient be admitted; a ward staff member was redeployed from the coronary care unit to cover the PCI so leaving the unit one staff member short. This compromised patient safety and was a concern and pressure to staff. The divisional risk register noted that reduced staffing due to obligation to cover cardiac catheter laboratories out of hours may result in compromise to patient care delivery and safety. This was highlighted at the previous inspection and had not been addressed safely at this inspection.
When staffing levels were low, bank and agency staff were used. Every effort was made to use consistent staff from these workforces, but this was an added pressure on permanent staff who had to be moved to support them when needed.

When agency staff were used an induction to the ward was not evident. Staff told us there was a verbal introduction but no induction checklist or point of reference was available for those staff to support them being new to the ward. This also meant there was no audit trail record that proved all staff had received an introduction and that the risk areas for the ward had been communicated to the agency nurse.

The numbers of planned and actual staff on duty was displayed at the entrance to each ward. Most wards we visited during our inspection had the right number staff on duty according to the planned numbers.

Wellington ward and the higher respiratory care bay was staffed appropriately for the level of patient need. Should the level of care increase, the staffing level flexed accordingly. Staff confirmed this system worked and there was appropriate cover for staff to take breaks or if they needed to leave the higher care bay for any reason.

Tintagel ward had both neurological and elderly patients. There were no defining numbers of how many of each patient and therefore there was no way to identify if the staffing levels were accurate in relation to patient dependency. Between March 2017 and August 2018 there varied between four and 16 neurological patients at any time on the ward. The level of staffing to support the patients did not vary. This may place patients and staff at risk if the staffing level did not meet the patient’s needs.

The Renal unit had high vacancies, which reduced the number of dialysis nurses available to deliver dialysis to patients.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Planned WTE Staff</th>
<th>Number in post as at April 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>384.5</td>
<td>308.5</td>
<td>80.2%</td>
</tr>
<tr>
<td>St Michael’s Hospital</td>
<td>14.5</td>
<td>14.0</td>
<td>96.7%</td>
</tr>
<tr>
<td>West Cornwall Hospital</td>
<td>40.7</td>
<td>42.5</td>
<td>Over-established by 4.4%</td>
</tr>
<tr>
<td>Total</td>
<td>439.7</td>
<td>365.0</td>
<td>83.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**West Cornwall Hospital**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The hospital completed patient acuity recordings three times daily to ensure staffing levels matched the complexity of patients. Staff told us that staffing levels usually felt safe with the appropriate skill mix. However, two band six registered nurses from one ward were due to go on secondment shortly. Advertisements to cover the vacancies were being prepared and any shortfall would need to be met by existing staff, bank staff or agency nurses.

Senior nurses told us they rarely used agency nurses as staff were prepared to work overtime and the bank covered most outstanding shifts.

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**St. Michaels Hospital, Marie Therese House**
The service had sufficient staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Senior staff told us the unit rarely used agency nurses as staff worked overtime and the trust bank covered the outstanding shifts. On the day of inspection, the ward manager had given up her management day and was working clinically to ensure the ward was staffed safely. The unit was struggling with staffing levels the week of the inspection. To try to address the problem a full time registered nurse post was out to advertisement and a full-time healthcare assistant post interviews were to be held shortly.

The unit did not have a discharge coordinator, and this was a further role taken on by the ward nurses.

Staffing levels were considered to ensure ward rounds and meetings were attended. The planned staffing level for all shifts was two registered nurses and between two and four healthcare assistants. On Monday, Wednesday and Thursday this was increased to three registered nurses in the daytime to accommodate ward rounds and multidisciplinary meetings and to feedback to staff from these meetings.

Therapy staff were needed as the band six occupational therapist was a long-term agency placement. Senior managers explained recruitment was taking place but expressed their concern if this wasn’t successful. Therapist are an essential part of the multidisciplinary team and are needed to support patient rehabilitation.

**Vacancy rates**

From May 2017 to April 2018, the trust reported a vacancy rate of 20.9% in medicine, compared to a target of 10% at March 2018 and 6% at March 2019. A site breakdown is below:

- Royal Cornwall Hospital: 22.1%
- St Michael’s Hospital: 14.4%
- West Cornwall Hospital: 10%

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 6.8% in medicine, compared to a target range of 10-14%. A site breakdown is below:

- Royal Cornwall Hospital: 7.8%
- St Michael’s Hospital: 0%
- West Cornwall Hospital: 0%

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

From May 2017 to April 2018, the trust reported a sickness rate of 4.1% in medicine, compared to a target of 3.8%. A site breakdown is below:

- Royal Cornwall Hospital: 4.1%
- St Michael’s Hospital: 4.9%
- West Cornwall Hospital: 4.6%

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*
Bank and agency staff usage

Trust wide

From May 2017 to April 2018, the trust reported 8,487 bank shifts and 463 agency shifts were filled by nursing assistants in medical care trust wide. There were 181 shifts left unfilled.

During the same period, the trust reported 5,124 bank shifts and 4,901 agency shifts were filled by qualified nurses across the three locations. There were 834 shifts left unfilled.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>8,487</td>
<td>5,124</td>
<td>13,611</td>
</tr>
<tr>
<td>Agency</td>
<td>463</td>
<td>4,901</td>
<td>5,364</td>
</tr>
<tr>
<td>Not filled</td>
<td>181</td>
<td>834</td>
<td>1,015</td>
</tr>
</tbody>
</table>

Royal Cornwall Hospital

From May 2017 to April 2018, the trust reported 7,349 bank shifts and 461 agency shifts were filled by nursing assistants in medical care at Royal Cornwall Hospital. There were 180 shifts that were unfilled.

During the same period, the trust reported 4,348 bank shifts and 4,886 agency shifts were filled by qualified nurses. There were 808 shifts that were unfilled.

Nursing staff on the medical wards when possible covered vacant shifts on their own wards. Regular bank and agency staff were booked when possible to provide continuity of care and an understanding of the ward speciality and environment for staff. Staff confirmed that not all agency shifts requested were filled and that when possible consistent agency staff were used.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>7,349</td>
<td>4,348</td>
<td>11,697</td>
</tr>
<tr>
<td>Agency</td>
<td>461</td>
<td>4,886</td>
<td>5,347</td>
</tr>
<tr>
<td>Not filled</td>
<td>180</td>
<td>808</td>
<td>988</td>
</tr>
</tbody>
</table>

St Michael’s Hospital

From May 2017 to April 2018, the trust reported 220 bank shifts and one agency shift were filled by nursing assistants in medical care at St Michael’s Hospital. There were no shifts that were unfilled.

During the same period, the trust reported 127 bank shifts and one agency shift were filled by qualified nurses. There were no shifts that were unfilled.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>220</td>
<td>127</td>
<td>347</td>
</tr>
<tr>
<td>Agency</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Not filled</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

West Cornwall Hospital

From May 2017 to April 2018, the trust reported 918 bank shifts and one agency shift were filled by qualified nurses in surgery at West Cornwall Hospital. There was one shift that was unfilled.

During the same period, the trust reported 649 bank shifts and 14 agency shifts were filled by qualified nurses. There were 26 shifts that were unfilled.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>918</td>
<td>649</td>
<td>1,567</td>
</tr>
<tr>
<td>Agency</td>
<td>1</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Not filled</td>
<td>1</td>
<td>26</td>
<td>27</td>
</tr>
</tbody>
</table>
Medical staffing
Royal Cornwall Hospital

Planned vs actual
There were consultant vacancies in different specialities throughout the medical care group. This meant the consultants were challenged to be present in all areas of their role and some had to prioritise the work they undertook. We spoke with medical staff of different seniority who all spoke of their concerns regarding the vacancies.

The vacancies were due to difficulty in recruiting medical staff despite continued efforts. From May 2017 to April 2018, the trust reported 504 shifts filled by locum staff in medicine. There were 180 shifts unfilled by locum staff.

Elderly care had grown in demand and the senior staff considered there to be not enough consultant cover. There were 14 individuals in post providing 10.9 whole time equivalent hours. The issues identified with the current elderly care consultant capacity included the need to provide multiple areas of cover with medical patients in four community hospitals including West Cornwall Hospital, St Michael's Hospital and Marie Therese House. The elderly care consultants also covered the elderly care wards, stroke ward and the frailty beds allocated on the Acute Medical Unit (AMU). The team also undertook ward rounds on ‘trauma one’ and ‘trauma two’ for the shared care of fractured neck of femur patients.

The number of cardiology consultants was ten which was an increase since the last inspection. With the increase in consultants some improvements were seen in waiting list times improvements were seen in referral to treatment times however despite staffing increases, nationally set targets were still not being met. Cover overnight consisted of one middle grade doctor and the cardiology consultant on call. The division risk register continued to record capacity in cardiology as a risk.

The respiratory consultants had 4.6 in total which was a decrease in number. This meant that the respiratory service was under pressure with waiting lists. There was also an impact from the high level of respiratory patients seen as part of the expected medical admissions.

Endocrine consultants were also required to cover complex respiratory patients for four out of nine weekends. The Endocrine consultant were all trained in general medicine but did not have up to date training or experience in the long-term management of complex and specialist respiratory problems seen on respiratory higher care. The trust risk register had noted that there was a risk for those patients.

The Hepatology service had been challenged for some time due to a shortfall in capacity. This had been heightened with the short-term absence from one of the two consultants.

The neurological consultant and junior doctors covered Tintagel ward with the medical registrar providing overnight cover and the elderly care consultant providing weekend cover.

Gastroenterology consultants were not staffed with seven consultants supporting wards and a further four consultants working part time in gastroenterology and hepatology. There were two whole time equivalent post vacancies. The gastroenterology team had a responsibility to cover the GI bleed rota and so did not contribute to any other rota for example the general medical take rota. To reduce waiting times some extra clinics were taking place, and this was included in the gastroenterology job plans.

Cover for the general medical rota was a challenge. The trust used a consultant of the day system for speciality areas, but this was not the case for the general medical rota. Some specialities had a
rota for a week at a time and the same consultant was on call. This meant the one consultant saw all patient specialities and could mean that a patient may not see the consultant for their specific need. There was also a demand on the consultant who would have a wide range of areas to cover. There was no consistent plan of how this rota was managed and so there was an inconsistency in how the cover was managed. The trust has advised that the rota has recently been re-written and was managed by the medical staffing team.

Medical cover arrangements for medical patients admitted to beds on outlier wards were considered and time was built into medical staff job plans to visit outlier patients.

There were low numbers of medical registrar level doctors with eight in total. There was only one medical registrar working overnight covering both the wards and the emergency department. This registrar could contact the on-call consultant for advice or contact the critical care consultant on duty overnight. The low number of this level of doctor would mean that patients would have to wait to be seen. This was highlighted on the divisional risk register with no timescale for action.

The divisional risk register noted there was a risk to patient care and safety at the trust due to a lack of junior medical cover. Due to junior doctor shortages, if one of those takes leave this usually leaves just one doctor covering two wards.

Medical staff confirmed there were learning opportunities within the hospital and all junior doctors we met said they felt supported by their consultants in terms of their day-to-day work and their ongoing professional development including teaching sessions.

Staff on all wards were aware of who the covering consultant and medical team were, with information clearly displayed on notice boards. Staff confirmed that the response they received from the covering physicians when contacted with queries or concerns about patients was timely.

A reshuffle of cardio respiratory leads took place in April 2018 to develop clinicians into manager roles. For this role, in all medicine areas, there was no induction or development programmes to develop management practice.

A job plan review was underway to look at the medical staff roles and expectations.

### West Cornwall Hospital

There was a junior doctor present on the ward five days a week. A clinical fellow and GP trainee covered day shifts, weekends and out of hours cover on a six-week rota, including weekends. The consultant was present five days a week. The division also had trust grade doctors that divided their time between clinical work and education.

Junior doctors told us they felt well supported by senior staff, clinical and educational supervisors. Medical staff took part in the daily handovers, rapid rounds and weekly multidisciplinary meetings.

Doctors told us that covering short term sickness was challenging. They managed by asking the medical division at Royal Cornwall Hospital for short term cover and by not taking admissions and obtained help from the urgent care doctors when necessary.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Planned WTE Staff</th>
<th>Number in post as at April 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>172.4</td>
<td>158.8</td>
<td>92.2%</td>
</tr>
<tr>
<td>West Cornwall Hospital</td>
<td>10.6</td>
<td>9.9</td>
<td>93.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>183.0</strong></td>
<td><strong>168.8</strong></td>
<td><strong>92.2%</strong></td>
</tr>
</tbody>
</table>

**St. Michaels Hospital, Marie Therese House**

The consultant on the unit worked two days a week. When the consultant was on leave, cover was provided by the trusts’ geriatric consultants. A GP trainee worked four days a week, a shared post
with the hospice on site. Medical cover on Thursday and out of hours was provided by the doctor on call for St Michael’s hospital. In a medical emergency, staff could call 999.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates
From May 2017 to April 2018, the trust reported a vacancy rate of 15.1% in medicine, compared to a target of 10% at March 2018 and 6% at March 2019. A site breakdown is below:

- Royal Cornwall Hospital: 14.9%
- West Cornwall Hospital: 19.4%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
From May 2017 to April 2018, the trust reported a turnover rate of 16.5% in medicine, compared to a target range of 10-14%. A site breakdown is below:

- Royal Cornwall Hospital: 17.8%
- West Cornwall Hospital: 0%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From May 2017 to April 2018, the trust reported a sickness rate of 0.9% in medicine compared to a target of 3.8%. A site breakdown is below:

- Royal Cornwall Hospital: 0.7%
- West Cornwall Hospital: 3.3%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage
From May 2017 to April 2018, the trust reported 504 shifts filled by locum staff in medicine. There were 180 shifts unfilled by locum staff.

A breakdown of staffing groups is shown below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>379</td>
<td>94</td>
</tr>
<tr>
<td>Middle grades</td>
<td>10</td>
<td>22</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>115</td>
<td>64</td>
</tr>
<tr>
<td>Total</td>
<td>504</td>
<td>180</td>
</tr>
</tbody>
</table>

The trust stated in their RPIR that they do not keep information regarding bank shifts filled centrally and so do not have the information available, which has highlighted the need to collate this and work on this for the future.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix
In March 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was the same.

Staffing skill mix for the 237-whole time equivalent staff working in medicine at Royal Cornwall Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Page 98
Consultant 35% 43%
Middle career^ 8% 6%
Registrar group~ 35% 29%
Junior* 22% 22%

<table>
<thead>
<tr>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>35% 43%</td>
</tr>
<tr>
<td>Middle career</td>
<td>8% 6%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>35% 29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>22% 22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce statistics)

Records
Royal Cornwall Hospital

Staff completed patient written records well with records maintained legibly, in date order and signed and dated. Patients’ records demonstrated a multidisciplinary approach with reviews, assessments and care plans from the medical team, nursing team, allied health care professionals and social workers. There were also a series of paper observational records stored with the patient. The trust also used electronic observation records to monitor patient’s condition which was not consistently reliable due to issues with connectivity in some areas of the hospital.

On all wards we found that there were integrated medical, nursing and therapies paper records. Staff said this, together with the electronic records used in some areas worked for staff to reduce duplication but also ensured that risks were appropriately managed and reviewed. Patients booklets had been developed for recording the initial assessments and for identification of patient’s primary needs, these included a space for a care plan. These care plans were generic with little space for detail of patient’s individual care needs. This meant that there was insufficient room to record a detailed individualised care plan to guide and direct staff on the patient’s specific care and treatment needs. We looked at 25 sets of records and found that nursing and allied health professional notes were well completed and legible but limited in their content with patients specific and individualised needs not always recorded.

The electronic system was a telephone sized piece of equipment kept in each nurse’s pocket that had access to a computer record for each patient. The pocket-sized equipment used to monitor observations used an algorithm which monitored the observations input by staff to calculate a risk level and actions to be taken. Staff told us this was in line with the National Early Warning Scores (NEWS). All patient records we looked at showed that people were admitted and continually assessed using this system. When the calculated score reached three, a red flag appeared which indicted to staff that a registered nurse needed to be informed. When the score got to five then a doctor would be informed by the electronic system. Patient records reflected when this had taken place.

However, there were connectivity problems in some areas including Tintagel, Kynance, Wheal Coates, Grenville and the discharge lounge. This meant that the observations may not be able to be uploaded and, in that instance, staff wrote the observations down on paper. They then input the information when the electronic system became available. This would be a risk if staff were not
diligent or became busy and did not update the electronic system. This was also a risk because the ongoing monitoring did not show an accurate audit trail to identify deterioration.

The divisional risk register noted there was a risk that patients with high NEWS scores were not being escalated. This was caused by the poor Wi-Fi signal on Roskear ward which intermittently cut in and out. In addition, the medical staff did not carry the electronic equipment or have the equipment when they were on call. This could lead to potential harm to patients who when deteriorating may not be escalated to medical staff or the critical care outreach team.

The electronic system also had electronic notes and electronic handover systems. Different wards and units engaged at different levels with the electronic system. The stroke and AMU used the handover record facility to record handover details but did not use the notes facility. The medical staff on the stroke ward used the electronic notes effectively.

The Royal College of Physicians recommendations for general medical record keeping standards (2015) states the name and designation of the person making the entry should be legibly printed against their signature and that every page in the medical records should have the patients name, identification number and location in the hospital. Patient records in paper format were mostly legible and all entries were dated and signed.

Paper records were stored securely in locked cabinets. We observed that staff were careful to ensure records were not left accessible and confidentiality was not compromised.

Medical staff completed discharge summaries for patients leaving hospital. A copy was provided to the patient and another sent to their GP to ensure important information about ongoing care was shared effectively.

**West Cornwall Hospital**

Staff did not always keep appropriate records of patients’ care and treatment. Records were not always clear, up-to-date and available to all staff providing care.

Care plans were not detailed enough and personalised enough to ensure individual care. We reviewed 15 sets of patient records. The care plans were pre-printed, generic, lacked specific detail and were not personalised. For example, on the urinary catheter care plan it did not state whether overnight bags should be used, how often collection bags should be changed or how to clean the flip flow valves used to empty the bags. Another example was the care plan for a patient with a central venous line inserted. The central venous line is a tube placed in a large vein and used to administer medicines. In the care plan, there were very few care instructions on how to clean the system and how often to change the dressing or care for the line appropriately.

Important individual patient details were not consistently included in care plans, which carried the risk of adversely affecting patient safety and wellbeing. We met a patient who had a visual impairment but there was nothing in the nursing care plans to alert staff to the extra support needed. Another patient was profoundly deaf but there was no mention of this disability in their care plans. This may mean the patient did not get the support they needed. We observed a patient with complex care needs including receiving oxygen therapy, skin damage and was fed through a gastrostomy (straight into the stomach) tube overnight. The patients care plan did not identify the specific plans of care for each of these issues. Another patient had a long term indwelling urinary catheter. Care plans were not available to staff to direct them to these specific needs and this created risks to patient safety. However, we found SBAR (situation, background, assessment and recommendations) forms to escalate deterioration in a patient’s clinical condition were used correctly.
Nursing documents were not always completed and did not measure effectiveness of care and treatment. For example, fluid balance charts were not always completed or added up to identify if further action was needed. This included patients who had intravenous fluids for whom measuring fluid balance was essential. This meant there was not enough assurance that patients had enough to drink or passed enough urine. We also saw gaps of up to seven hours on intentional rounding charts which are used to monitor and record checks on the patient that should have been completed hourly. Skin bundle documentation for pressure area care was not completed correctly. Diabetic patients did not always have records of their blood sugars having been taken. We found a patient receiving pain relief in the form of a skin patch. The site of the patch should be varied, however, there was no documentation about the site of the patch.

On both wards, medical records were kept in locked trolleys to ensure patient confidentiality. Each trolley had a combination lock that was the same throughout the trust, the code was changed every three months. This meant staff moving between wards could access notes easily. We did not see any notes left unattended on the ward.

**St. Michaels Hospital, Marie Therese House**

Records stored safely and securely to maintain confidentiality. However, did not always keep appropriate records of patients’ care and treatment. Records were not always clear, up-to-date and available to all staff providing care.

We reviewed four sets of patient records. The unit used the trust care plans which were pre-printed, generic, lacked specific detail and were not personalised. For example, in the stoma care plan it did not state when to clean the stoma and what with, the type of bag used, and the skin care regime required to keep it healthy. This meant that individualised, personal care may not be provided.

**Medicines**

**Royal Cornwall Hospital**

Medicines were managed and stored safely. An electronic patient record system (EPMA) was used which included systems to ensure patient safety.

The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and its associated regulations. All checks undertaken were recorded accurately. Controlled drugs (CD) were stored securely. Patient medicine charts we reviewed were legible, signed and dated and had any allergies documented.

Medicines were administered safely and were observed to be given one patient at a time with all the necessary checks being completed. Two medicine administration rounds were observed. The nurses undertaking the round wore red aprons which identified that they were occupied and preferably not to be disturbed. On each round the nurse discussed with the patient what the medicines were for and whether they wanted to take ‘when required’ medicines such as paracetamol and laxatives. They did not rush the patients and stayed with them until they had swallowed the medicines.

Nurses had medicines management training at induction and a calculation test at interview to ensure they were competent to safely to administer medicines. Intravenous medicines were administered by nurses who have completed an IV administration course. Nurses were only able to administer medicines once signed off as competent.

Patients could self-administer their medicines if they were assessed as safe to do so. There was no locked storage available for patients to do this, but on Grenville ward there was a self-
administration tool for insulin administration, patient administration lockers have been ordered for this purpose.

The EPMA system recorded that the doses of medicine were given and therefore it was possible to see if a medicine record was blank (either the medicine was not given, or the medicine administration not recorded). If there were any gaps in the record the ‘page’ will not turn (at 2 a.m.) and it was not possible to administer any more medicines until the gap has been investigated.

The system would also not allow the administration of medicine for Venus thromboembolism (VTE) unless a risk assessment had been completed, this was to ensure safe prescribing and administration.

In the endoscopy unit all medicines were administered by a doctor and recorded on the EPMA.

Medicines were disposed of safely. Staff disposed of individual doses of medicines prepared but not given to patients.

The trust had a framework to ensure that antimicrobial medicines, these included antibiotics, were used appropriately and in line with the trust policy. There was an Antimicrobial Stewardship Management Committee, a subcommittee of the Medicines Practice Committee who oversaw polices and the use of antimicrobial medicines. This meant that the use of antibiotics was monitored and reviewed to ensure patient safety.

Medicine checks for each patient took place to ensure they were the right medicines for each patient. A member of the pharmacy team completed medicines reconciliation for all new admissions at each ward visit to ensure patient records were accurate.

The electronic system printed off information for each ward, so the clinical pharmacist could target new admissions, high risk medicines, any missed doses and medicines that required monitoring. This information was also available via computer screens in the pharmacy so that any requests for medicines could be checked against test results and the patient’s medicine history and current prescription.

Nurse prescribing was used for some patients for example palliative and end of life patients. Paper palliative care prescription document could be signed by the palliative care nurse as an independent prescriber.

Fridge temperatures were monitored daily. Fridge temperatures and clinic room temperatures were monitored remotely by pharmacy department and action taken if they were outside the required temperature range.

Medical alerts were received via e-mail and distributed by the ward manager to be disseminated to staff via the safety brief.

The pharmacy had extended opening hours Monday to Friday 7am to 7pm, Saturday and Sunday 8.30am to 17.30pm. An on-call pharmacist was available out of hours and an emergency medicine cupboard was in use if needed.

**West Cornwall Hospital**

Medicines were not always recorded and stored safely. Medicines were not always administered in accordance with the trust policy and national standards.

Pharmacists completed annual controlled medicines audit, the yearly results were satisfactory for the medical wards. The medical wards did not do well in the pharmacy weekly audit. in the week prior to inspection weekly audit, ward MED 1 ward scored 90% and ward MED 2 ward scored 41%, both below the target of 92% compliance. This was due to:
- medicines found left out on the side in the treatment room
- medicine fridges were not always locked
- treatment room were not always locked.

We did not see any associated action plan to remedy this. However, on inspection we did not see any medicines left out and both medicine fridges and treatment room doors were locked.

Medicines were not always administered correctly. We could not find the prescription for flushes for peripheral or central intravenous lines. When we discussed this with a registered nurse, she told us the flushes were not prescribed, “we just know to use saline” This was a patient safety risk as there was no documentation to prove when and if an intravenous line had been flushed. This was not in accordance with Standard one, Standards for Medicine Management 2010, Nursing and Midwifery Council.

The medical prescribing system provided a daily report to the ward managers about drugs that had been ordered, missed medicines and reminders for doctors if medicines needed reviewing.

Controlled medicines were securely locked away and were checked twice daily in line with trust policy. Ward MED 1 had three sets of controlled drug keys for each team leader. This was against trust policy of only one available set on the ward.

We checked a random selection of medicines for to establish that medicines were used within the stated expiry dates. We found Diazepam liquid and Morphine liquid were not dated when they were opened. This meant that if these medicines were administered, they may have expired and so may not be effective.

**St. Michaels Hospital, Marie Therese House**

Medicines were managed safely. The service prescribed, administered, recorded and stored medicines correctly. Patients received the right medication at the right dose at the right time.

Medicines were prescribed and reviewed using an electronic system. The electronic medical prescribing system was used to support staff and provided a daily report to the ward manager about drugs that had been ordered, missed medicines and reminders for doctors if medicines needed reviewing. We reviewed six electronic prescription charts. We found there were no missed doses and medicines were given on time which met patients' needs.

Medicines were stored safely and correctly however stock management was not consistently safe. Medicine fridges were monitored remotely by Pharmacy and detailed records kept and actions taken as necessary to ensure medicines were stored safely. Stock rotation prevent the use of expired medicines was not well managed and may impact on patient safety. We checked the box containing immediate medicines when patients suffered from hypoglycaemia (low blood sugar). The 500ml bag of Dextrose 5% had expired. The ward manager removed this immediately.

Controlled medicines were managed safely and in line with current legislation. We saw they were securely locked away and were checked twice daily in line with trust policy. We checked a random selection of medicines for expiry dates and found them all to be within date.

Medicines were safely administered. On medicine rounds, nurses wore red tabards to alert other staff, patient and relatives that they were not to be disturbed. This was used to promote patient safety by avoiding nurses being distracted by other issues.

Systems were used to safely dispose of medicines no longer needed. Medicines no longer required or expired should be disposed of in proper pharmaceutical waste bins. The unit did not
have a proper pharmaceutical waste bin for medicines. Staff told us they put them in the sharps bins which was an inappropriate method of disposal.

Incidents

Royal Cornwall Hospital

The medical care group reported patient safety incidents and took appropriate action in response to significant incidents. There was a strong incident reporting culture at ward and unit level. The trust had an electronic incident reporting system and staff understood their responsibilities to report incidents. Staff felt confident in using the incident reporting system to raise concerns, record safety incidents and near misses and were encouraged by senior ward staff to do this. Staff were encouraged to report incidents and other concerns and told us individual feedback following this reporting varied from ward to ward. Staff were confident that learning was shared across the trust when significant issues arose through emails, safety briefs and newsletters.

Opportunities for learning or prevention of reoccurrence may have been missed through the reporting of incidents as ‘no harm’ where they may have been moderate, major or catastrophic. The level of harm for incidents was initially decided by the staff member raising the electronic record. The electronic record was then sent to a directorate governance lead who would review and allocate the incident for investigation. Some incidents could be addressed immediately by senior ward staff. For more serious incidents an investigation was required, and the governance lead would allocate this role. Reported incidents were delegated for investigation to senior staff and most staff investigating incidents had received training to do so. At this point the level of risk could be amended, it could then be amended again post investigation.

Incidents were investigated, and learning was shared with staff to prevent reoccurrence. Senior ward staff attended monthly clinical governance meetings where incidents were discussed to enable learning to be utilised. We reviewed six investigation reports into serious incidents and found these to be thorough, with an action plan for identified learning from the incidents.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with patients when things go wrong. All staff had a good understanding of the duty of candour and could describe when it would be used. The incident reporting system had a section for duty of candour which was a prompt for staff if action was needed. However, opportunities to implement the duty of candour may have been missed through the reporting of incidents as ‘no harm’ where they may have been moderate, major or catastrophic.

Reviews of mortality were undertaken to look at if care and treatment provided was appropriate. Not enough patient reviews had been completed. Mortality meetings took place for each speciality where deaths needed to be reviewed. A monthly report went to all consultants to share any learning identified. The mortality review committee met monthly and reviewed findings and identified learning to be disseminated. The level of records reviewed did not meet the trusts identified target and on the Patient Assurance Framework showed that on 52% was achieved. This meant that there may be missed opportunities for learning and development of practice.

West Cornwall Hospital

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
Staff told us they knew how to report incidents and received feedback. Staff were also informed of trust wide incidents. The wards had a folder of incidents and learning, and staff had an individual printout to read and sign to identify they had read all updates. Falls was the wards highest reported area of incidents. Staff gave us an example of learning from an incident and as a result staff did not leave the area when taking a patient to the toilet but waited outside until the patient was ready to be accompanied back to their bed. From March – August 2018, the main incidents reported at West Cornwall hospital were slips, trips and falls, 118 incidents, and pressure ulcers, 42 reported. High level of reported incidents showed a good reporting culture within the hospital.

**Duty of Candour**

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service had a duty of candour policy to inform staff. Managers showed us letters sent to patients and relatives involved in patient safety incidents which showed duty of candour had been applied. Patients and relatives were also offered duty of candour meetings to explain any issues they wanted to discuss further.

**St. Michaels Hospital, Marie Therese House**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The trust had an electronic reporting system which all staff could easily access. Staff told us they knew how to report incidents and received feedback. Staff were also informed of trust wide incidents.

Incidents and trends were discussed at governance and management meetings on the unit. This information was taken back to the different teams and staff informed to develop care and improve patient safety.

Incidents were discussed at nursing handover between shifts. For example, a patient was leaning on a bed rail. The bed rail was not fixed to the bed correctly and the patient fell out of bed. The learning was shared at handover that all bed rails must be regularly checked.

At daily team huddles for physiotherapy there was a safety element where incidents were discussed and learning fed back to staff.

**Duty of Candour**

All staff had a good understanding of the duty of candour and could describe when it would be used. An example of duty of candour was given to us. A controlled medicine was given to the wrong patient. The ward manager investigated the incident and found that when controlled drugs were given at 8 am, this was the same time as the daily controlled drug count. The learning from this incident was the timing for the controlled drug count was moved so that the nurses were not rushed in the morning to administer and count controlled drugs. The patient suffered no ill effects, but the ward manager fulfilled the duty of candour requirement by informing the patient.

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to
cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From June 2017 to May 2018, the trust reported two surgical/invasive procedure incidents classified as never events for medicine, which were both for an incorrect stent type implanted. A full investigation had taken place and staff explained the learning from this and how changes had been implemented as a result.

(Source: Strategic Executive Information System (STEIS) - June 2017 – May 2018)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 75 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from June 2017 to May 2018.

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with 26 (34.7% of total incidents).
- Slips/trips/falls meeting SI criteria with 19 (25.3% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with 11 (14.7% of total incidents).

(Source: Strategic Executive Information System (STEIS) - June 2017 – May 2018)

Safety thermometer

Wards and departments monitored harm free care using a ‘safety thermometer’ tool. The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. All wards and departments displayed monthly safety thermometer audits at the ward entrance for all to see, this was updated monthly.

Data collection takes place one day each month. Data from the Patient Safety Thermometer showed the trust reported 45 new pressure ulcers, 17 falls with harm and 11 new urinary tract infections in patients with a catheter from May 2017 to May 2018 for medical services.

St. Michaels Hospital, Marie Therese House

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service. Data from the Patient Safety Thermometer showed Marie Therese House reported no harm in August 2018.

(Source: Safety thermometer)

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Royal Cornwall Hospitals NHS
Total Falls (17)

Total CUTIs (11)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: Safety thermometer)

Is the service effective?

Evidence-based care and treatment

Royal Cornwall Hospital

Policies and guidelines had been developed in line with national policy including the National Institute for Health and Care Excellence (NICE) guidelines. Staff had good access to the intranet to look at clinical guidelines policies and procedures. However, some care pathway guidance we viewed on the trust intranet were outside of their review date including Parkinson’s disease, chronic obstructive pulmonary disease, diabetic ketoacidosis and acute stroke management.

The endoscopy unit had gained Joint Advisory Group (JAG) accreditation. To gain this accreditation, the unit was assessed against many national standards and continued to monitor its own service provision to ensure compliance. The endoscopy unit used the world health organisation (WHO) checklist for invasive procedures. The (World Health Organisation (WHO), 2008) formed the process of theatre safety checks to ensure all staff were aware of their responsibilities in line with national guidance.

The National Institute of Clinical Excellence QS 61 Statement states that people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. We saw staff consistently wash their hands between patients and hand hygiene audits confirmed this was a routine action.

Sepsis screening and management was undertaken using the Sepsis Six guidelines and Buffalo action plan. These are tools to identify sepsis and prompts for actions to complete within a timescale.

Best practice guidelines had been used to ensure effective patient care. We saw Wellington ward used National Institute of Clinical Excellence guidelines for management of conditions associated with Cystic Fibrosis and were working with the respiratory team to include cystic fibrosis in MDT meetings.
A dementia care strategy had been implemented. The policy was planned to be updated to reflect new NICE guidelines. The current strategy is based around the older nation strategy. Audits were undertaken monthly for ten patients and an action plan was formalised to address any issues. The results are fed back to the dementia action group quarterly. The Alzheimer’s society also audited and had identified boredom as a problem and so were looking at ways to address this problem. Training was provided for staff with a plan to bring dementia, delirium and depression together for training purposes.

However, the Neurology risk register noted noncompliance of NICE Quality Statement (QS)26 Epilepsy in adults. Adults with epilepsy were seen by an epilepsy specialist nurse who could be contacted between scheduled reviews. The trust employed one nurse specialist for epilepsy and to meet the NICE guidance the workforce would need to increase.

West Cornwall Hospital
The service provided care and treatment based on national guidance. Managers checked to make sure staff followed guidance.

We found the trust policies, procedures and processes provided for staff complied with national guidance and good practice recommendations. Staff told us they could access specialist nurses for advice, such as the diabetes nurse specialist and dementia specialist nurse. Referrals to specialist services were made by telephone or by the internal intranet.

Patients were assessed for risk of venous thrombosis (VTE) in accordance with the National Institute for Health and Care Excellence (NICE) (QS3 Statement 5) through the electronic prescribing system. Doctors could not prescribe any medication until the VTE assessment had been completed.

We reviewed 15 sets of medical records which showed that patients had a treatment plan and were reviewed by medical staff at least every 48 hours, more frequently if they were clinically unstable.

The wards had taken part in a national challenge from NHS England to ‘End pyjama paralysis’ Patients were encouraged to get up and dress in day clothes to encourage a speedy recovery. This was successful and was planned to be rolled out across the whole trust.

St. Michaels Hospital, Marie Therese House
Policies and guidelines had been developed in line with national policy including the National Institute for Health and Care Excellence (NICE) guidelines. In line with the acute trust NICE guidance was followed for example the use of an assessment tool, MUST (malnutrition universal screening tool) was used to assess patient’s nutritional needs. The tool also identified when a referral was required to a dietitian (NICE QS15 statement 10).

The service provided care and treatment based on an individual rehabilitation plan for each patient. The rehabilitation plans were reviewed both daily and weekly and records audited every six weeks.

Nutrition and hydration
Royal Cornwall Hospital
Staff assessed patients’ nutritional and hydration needs in line with national guidance. The trust used a malnutrition universal screening tool (MUST) to identify patients at risk of malnutrition.
Care plans included information about nutritional care and fluid needs and how they were to be met. We saw clear instructions for patients with swallowing difficulties and staff could quickly and easily tell us which patients needed what help.

There were different menus to meet patients’ nutritional and cultural needs. We observed meals being served in a supportive and unhurried manner with staff asking patients what they wanted and changing the choices when needed.

Nursing staff supported patients who needed assistance to eat and drink. A system of red trays and cups was used to discreetly identify to staff which patients needed more support. Food and fluid charts, we saw, were kept up to date.

Drinks and snacks were available to supplement patients who needed extra nutrition and staff could access the dietician if they had any concerns about how best to support a patient’s individual dietary needs.

We received mixed views from patients of the food they received while in hospital, but all were complimentary about the way the meals were served and how they were assisted.

**West Cornwall Hospital**

Staff supported patients with nutrition and hydration to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients’ religious, cultural and other preferences.

The MUST (malnutrition universal screening tool) was used to assess patient’s nutritional needs. The tool also identified when a referral was required to a dietitian (NICE QS15 statement 10). We found the MUST score was not completed for five patients of the 15 sets of notes we reviewed. This meant that patients may not have their nutritional needs identified and met.

Staff told us how they could access snacks and meals out of hours for patients. We also saw staff assisting patients to take fluids and eat meals. Finger food snacks and drinks were provided for patients living with dementia as they often did not eat at set meal times. Patients told us they thought the standard, quality and quantity of food was good. The hospital scored 93.3% for ward food against a national average of 90.5% (Health and Social Care Information Centre. 2018)

**St. Michaels Hospital, Marie Therese House**

Patients had nutrition and hydration which met their needs. Staff used special feeding and hydration techniques when necessary. The service adjusted for patients’ religious, cultural and other preferences.

An assessment tool, MUST (malnutrition universal screening tool) was used to assess patient’s nutritional needs. All patients should be assessed on admission. The tool also identified when a referral was required to a dietitian (NICE QS15 statement 10). We found the MUST score was completed for patients in the four sets of notes we reviewed.

Staff told us how they could access snacks and meals out of hours for patients. We also saw staff assisting patients to take fluids and eat meals with adapted cutlery. Patients told us they thought the standard, quality and quantity of food was “fantastic”. St Michael's hospital scored 91.4% for ward food against a national average of 89.9%

*(Health and Social Care Information Centre. 2018)*

Menu’s within the trust changed every two weeks. However, as patients usually stayed for long periods in Marie Therese house, a more varied long stay menu was available for patients to order
from for lunch and teatime to offer more choice. Hot drinks were available at any time. Patients, if able, were encouraged to make their own hot drinks.

However, we found fluid balance charts for several patients had not been completed correctly. There were long gaps in time of the recording of fluid taken in and urine output. There were also no action plans seen to address any poor intake and output in the nursing care plans. This meant that it may not always be identified when patients had not had sufficient food and drink and so not identify any associated health implications

**Pain relief**

**Royal Cornwall Hospital**

Staff assessed and managed patients' pain effectively. Pain assessment tools were used as part of the patients checks and we observed staff asking patients to describe levels of pain and ensuring they received pain relief medication. Medication charts reflected when medicine had been administered and the rationale for any omissions or delays.

Staff used a nationally recognised pain assessment tool to identify the severity of patients’ pain. The trust had a pain specialist nurse who worked under the anaesthesia service, who could provide advice or review referred patients.

**West Cornwall Hospital**

Pain relief management was seen to be effective. Nursing staff assessed patients for evidence of pain using a nationally recognised pain assessment tool to identify the severity of patients’ pain. We saw staff asking patients if they had any pain during the medicine rounds and there was evidence of administration of regular pain relief. This was recorded on the electronic prescription chart.

We saw a dementia specific pain assessment tool being used. However, this could not be documented in the electronic prescribing system and this meant that there needed two records to work together to provide an audit trail of pain management.

**St. Michaels Hospital, Marie Therese House**

The management of patient's pain was seen to be effective. Nursing staff assessed patients pain by discussing this with the patient and by observing behaviour. The level of pain was then reviewed using a nationally recognised pain assessment tool to identify the severity of the pain. We then saw staff administer pain relief medication.

We saw staff asking patients as a matter of routine if they had any pain during the medicine rounds and care rounds and appropriate action being taken. We saw medicine records which recorded evidence of administration of regular pain relief when needed.

There was no specific tool used for patients with extra needs. Staff told us that they did not use a specific pain assessment tool for learning disability patients, they just asked the patient on every drug round.

**Patient outcomes**

**Relative risk of readmission**

**Trust Level**

From February 2017 to January 2018, patients at the trust had lower than expected risks of readmission for elective and non-elective admissions when compared to the England averages.

**Elective Admissions – Trust Level**
• Patients in clinical oncology (previously radiotherapy) had a lower than expected risk of readmission for elective admissions

• Patients in gastroenterology had a lower than expected risk of readmission for elective admissions

• Patients in clinical haematology had a similar to expected risk of readmission for elective admissions

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite.

Non-Elective Admissions – Trust Level

• Patients in general medicine had a lower than expected risk of readmission for non-elective admissions

• Patients in cardiology had a lower than expected risk of readmission for non-elective admissions

• Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite.

Royal Cornwall Hospital (Treliske)

The medical division completed audits against key measures and objectives and reported their findings through the medical governance structure and up to board level. From February 2017 to January 2018, patients at Royal Cornwall Hospital (Treliske) had lower than expected risks of readmission for elective and non-elective admissions when compared to the England averages.

Elective Admissions - Royal Cornwall Hospital (Treliske)

• Patients in clinical oncology (previously radiotherapy) had a lower than expected risk of readmission for elective admissions

• Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
• Patients in clinical haematology had a higher than expected risk of readmission for elective admissions

![Bar chart showing ratio of observed to expected emergency readmissions for different specialties.](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.*

**Non-Elective Admissions - Royal Cornwall Hospital (Treliske)**

• Patients in general medicine had a lower than expected risk of readmission for non-elective admissions

• Patients in cardiology had a lower than expected risk of readmission for non-elective admissions

• Patients in respiratory medicine had a lower than expected risk of readmission for non-elective admissions

![Bar chart showing ratio of observed to expected emergency readmissions for different specialties.](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.*

**West Cornwall Hospital (Penzance)**

The medical division completed audits against key measures and objectives and reported their findings through the medical governance structure and up to board level.

From February 2017 to January 2018, patients at West Cornwall Hospital (Penzance) had a lower than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions - West Cornwall Hospital (Penzance)**

• Patients in gastroenterology had a lower than expected risk of readmission for elective admissions

• Patients in clinical haematology had a lower than expected risk of readmission for elective admissions

• Patients in rheumatology had a higher than expected risk of readmission for elective admissions
Non-Elective Admissions - West Cornwall Hospital (Penzance)

- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in general medicine had a higher than expected risk of readmission for non-elective admissions

St Michael's Hospital

From February 2017 to January 2018, patients at Marie Therese house (Penzance) had a lower than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions - St Michael's Hospital

- Patients in pain management had a higher than expected risk of readmission for elective admissions
- Patients in rehabilitation service had a higher than expected risk of readmission for elective admissions
Sentinel Stroke National Audit Programme (SSNAP)

Royal Cornwall Hospital

Royal Cornwall Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade C in latest audit, for August 2017 to November 2017, which was the same as the previous audit, for April 2017 to July 2017.

The trust provided the most recent data evidence which showed the SSNAP rating from April to June 2018 have increased to a level B.

Royal Cornwall Hospital (Treliske)

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Aug - Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr - Jul 17</th>
<th>Aug - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>D</td>
<td>B↑↑</td>
<td>C↓</td>
<td>C</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
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<td>A↑</td>
<td>B↓</td>
<td>A↑</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>C↑</td>
<td>B↑</td>
<td>B</td>
<td>C↓</td>
</tr>
</tbody>
</table>

- The audit compliance band has seen an improvement in performance from grade B to grade A in the latest audit.
- The combined total key indicator level has seen a decline in performance from grade B to grade C in the latest audit.

<table>
<thead>
<tr>
<th>Patient centred performance</th>
<th>Aug - Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr - Jul 17</th>
<th>Aug - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>D↓</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>C↑</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>B↑↑↑</td>
<td>B</td>
<td>C↓</td>
<td>C</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>D</td>
<td>C↑</td>
<td>D↓</td>
<td>C↑</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
<td>C↓</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>D↑</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>B↓</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Patient-centred Total Key Indicator Level</td>
<td>C↑</td>
<td>B↑</td>
<td>B</td>
<td>C↓</td>
</tr>
</tbody>
</table>

(Source: HES - Readmissions (February 2017 – January 2018))
• Domain 2: Stroke unit has seen a decline from grade C to grade D in the latest audit for patient centred performance.

• Domain 3: Thrombolysis has seen a decline from grade C to grade D in the latest audit for both patient and team centred performances.

• Domain 5: Occupational therapy has seen an improvement from grade C to grade B in the latest audit for team centred performance.

• Domain 6: Physiotherapy has seen an improvement from grade D to grade C in the latest audit for team centred performance.

• Domain 7: Speech and language therapy has seen a decline from grade B to grade C in the latest audit for patient centred performance.

• Domain 8: Multi-disciplinary team working has seen a decline from grade B to grade C in the latest audit for team centred performance.

• Both patient-centred and team-centred total key indicator levels have declined from grade B to grade C in the latest audit.

A stroke pathway was effective and meant that patients could be treated quickly in the emergency department and transferred to a higher care bed on the stroke unit. Patients would be treated and cared for by a specialist stroke nurse and a stroke consultant.

Phoenix ward was the specialist ward for stroke patients and a specialist stroke nurse was on duty each day and overnight. The stroke specialist nurses were responsible for caring for patients in the higher care beds. This meant they were not always available to see patients in the emergency department. They could only care for one higher care patient at a time. Thrombolysis treatment took place in the emergency department before transfer to a suitable bed. Patients received post-thrombolysis care in the critical care unit.

Ambulance staff informed the hospital of any potential new stroke patient arriving at the hospital. This patient would be given priority access to the emergency department where a doctor and the specialist stroke nurse would see the patient. Should a stroke patient have to be on another ward, because of capacity issues, the stroke nurse kept a record of where they were and ensured they were seen and reviewed by the stroke team.

The stroke pathway was used to ensure the patient was assessed and treated within a specific timescale. This pathway was implemented to improve outcomes for those patients. However, we
saw a patient who was admitted to the AMU with a potential stroke and was subsequently found not to have had a stroke, there were delays in agreeing who their care would be provided by. As a result, the outcome was the patient had remained in the Acute Assessment Unit for five days, with no onward plan seen during our inspection.

Staff confirmed staffing levels on the stroke ward were a suitable level to meet patients’ needs. The medical care of the stroke ward was provided by the elderly care team seven days a week. There were three consultants who specialised in stroke care, however all elderly care consultants were suitably qualified as stroke physicians and contributed to seven-day cover. There were also two registrar level doctors and three junior doctors providing medical care on the ward. Overnight medical cover was provided by the on call medical senior house officer for the Trelawney building and so was also covering over areas of the hospital. This meant the ward would have to be prioritised when the doctor was called. There was a non-resident consultant on call after 10pm, contactable by phone. There was limited consultant cover at the weekend with cover between 8am and 12md with cover until 5pm by a consultant working in the outpatient clinic.

An increase in therapy access to the stroke ward meant they were available for part of the weekend. The increase in therapy cover had enabled a six-day service. This service only covered one day at the weekend. Those patients who were not on the stroke ward may experience a delay in accessing the specialist therapy available on the stroke ward.

A stroke mortality review had been undertaken and the resulting recommendations had started to be implemented. Further developments being looked at were how to increase capacity for a higher dependency area for stroke patients.

The Myocardial Ischaemia National Audit Project (MINAP) was last completed to report between April 2015 and March 2016. As such the data would not have been relevant to this inspection.

The Heart Failure Audit had no updated report since 2016 and the data would not have been relevant for this inspection.

The National Diabetes Inpatient Audit was last completed in 2017. Recommendations had been made several areas and an action plan had been implemented. The areas of improvement not yet achieved included, foot screening, electronic prescribing and insulin safety.

An improved electronic system had been introduced which provided monitoring information for patients with diabetes to provide a more focussed overview. New blood glucose meters had been introduced which recorded data which produced a daily report that could be accessed by the diabetes specialist nurses. These nurses could then review all newly diagnosed type one diabetic patients and target patients who experienced hypoglycaemic episodes.

**St Michael’s Hospital**

St Michael’s Hospital did not participate in the Sentinel Stroke National Audit programme.

**West Cornwall Hospital**

West Cornwall Hospital did not participate in the Sentinel Stroke National Audit programme.

(Source: Royal College of Physicians London, SSNAP audit)

**UK Rehabilitation Outcomes Collaborative**

Marie Therese house submitted data every three months to the national registry for UK Rehabilitation Outcomes Collaborative (UKROC, a national database for collating case episodes for neurology inpatient rehabilitation) as this was mandatory. This data was discussed at governance and management meetings.
National Lung Cancer Audit 2017

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 82.4%, which did not meet the audit minimum standard of 90%. The 2016 figure was 6.0%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 15.0%. This is within the expected range. The 2016 figure was not significantly different from the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 47.5%. This was a negative outlier. The 2016 figure was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 74.9%. This is within the expected range. The 2016 figure was not significantly different from the national level.

The one-year relative survival rate for the trust in 2017 is 40.4%. This is within the expected range. The 2016 figure was not significantly different from the national level.

(Source: National Lung Cancer Audit 2017)

National Audit of Inpatient Falls 2017

Royal Cornwall Hospital

The trust was undertaking a review of falls and how there were being managed. The information was being used to reduce the risk of falls taking place. Falls sustained by patients were reviewed at the staff huddle meeting and how they could have been avoided were discussed.

A new nursing role had been implemented and the falls practitioner nurse was developing immediate actions to take post fall and review of any causes or trends of falls to promote prevention. A falls collaborative review had already taken place on Kerenza and Tintagel wards. This was an ongoing piece of work but as a result some actions already taken included falls alarms were being used, red folders used to identify patients at high risk of falls, falls posters were being put on doors to remind patients to call for help and the wards were considering falls maps to look at trends and high-risk areas. The stroke ward had already completed a falls map and no specific trend areas were seen. All falls data was collated monthly on Kerenza ward and shared with the staff in the morning safety brief.

Records reviewed showed a post falls sticker was in used to identify the risk and management plans to support prevention.

The crude proportion of patients who had a vision assessment (if applicable) at Royal Cornwall Hospital was 100%. This met the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 27%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 28%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 100%. This met the national aspirational standard of 100%.

St Michael’s Hospital

St Michael's Hospital did not participate in the National Audit of Inpatient Falls 2017.
West Cornwall Hospital

West Cornwall Hospital did not participate in the National Audit of Inpatient Falls 2017.

(Source: Royal College of Physicians)

Competent staff

Appraisal rates

Trust wide:

Trust staff did not all receive an appraisal within the trusts target. Up to August 2018, 75.7% of medical staff and 77.2% of nursing staff within medicine at the trust had received an appraisal compared to a trust target of 95%.

A split by location and staff group can be seen in the tables below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic and technical staff</td>
<td>31</td>
<td>35</td>
<td>88.6%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>58</td>
<td>67</td>
<td>86.6%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>247</td>
<td>320</td>
<td>77.2%</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>106</td>
<td>140</td>
<td>75.7%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>266</td>
<td>355</td>
<td>74.9%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>2</td>
<td>7</td>
<td>28.6%</td>
</tr>
<tr>
<td>Total</td>
<td>727</td>
<td>945</td>
<td>76.9%</td>
</tr>
</tbody>
</table>

Royal Cornwall Hospital:

At Royal Cornwall Hospital, 76.5% of medical staff and 81.8% of nursing staff within medicine had received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic and technical staff</td>
<td>30</td>
<td>34</td>
<td>88.2%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>58</td>
<td>67</td>
<td>86.6%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>224</td>
<td>274</td>
<td>81.8%</td>
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<tr>
<td>Support to doctors and nursing staff</td>
<td>247</td>
<td>308</td>
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<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>104</td>
<td>136</td>
<td>76.5%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>9</td>
<td>12</td>
<td>75.0%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>2</td>
<td>7</td>
<td>28.6%</td>
</tr>
<tr>
<td>Total</td>
<td>682</td>
<td>847</td>
<td>80.5%</td>
</tr>
</tbody>
</table>

Staff had the right skills and knowledge to provide safe care and treatment for patients. Newly appointed staff were provided with a trust induction and a period of supernumerary time on the wards. Some staff had obtained additional qualifications within the speciality they were working, and ongoing training was being provided on the wards. Staff told us about a plan called ‘Thirsty Thursday’ and ‘Mash Up Mondays’. The plan was to cover specialist areas in short sessions to update staff. Topics included dementia, Parkinson’s disease, Alcohol liaison, sepsis, nutritional screening, falls and palliative care. These sessions were provided by the specialist nurses on a rolling programme to try and support as many staff as possible.
Students nurses told us about the collaborative learning in practice project. This involved feedback from the students to the ward staff to ensure that student nurses were getting the support they needed.

Specialist nurses provided training and guidance to staff within the hospital setting for staff when they were caring for patients with complex wound care needs. Training sessions were planned and delivered by the specialist nurses to groups of staff when requested. For specialist nursing competencies training was provided and records of competency assessments maintained.

Training was sometimes delayed by the staffing difficulties in the hospital. Staff told us that when the hospital was at full capacity, time for staff training was not possible and the training sessions were delayed.

Staff were aware of the signs of sepsis and what their actions should be. Some staff said they had received training on sepsis and that it was a topic highlighted at induction. A further sepsis module was being implemented in September 2018 to enable a wider understanding of sepsis monitoring.

Staff had link roles on their wards and attended training sessions to support the link role. They in turn cascaded training to their colleagues.

Clinical staff received mandatory training on patients with mental health needs, learning disabilities, autism and dementia. Staff did not feel this training was sufficient to provide them with the knowledge and skills required to care for these patients. Staff feel they learn on the job and rely on specialist teams (such as psychiatric liaison) for specialist skills and support.

Junior doctors had protected learning time and three hours weekly for clinical skills as part of the national foundation programme (teaching programme for junior doctors). Junior medical staff did not receive training to support them to use the information technology equipment. This had to been taught by other staff while they worked. This may pose a risk of inaccurate recording.

**St. Michaels Hospital, Marie Therese House**

The service made sure staff were competent for their roles. p Managers but did not always hold supervision meetings with staff to provide support and monitor the effectiveness of the service.

At Marie Therese house, 50% of medical staff and 53.1% of nursing staff within medicine had received an appraisal compared to a trust target of 95%. This meant that opportunities for discussion and development did not routinely take place.

At the last inspection of the trust in January 2016, clinical supervision for nursing staff was highlighted as an area in need of improvement. Despite this, there remained no structured, documented clinical supervision with them to provide support and monitor the effectiveness of the service. This meant that staff may not have the support and development they need. However, staff told us they felt supported by senior staff and had occasional informal supervision when needed. Allied health professionals had monthly supervision and showed us records of this.

Some nursing staff were undertaking further study. For example, two nurses were to become manual handling trainers for the unit and a nurse was studying a master's degree in rehabilitation. The unit also promoted the use of assistant practitioners, a band four nurse, to assist registered nurses.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>6</td>
<td>14</td>
<td>42.9%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>4</td>
<td>14</td>
<td>28.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>28</strong></td>
<td><strong>35.7%</strong></td>
</tr>
</tbody>
</table>
West Cornwall Hospital:
Training was provided to ensure staff were competent for their roles. Managers appraised staff’s work performance but did not meet the trust target for appraisal rates. At West Cornwall Hospital, 50.0% of medical staff and 53.1% of nursing staff within medicine had received an appraisal compared to a trust target of 95%.

At the last inspection in January 2016, clinical supervision was highlighted as an area in need of improvement. Despite this, there remained no structured, documented clinical supervision with nursing staff to provide support and monitor the effectiveness of the service. However, staff told us they felt supported by managers but only had occasional informal supervision from senior staff when needed.

Ward managers had a ‘managers passport’ to document their advanced skills. Senior staff told us they had opportunity to develop professionally and felt supported by their managers.

Junior doctors had protected learning time and three hours weekly for clinical skills learning as part of the national foundation programme (teaching programme for junior doctors). They met with their clinical and educational supervisors at the beginning and end of every placement, setting objectives to achieve.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to scientific, therapeutic and technical staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>17</td>
<td>32</td>
<td>53.1%</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>2</td>
<td>4</td>
<td>50.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>15</td>
<td>33</td>
<td>45.5%</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>70</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working
Royal Cornwall Hospital
Staff worked collaboratively with other health professionals and across health care disciplines to ensure continuity of care to patients. There were good working relationships with various specialist teams both employed by the trust and external to the trust.

Ward board rounds were used to ensure that all aspects of patient care were included and monitored. We observed board rounds, which were attended by medical staff, nurses, allied health professionals and discharge coordinators. Referrals to allied healthcare professionals, frailty team, palliative care team, learning disability team and specialist nurses were included and all provided updates and identified actions needed.

Multidisciplinary team meetings took place on the wards to ensure a full medical overview was maintained and action plans completed. Some transfers were outside of the hospital, to another hospital or service. These were consultant to consultant referrals and so required multidisciplinary working.

At handover meetings, staff did not routinely refer to the psychological and emotional needs of patients, their relatives and carers.

The service included round the clock access to mental health liaison (covering the age range of the ward/ clinic) and/or other specialist mental health support if staff were concerned about risks associated with a patient’s mental health.
Therapy staff worked on wards and units to facilitate care and treatment and assist patients to improve enough to go home. There had been an increase in therapy staff numbers on the Acute Medical Unit to promote patient’s wellbeing and earlier discharge.

The complex care, dementia team, learning disability team, alcohol liaison team employed by the trust were well respected by staff. There were also strong links with the local substance misuse service, local mental health services and social care teams.

Discharge was variably organised depending on the complexity of discharge. Wards organised their own simple discharges and this was often undertaken by an allocated discharge nurse coordinator with the support of the onward care team. A discharge lounge was available but was limited in its scope for use. Complex discharges which involved multiple health needs and multiple service input, were managed by the complex discharge team. The ward staff would make a referral to this team who would then assess the patients and plan the discharge process. This team was nurse led and included a case coordinator and administrative staff. A discharge summary was sent to patients’ GPs to ensure effective communication and sharing of information about patients’ health conditions to ensure ongoing care was maintained.

Some specialist areas worked together within the hospital to promote patients care. The medical Day Unit worked in collaboration with the haematology clinic to support patients who could be seen in the outpatient clinic and then received treatment in the day unit.

The respiratory department specialist respiratory nurses provided support and advice to respiratory areas including Wellington and Roskear ward specialising in cystic fibrosis and bronchiectasis. Their principal function is to support patients to avoid admissions.

The Onward Care team assisted the ward staff to identify individuals who required specialist referral to the community teams and managed the interface between the acute and primary care and community service.

The same day care unit worked with the on-call GP service to try and avoid admissions by treating patients and trying to get them home in the same day. This department also worked with the inpatient hospital for when patients needed to be admitted.

West Cornwall Hospital

Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Multidisciplinary meetings were held weekly and involved doctors, nurses, discharge nurses, occupational and physiotherapists. Rapid rounds were held daily on the wards to briefly discuss progress and plans for the day. Multidisciplinary working was well documented in patient records in accordance with NICE quality standard 15 Statement 12.

The wards had a designated discharge coordinator. This role was a rotational role for all band five nurses on the two medical wards. Staff told us this post had increased awareness of complex discharges and improved communication. We found good recorded evidence of communication and clear discharge planning between health professionals to ensure a coordinated approach to care.

St. Michaels Hospital, Marie Therese House

Staff worked with health professionals across all areas to ensure continuity of care to patients. All patients on the unit were under the care of one consultant. The unit had well established multidisciplinary working practices. Staff from different teams and services were involved in
assessing, planning, and delivering patient’s care. Multidisciplinary meetings were held weekly and involved doctors, nurses, psychologists, occupational and physiotherapists.

We observed effective multidisciplinary working on the unit with evidence of good communication and clear discharge planning between health professionals. Occupational and physiotherapists attended nursing handover three days a week or had a handover from a registered nurse. All staff from the multidisciplinary team had access to the handover sheet kept in the office. Marie Therese house also worked closely with other medical and surgical neurology teams based in the south west.

Morale appeared good among the multidisciplinary team. Staff told us they felt they worked well as a team. Staff had good links with therapy teams in the community and with social workers. Occupational and physiotherapists worked across inpatients and the community which helped to provide seamless care for patients.

**Seven-day services**

**Royal Cornwall Hospital**

Medical and health cover was available to support patient care; however, seven-day services were not available in all areas.

The Trust did not have a bespoke seven-day service strategy. Instead there was an action plan and a steering group that met quarterly, with oversight and engagement from NHS England.

The latest nationally coordinated seven-day service audit showed a significant improvement in coverage of services at the trust. The trust completed the seven-day service self-assessment readiness tool in line with best practice in January 2018 and reviewed the gaps in service and potential future developments at the last working group meeting in January 2018. The survey showed an improvement from 67% of patients being seen within 14 hours to 82%. Some medical specialities achieved 100%, these included cardiology, elderly care, respiratory medicine and stroke services. An action plan had been implemented and a planned follow up review to take place.

Many specialities ran a seven-day consultant service. Cardiac medicine, renal medicine, gastroenterology medicine, and general medicine all had services during the week, at weekends, on bank holidays, and provided on-call services 24 hours a day seven day a week. For respiratory medicine and endocrine medicine cover by the consultant of the day was provided during the week, and in the mornings on weekends and bank holidays. The acute medicine speciality and eldercare had consultant cover during weekdays, and in the mornings on weekends and bank holidays but no on call cover was provided. The on call was provided by the consultant of the day and the medical registrar for the hospital.

Patients on the medical admissions unit were seen by consultants each day. Audits of seven-day services recorded that 97% of the overall proportion of patients who required a daily consultant review, were reviewed by a consultant. Each patient was reviewed within 14 hours of admission by a consultant and then referred to the appropriate speciality medicine consultant. The speciality consultant or registrar would then visit the patient on the AMU to implement a plan of care and arrange transfer or discharge. Each day there was a daily board round which was attended by a multi-disciplinary team, which reviewed patients care and treatment.

At the time of our inspection, all medical specialities except neurology, respiratory and endocrine held ward rounds daily, including at weekends and on bank holidays. The trust informed us after the inspection that daily ward rounds had since been implemented for respiratory and endocrine. Neurology was not providing a seven-day consultancy led service which put patients at higher risk
during weekends as there was no specialist cover. Elderly care consultants provided any out of hours cover needed.

Patients had access to x-ray services 24 hours a day seven day a week. Diagnostic scanning services such as MRI, CT and ultrasound were available seven days a week, out of hours there was availability for urgent scans only.

Therapy staff provided care and treatment Monday to Friday with a reduced service at the weekends and out of hours. There was a seven-day service for physiotherapy with an out of hours on call service for urgent patients, for example patients requiring urgent respiratory physiotherapy. Occupational therapists and speech and language therapists provided a six-day service.

Staff had access to mental health liaison services seven days a week. Staff made referrals to the mental health liaison team who would review and triage all referrals each day. Out of hours a referral could be made.

The same day service was open seven days a week between 8am and 6pm. This was a nurse led service which meant that it was managed and staffed by nurses with support from the on-call GP service if needed.

There was access to out of hours pharmacy support which staff said provided a prompt service. Pharmacy was on site for clinical service and supply of stock medicines. A stock top-up service was provided by pharmacy. Each ward, except for the discharge lounge and the Kynance Independence unit, were visited daily by a clinical pharmacist, Monday to Friday. The pharmacy had extended opening hours Monday to Friday (7am to 7pm) and 8.30am to 5pm at weekends. The on- call pharmacist was available out of hours and there was an emergency cupboard for urgent access by ward staff.

West Cornwall Hospital

Medical and health cover was available to support patient care; however, seven-day services were not available from all medical and therapy staff.

Medical cover was available mid-week but was reduced at weekends. GPs from the urgent care service supported medical staff on the wards at weekends if required.

Pharmacy cover was provided from the Royal Cornwall hospital at weekends.

Therapy and social care input was only available on week days. This meant that unless the therapy was provided by nursing staff, therapy was not supported at the weekends.

St. Michaels Hospital, Marie Therese House

Medical and health cover was available to support patient care; however, seven-day services were not available from all therapists.

Therapists worked Monday to Friday, only nursing staff worked seven days. However, we observed physiotherapists training nursing staff to use a piece of static cycling equipment so that patients could continue their physiotherapy at weekends.

Medical cover for weekends and out of hours was provided from St Michael’s hospital.

Health promotion

Health promotion information and feedback was available for patients.

Information for patients was available on all wards and covered a range of general subjects and the specialist service provided. The leaflets were of good visual quality and could be photocopied
to increase the size if needed. The leaflets were not available in other languages but there was a translation service available for staff so that the information could be provided verbally.

For each ward speciality, information was available to support those patient’s needs. For example, there were leaflets to support patients with respiratory problems. There were leaflets for wider health issues including alcohol services and domestic violence.

Notice boards at entrances to wards showed information for patients, for example, results from hand hygiene audits, level of falls and a cleaning analysis.

St. Michaels Hospital, Marie Therese House
Staff told us about the importance of relationships with the patients living with dementia, and how they promoted their wellbeing with activities on the ward. We found that the medical wards at West Cornwall Hospital supported patients living with dementia and their carers. This included a memory café weekly, held in the dayroom on a ward. This was staffed by ward staff and volunteers. Patient, relatives and carers were encouraged to attend for refreshments, activities and advice.

We reviewed four sets of medical records which showed that all patients had a treatment and individual rehabilitation plan. All patients were reviewed by the consultant at the weekly ward round, and daily by a junior doctor. Patients on the unit were generally clinically stable and mostly required therapy. If patients needed increased medical input medical staff reviewed patients more frequently if needed. Therapy notes were audited every six months in the physiotherapy department to ensure that the appropriate level of physiotherapy was being provided and all therapy results were shared at huddles and Friday therapy training session.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Trust wide
The trust reported that from May 2017 to April 2018 Mental Capacity Act (MCA) level 1 training had been completed by 98.3% of staff within medicine. Medical staff had a 92.5% completion rate and nursing staff had a completion rate of 99.5%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level one training had been completed by 98.4% of staff within medical care trust wide. Nursing staff had a completion rate of 99.5% and medical staff had a 94.1% completion rate.

(Source: Updated data provided by the trust)

Royal Cornwall Hospital
Staff were aware of all policies regarding consent, mental capacity act and deprivation of liberty safeguards and had access to them through the intranet.

The trust reported that from May 2017 to April 2018 Mental Capacity Act (MCA) level 1 training had been completed by 98.2% of staff within medicine at Royal Cornwall Hospital. Medical staff had 92.8% completion rate and nursing staff had a completion rate of 99.7%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level 1 training had been completed by 98.4% of staff within medical care at Royal Cornwall Hospital. Nursing staff had a completion rate of 99.7% and medical staff had a 93.9% completion rate.

(Source: Updated data provided by the trust)
Staff understood the relevant consent and decision-making requirements of legislation, including the Mental Capacity Act 2005. Patients gave their consent when they were mentally and physically able and we observed staff discussing procedures and agreeing consent.

When patients did not have the mental capacity to give informed consent, mental capacity assessments needed to be completed. Nursing staff told us they lacked confidence in making capacity assessments, they felt the mandatory training was not sufficient and so they deferred capacity assessments to medical staff. Staff lacked understanding around best interest’s decisions and documentation of these decisions. This meant that patients assessments may not be correctly or accurately completed.

Documentation relating to the Mental Capacity Act was poor, often it was missing completely or lacked detail and involvement of appropriate persons. We saw that in some cases the documentation relating to the mental capacity act was incomplete or missing. Some staff were unaware of the process to follow and in one instance staff were not aware that a person detailed under the mental health act was in their direct care. This meant that staff were not aware of the implications of the patient leaving the ward or the decisions the patient was making.

However, we also saw several examples of when the capacity and application for Deprivation of Liberty (DoLS) had been fully completed but from the records seen, a significant number were not completed.

**West Cornwall Hospital**

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

The trust reported that from May 2017 to April 2018 Mental Capacity Act (MCA) level 1 training had been completed by 98.9% of staff within medicine at West Cornwall Hospital. Nursing staff had a completion rate of 97.9%.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level one training had been completed by 100% of staff within medical care at West Cornwall Hospital. All eligible nursing and medical staff had completed this training.

*(Source: Updated data provided by the trust)*

Neither ward had patients detained under the mental health act. Staff could tell us the process for getting specialist advice from the mental health team. They showed us how to access information on the trust intranet for guidelines when a patient needed to be detained under the mental health act.

We reviewed the records of a patient subject to a deprivation of liberty order. The paperwork was completed correctly, and the patient was waiting assessment from the local council. A mental capacity assessment should have been completed as the patient was living with advanced dementia. We were unable to find the mental capacity assessment. This was brought to the attention of the ward manager.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

**St. Michaels Hospital, Marie Therese House**

The trust reported that from May 2017 to April 2018 Mental Capacity Act (MCA) level one training had been completed by 100% of medical staff within medicine at Marie Therese house. Nursing
staff had a completion rate of 92.9% against the trust target of 95%. The unit did not have any patients detained under the mental health act.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level one training had been completed by 96.4% of staff within medical care at Royal Cornwall Hospital. Nursing staff had a completion rate of 92.9% while no data was provided for medical staff.

(Source: Updated data provided by the trust)

Mental capacity assessments were completed when required. Doctors usually completed the mental capacity assessments on the unit. No current patients were detained under the mental health act. One patient was subject to a deprivation of liberty order and we found the paperwork was in order.

Is the service caring?

Compassionate care

Friends and Family test performance

Trust wide

From July 2017 to June 2018, the friends and family test response rate for medicine at the trust was 30% (based on 7,204 responses).

A breakdown of the friends and family test performance by ward for medical wards at the trust from July 2017 to June 2018 with total responses over 100 is below. The monthly figures show recommendation rates.

Friends and Family Test – Response and recommendation rates from July 2017 to June 2018 by ward

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Endoscopy Unit</td>
<td>2457</td>
<td>21%</td>
<td>97%</td>
<td>83%</td>
<td>100%</td>
<td>96%</td>
<td>95%</td>
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<td>Wellington</td>
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<tr>
<td>Rojkalaf</td>
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<td>Tintagel</td>
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<td>CCU</td>
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</tr>
</tbody>
</table>

Key: Highest score to Lowest score

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Note: Sorted by total response

All wards and departments had annual recommendation rates of above 90%.

Royal Cornwall Hospital:

Staff showed a kind and supportive attitude to patients and their relatives. We observed staff caring for patients with compassion. Staff took time to interact with patients and their relatives in a respectful and considerate manner.

We overheard staff explaining procedures and apologising when a short delay had occurred.
Patients spoke positively about the care they have received. Their comments included, “They have been brilliant, even had a cup of tea in the night”, "the doctor held my hand while she talked to me, how kind”.

We saw patients treated with respect. We observed when staff asked about patient’s choices for meals, asked about pain levels and if patients were comfortable. Despite being busy staff waited for the patients answer and spent time getting the care right for each patient. We observed a member of cleaning staff sitting with a patient, helping with a jigsaw and chatting, this provided a distraction for the patient’s anxiety.

Staff maintained patients’ privacy and dignity when attending to patients’ needs. Staff introduced themselves to patients and curtains were drawn around patients’ bed spaces when care was provided.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia. We saw that staff were kind and thoughtful and for a person with learning disability they had a care plan that reflected the persons preferences and was personalised to support staff to provide the right care for the patient. Staff had access to communication aids via the learning disabilities team to help patients become partners in their care and treatment.

Staff supported patients who became distressed and requested extra support when required. Staff did not have training in de-escalation techniques and told us they would often call for psychiatric liaison or security.

The trust encouraged patients to complete the friends and family test, to help them evaluate their services. Royal Cornwall Hospital had a response rate of 29% (based on 6,958 responses).

A breakdown of the friends and family test performance by ward for medical wards at Royal Cornwall Hospital from July 2017 to June 2018 with total responses over 100 is below. The monthly figures show recommendation rates. The endoscopy unit had the lowest response rate with 21%. All wards and departments had annual recommendation rates of above 90%.

**Friends and family Test – Response and recommendation rates from July 2017 to June 2018 by ward**

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<tbody>
<tr>
<td>Endoscopy Unit</td>
<td>2157</td>
<td>21%</td>
<td>97%</td>
<td>93%</td>
<td>100%</td>
<td>90%</td>
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**Key**
- 100%: Highest score
- 50%: Mid-point
- 0%: Lowest score

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Note: Sorted by total response

**West Cornwall Hospital:**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
Staff understood and respected personal, cultural, social and religious needs of people and how these related to care needs. We observed that patients were addressed respectfully by all staff. We saw patients treated with privacy and dignity. For example, we saw a healthcare assistant deliver a commode to a patient for their toilet needs. Privacy and dignity was maintained for the patient always.

Staff arranged a social dinner for National Dementia day. All inpatients living with dementia, their relatives and carers, were invited to a dinner in the dayroom of a ward. The purpose was to socialise, meet and chat. This was at no cost to the patients or relatives.

A patient told us their care had been “excellent” and another said the staff always had “a quick response if I ring my bell” and “staff are always smiling”.

Patients living with dementia who required direct staff observation were able to move freely around the ward as it was a secure unit for patient’s safety. This helped calm these patients as they were not confined to their chair or bay.

When patients were terminally ill, and relatives wished to stay with them, comfort boxes were provided for relatives to use. These contained tea, coffee, sugar and a flask of hot water. Relatives could have these in patients’ rooms, so they did not need to leave for refreshments. Relatives were also given a comfortable chair, pillows and blankets if they wished to stay overnight.

The trust encouraged patients to complete the friends and family test, to help them evaluate their services. West Cornwall Hospital had a response rate of 40% (based on 239 responses).

The ward MED1 at West Cornwall Hospital was the only department with total friends and family test responses of 100% from July 2017 to June 2018. The performance of this unit is shown below. The monthly figures show recommendation percentages.

**Friends and family Test – Response and recommendation rates from July 2017 to June 2018**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
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<tbody>
<tr>
<td>MED1</td>
<td>213</td>
<td>47%</td>
<td>81%</td>
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**Key**

- Highest score to Lowest score
- Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.
- Note: Sorted by total response

MED1 had a response rate of 47%, with an annual recommendation rate of 93%.

*(Source: NHS England Friends and Family Test)*

**St. Michaels Hospital, Marie Therese House**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. A patient told us “I came here just before Easter and with the relentless rehabilitation work I am almost at the point of feeding myself”.

Staff understood and respected personal, cultural, social and religious needs of people, how these related to care needs and took these into account. We observed kind and compassionate care given to patients which included respecting their privacy and dignity.
Nurse call buttons were answered quickly. A patient said he always shouted for help and was always responded to.

**Emotional support**

Emotional support was considered by staff and was included as part of review and handover information. We overheard staff being supportive to patients. For example, one staff member was overheard speaking to an anxious patient saying “I understand this is scary, but we are going to try our hardest to make you feel better as quick as possible. If you need me, don’t be scared to press the button and I will come”. Another relative told us that as they visited the hospital often, one staff member they had met previously had found them and made a point of coming to see them, they felt welcomed and reassured by this.

Religious and cultural needs of patients were met and respected. The trust provided a multi-denominational pastoral dedicated space for quiet contemplation. Staff told us that the chaplaincy provided emotional support for patients and staff and was available during office hours with on call arrangements 24 hours a day. Staff could arrange contact with a minister of any faith or support from a layperson through the switchboard.

Staff provided support for patients’ relatives as well as to the patients. We spoke with two family members who told us they felt the ward staff looked after them well.

**West Cornwall Hospital**

Staff provided emotional support to patients to minimise their distress. We saw staff talking to a distressed patient who was living with dementia. They were kind and compassionate to the patient and calmed them down, taking them gently back to their own chair.

To provide more emotional support for patients, the medical wards held “Chatty Tuesday” whereby volunteers and staff took extra time to chat to patients. The wards were visited by ‘pat dogs’ to lift morale of patients.

We observed patient’s privacy and dignity maintained by staff when attending to toilet needs. Curtains were drawn, and staff stayed outside the curtains for privacy but were on hand when help was needed.

**St. Michaels Hospital, Marie Therese House**

Staff provided emotional support to patients to minimise their distress.

As the patients had a long stay in the unit, they told us they got to know all the staff well and they were very friendly and supportive.

The access to psychological support for patients was currently at a reduced level. The need for psychological support was evident to support patients who had significant life changing adjustments to make. A psychologist had recently left, and the service was having difficulty in recruiting to replace them. This left one psychologist to care for the patients. However, all staff supported patients to enable them to accept any altered reality of their life following brain injury.

**Understanding and involvement of patients and those close to them**

Patients told us that staff kept them well informed of their care and treatment plans. All patients we spoke with felt involved in decision-making processes and could tell us what the next plan was for them. We overheard several conversations between patients and staff, with discussions about care and treatment and patients were provided with opportunities to ask questions to ensure their understanding.

**West Cornwall Hospital**
Staff involved patients and those close to them in decisions about their care and treatment.

We observed staff talking to patients and relatives in a sensitive and caring manner so that they understood about their condition, treatment and care. Staff took time to make sure patient and relatives understood what they were saying.

Patients were supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences. We saw a doctor who took time to explain to a patient and answer their questions in a kind and compassionate manner.

**St. Michaels Hospital, Marie Therese House**

Staff involved patients and those close to them in decisions about their care and treatment.

Patients told us they had good relationships with the therapists. They felt involved when therapists were working out rehabilitation programmes for them. The consultant, nurses and therapy staff would meet with the patient and their families on a regular basis to discuss progress and discharge arrangements.

Accommodation was not provided for relatives who wished to stay with patients. However, reclining chairs were available for them to use to ensure they were comfortable.

### Is the service responsive?

**Service delivery to meet the needs of local people**

Staff and the care systems available provided care to patients including those in need of additional support. The trust had appropriate discharge arrangements for people with complex health and social care needs. The Onward Care Team provided support to ward staff in planning the discharge of patients with complex health and social care needs.

The service had arrangements, known to all staff on duty, to meet patients’ urgent or emergency mental health care needs always, including outside office hours and in an emergency.

The capacity issues of the medicine division were having an impact on the surgical division. The trust had set up an intermediate care and discharge ward where patients who were clinically stable and ready for discharge could be transferred to while they waited for ongoing care. This intermediate care ward was meant to be an area for short term stays to free up beds on the wards. However, patients were staying in this area for a long time awaiting discharge due to delayed transfers of care. The length of stay data was gathered for assessment purposes by the trust.

Further additional areas were opened to accommodate medical patients including the discharge lounge and Newlyn day case recovery unit. Because of the extra medical patients on surgical wards some elective surgery was delayed.

Bed management for the winter was of concern. The trust had a provisional winter plan for 2018 under review. The plan was not fully agreed and confirmed but the winter pressures were already evident. The focus of the winter response was to address the issue of patients with a delayed transfer of care. This meant that patients could not be discharged because they did not have the services in the community to safely support them.

Increased pressure the previous winter had caused multiple episodes of escalation which would inform a winter plan. Operational Levels Escalation Framework (OPEL) was used. This this policy framework was used to provide a consistent approach in times of pressure. This escalation is graded one to four with four being the most heightened level. The trust had escalated to OPEL four throughout the previous winter:

- September 18 times
• October 12 times
• November 13 times
• December 22 times
• January 27 times
• February 26 times
• March 15 times

During this inspection a meeting took place with the local commissioning group to review delayed transfers of care (DTOC) patients and review how this could be managed in the wider community.

The two main reasons discussed with us for DTOC were a lack of elderly dementia residential home placements and a lack of packages of care available in the community. No consideration was evident for areas of escalation or how any surge in medical activity would be managed other than promoting transfers of patients who were delayed in their discharge.

**West Cornwall Hospital**

The trust planned and provided services in a way that met the needs of local people.

Patients were transferred from the Royal Cornwall hospital but could be admitted directly from home. This meant that patients were looked after closer to home. Both wards had comfortable day rooms which allowed family and friends to spend time with the patients. MED 1 ward had a small sensory garden that patients and relatives could access.

**St. Michaels Hospital, Marie Therese House**

The unit planned and provided services in a way that met the needs of local people.

Patients requiring neurological rehabilitation were reviewed by the unit’s consultant for suitability for admission. In turn, the consultant discussed potential patients with the wider multidisciplinary team. The consultant felt well supported by senior trust management to ensure the correct type of patients were cared for on the unit.

Staff told us of systems to aid the delivery of care to patients in need of additional support. For example, access to the learning disability team and mental health specialist team.

We found appropriate arrangements were made to take account of individual needs of people being discharged who had complex health and social care needs that required special consideration. For example, taking account of disabled patients who required more tailored accommodation and care package on discharge.

**Average length of stay**

**Trust Level**

From March 2017 to February 2018 the average length of stay for medical elective patients at the trust was 6.4 days, which is higher than the England average of 5.9 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology is lower than the England average.
- Average length of stay for elective patients in gynaecological oncology is lower than the England average.
- Average length of stay for elective patients in clinical oncology (previously radiotherapy) is higher than the England average.
For medical non-elective patients, the average length of stay was 6.2 days, which is similar to the England average of 6.4 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is similar to the England average.
- Average length of stay for non-elective patients in cardiology is higher than the England average.
- Average length of stay for non-elective patients in geriatric medicine is higher than the England average.

Royal Cornwall Hospital

From March 2017 to February 2018 the average length of stay for medical elective patients at Royal Cornwall Hospital was 5.6 days, which is similar to the England average of 5.9 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology is lower than the England average.
- Average length of stay for elective patients in gynaecological oncology is lower than the England average.
- Average length of stay for elective patients in clinical oncology (previously radiotherapy) is higher than the England average.
For medical non-elective patients, the average length of stay was 5.9 days, which is lower than England average of 6.4 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is similar to the England average.
- Average length of stay for non-elective patients in cardiology is higher than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

Non-Elective Average Length of Stay - Royal Cornwall Hospital

From March 2017 to February 2018 the average length of stay for medical elective patients at West Cornwall Hospital was 13.9 days, which is higher than England average of 5.9 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in geriatric medicine is lower than the England average.
- Average length of stay for elective patients in general medicine is higher than the England average.
- Average length of stay for elective patients in clinical haematology is lower than the England average.

Elective Average Length of Stay - West Cornwall Hospital
For medical non-elective patients, the average length of stay was 322.3 days, which is much higher than England average of 6.4 days. However, this likely to be based on a small number of patients which has inflated the average.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in geriatric medicine is higher than the England average.
- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

**Non-Elective Average Length of Stay - West Cornwall Hospital**

For medical elective patients at St Michael's Hospital was 91.4 days, which is higher than England average of 5.9 days. However, this likely to be based on a small number of patients which has inflated the average.

Average length of stay for elective specialties:

- Average length of stay for elective patients in rehabilitation service is higher than the England average.
- Average length of stay for elective patients in pain management is lower than the England average.
- Average length of stay for elective patients in general medicine is much higher than the England average.

**Elective Average Length of Stay - St Michael’s Hospital**
For medical non-elective patients, the average length of stay was 18.9 days, which is higher than England average of 6.4 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is much higher than the England average. However, this likely to be based on a small number of patients which has inflated the average.

**Non-Elective Average Length of Stay - St Michael's Hospital**

(Source: Hospital Episode Statistics)

St. Michaels Hospital, Marie Therese House

From March 2017 to February 2018 the average length of stay for medical elective patients at Marie Therese house was 13.9 days, which is higher than England average of 5.9 days.

**Meeting people’s individual needs**

Royal Cornwall Hospital

Staff assessed patients’ individual needs and ensured that the appropriate specialist services were involved.

Staff had a good understanding of managing and helping patients living with dementia. Training in supporting people living with dementia was part of regular mandatory updates and was included in short top up training sessions. The wards demonstrated some adjustments for patients with dementia such as contrasting toilet seats and clear contrasting signage which included pictures for exits and toilets. Snacks and finger foods could be made available for patients living with dementia. This enabled patients to eat when they wanted to and where they wanted to ensure they received sufficient nutrition.

Specialist nursing staff were available to support patients identified needs. The specialist tissue viability nurses were available to support staff with advice for caring for patients who required wound care. Staff told us that when they referred to the specialist team, the tissue viability nurses visited the patients promptly.
The trust had a psychiatric liaison team to support patients with identified learning disabilities. This team had a long-term commitment to improve patient care and experiences tackling health inequalities for people with learning disabilities and autism. This was a service comprising of a small team of skilled nurses delivering acute hospital-based liaison service to children and adults with learning disabilities and / or autism spectrum conditions of Cornwall and Isles of Scilly that best suited their needs in accessing health services.

Some staff had been trained to manage challenging behaviour. Staff told us that while they had not received training in restraint, they had confidence that the security staff would assist and support them. We observed the security staff response when it was requested. It was calm, measured and guided by the staff.

The trust took account of patients’ suggestions to improve the inpatient wards. A more flexible approach to visiting hours had been introduced. Staff told us this worked well and enabled some relatives to support patients with food and drinks.

Inpatient wards had side rooms which they used for patients who may have a transferable infection, needed more privacy or were in their last days of life. When used for patients at the end of life, facilities were made available for relatives to remain with the patient.

Patients were cared for in either female or male (single sex) bays wherever possible. Every effort was made to support care to be provided in single sex areas. In endoscopy, there were separate changing rooms and toilets for male and female patients although patients were required to pass through mixed sex corridors to access the treatment/procedure room.

There were systems to meet patients’ additional communication needs. Staff knew how to access interpretation services and told us that they used the diversity of staff to help identify what language support was needed.

Staff understood the process to ensure a safe discharge of patients who were homeless. They could describe who to contact to access the support services available.

**West Cornwall Hospital**

People could access the service when they needed it. Waiting times and arrangements to admit, treat and discharge patients were in line with national averages.

Notice boards on the wards provided a range of information for patients and relatives. For example, support groups, how to complain and spiritual support within the hospital.

Staff were planning to introduce a breakfast club. This aimed to promote independence for patients to prepare their own breakfast and allow assessment for discharge.

West Cornwall hospital was considered an exemplar site within the trust where staff were passionate about providing high quality care for patients living with dementia. Activities were provided by staff and volunteers most afternoons on the ward, such as crafts, music and art sessions. There was also a sensory garden which could be used by patients and relatives for quiet time. Wards were dementia friendly with different coloured doors and door handles. Toilets had signs and pictures on them. The staff had worked with the meal provider and plates were now in two sizes and blue in colour. This helped patients living with dementia to see their food more easily and they were helped to eat if needed with encouragement from staff. A variety of snacks were available for patients throughout the day and night and tea and coffee.

The trust did not have any designated end of life care beds. Both medical wards cared for patients at end of life. Staff knew how to access specialist support from the palliative care team. Staff knew how to access specialist advice for patients with enhanced needs, such as learning disabilities.
The learning disability team were available Monday to Friday each week. Staff also had access to translation services for patients for whom English was not their first language.

**St. Michaels Hospital, Marie Therese House**

People could access the service when they needed it. Waiting times from treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Care and treatment was individually planned to meet the patient’s needs. Patients on the unit generally needed medical, nursing and therapy support, education and psychological support for significant and often acute changes in their life due to their changed neurological status. Each patient’s needs were different and so individual care plans were needed.

When a patient was admitted they had time to settle in and rehabilitation started. The multidisciplinary team met with the patient and family after three weeks to discuss goal setting and further planning for rehabilitation. Regular meetings were held thereafter to discuss progress and discharge arrangements.

Specific goals of rehabilitation were completed for each patient. We found detailed planning for nutrition. For example, the use of special adapted cutlery, use of a plate guard and non-slip mat for the plate. Moving and handling plans for the patients included specific needs for each patient. This included how the patient was to be moved and the equipment to be used.

Patients when transferred in from other hospitals usually had a “This is Me” document. This explained about the preferences of the patient and was usually completed by relatives or carers. This informed staff of specific needs to ensure the patient received the care they needed in a way they wanted.

Facilities were available to support patients with increased or diverse communication requirements. There were suitable arrangements available for patients who needed translation services and staff knew how to access them. The trust learning disability team was available for advice for staff to manage people with a learning disability. The speech and language therapists provided letter boards and pictures for patients with communication difficulties, for example people living with learning disability patients.

The unit coped well with people with complex physical needs. The corridors were wide to accommodate wheelchair access. Most patients had a larger than average sized wheelchair as they were bespoke for the individual.

Most of the discharges were complex owing to the nature of the patient’s needs. Complex discharges were well supported by the multidisciplinary team and good relationships with community services. This meant that when discharge was planned they supported the patient to successfully transition to new accommodation. Following discharge, patients received up to three visits from a therapist or nurse to ensure the patient and relatives were coping and support any extra needs identified. Physiotherapists did not offer generic information leaflets for patients but provided individualised information for patients, for example, specialised exercise regimes.

Additional support and information was provided. Staff invited outside speakers to talk to staff and patients. For example, the Spinal Injury Association came in to talk to patients, newly injured or with a longstanding injury, about how they could help and support them.

**Access and flow**

**Royal Cornwall Hospital**

There were systems used to promote flow, but these were not always effective, with increasing demand outweighing the inpatient capacity available within the trust. The hospital continued to
receive high levels of patients presenting at the hospital for either emergency or planned admission. The difficulty maintaining flow through the hospital was compounded by ongoing difficulties in safely discharging patients. This had the outcome of some longer lengths of inpatient stay and difficulty in finding enough beds for patients.

The Operational Pressures Escalation Framework (OPEL) details how the trust identified and responded to pressures within its system daily as well as times of extra-ordinary pressure. This framework relates to adult beds and includes medical beds. Each day bed meetings took place at 08:00, 12:00 and 16:00 to review the flow of patients through the hospital.

Those meetings were attended by the site management team, bed managers, ward senior staff, transport staff and any other interested and affected partners. It was clear that the focus of the meetings was based on safety for patients always and staff worked cohesively and persistently to drive flow through the hospital. All meetings attended during inspection were not supported or attended by any members of the trust board.

In between those meetings safer staffing meetings took place to review the staffing levels against the patient’s identified needs. At 11:30 an all systems call took place with commissioners and other stakeholders to discuss the flow of patients through the hospital and out into the wider community.

While the hospital tried to have early decisions made about patient discharge, this was not always managed. There was a focus on discharge and overcoming any barriers to this, early in the patients’ stay. On admission, all patients had an estimated date of discharge, but this was not always met. Processes to identify possible discharges and actual discharges were overseen by the site management staff, the systems used were consistent, but their effectiveness was affected by the demand for beds.

The hospital bed management team included site managers who could work clinically in all areas of the hospital to support access and flow. This meant they could go onto a ward to assist staff if needed. There was also the outreach team provided by the intensive care unit. This facility enabled ward staff to have the expertise and support of intensive care staff on the ward.

A system of bronze, silver and gold command meetings were used to escalate any developing issues around bed management and flow of patients. The 11:30 call each day was a bronze command meeting. A silver command meeting was called during inspection to review delayed transfer of care patients and in April 2018 a gold command meeting had been called to address a crisis in the flow of patient. At that time an extra 60 beds had been made available in the community to enable the flow of patients out of the hospital.

The hospital had problems maintaining flow from the emergency department, through in patients stay to timely discharge because of both the increased demand for admission but also because patients had a delay in being discharged. The trusts flow policy stated that the use of extra escalation beds in the hospital was triggered at OPEL three, with a target time for repatriation to the correct ward within 24 hours. We saw that both of those guidelines were not met.

At midday on the second day of our inspection the bed managers reported 42 outlying patients. Outlier patients are those patients because of a lack of beds were located on wards not of the patient’s speciality need. For example, 17 medical patients were on Eden ward which is obstetrics and gynaecology. There were 106 patients ready for transfer but unable to leave the hospital safely.
On the third day of our inspection there were 30 outlier patients and 124 patients medically fit for discharge. At that time there were 13 patients breaching the four-hour waiting time in the emergency department and two patients had spent the night in the discharge lounge.

Data provided by trust showed that from August 2017 to July 2018 there was up to 42 medical outliers each day.

The ward staff on some outlier wards did not have the specific medical skills needed to safely care for the patients outlying on their ward. Most outliers were on Eden ward and Wheal Coates ward, which meant that the ward staff with surgical skills were looking after medical patients. These patients were cared for medically by the Eden junior medical staff and seen on a ward round by the medical consultant. The divisional risk register noted that the acuity of patients on Eden ward was rising, with medical patients to this ward regularly breaching the agreed limit of how many outlier patients could be transferred to Eden ward, making managing these patients difficult. Because this was a regular and ongoing problem, the bed management team tried to cohort medical patients on outlying wards to enable doctors to see them in groups. This was not always possible and when the hospital was under pressure patients were admitted wherever there were bed spaces available. We saw nine patients were on the surgical assessment unit, nine patients were on Wheal Coates ward and four patients were on the trauma ward.

The divisional risk register noted that there was a risk of sub-optimal patient care due to medical patients outlying on non-medical wards. The register lists the risks as patients being in the wrong place, not being seen by the right medical teams or risk of being missed from review, increased medical workload and the reduced continuity of care for the patients involved. Actions were listed to promote patient safety but there were no timescales noted for review of effectiveness.

Further admission to the middle of a bay, referred to as Safer Placement for Patients, for a temporary period, also did not meet the patient’s needs. Trust policies used by staff including the Safer Placement Policy, the Flow Policy and the Capacity Management Escalation Plan. The policies did not inform staff of actions to take should patients arrive on the ward and there wasn’t suitable discharge information, the patient was unwell, or the planned discharge was not in place. We reviewed five reported incidents when patients were placed using the Safer Placement for Patients strategy and the transfer was inappropriate or unsafe. For example, we saw that patients with dementia and sepsis had been admitted and the ward staff reported the admission as unsafe.

Some areas had been developed to try to address the issue and the Same Day Emergency Care area was used to try whenever safely possible to treat patients and return them home. This area was also used to accept patients referred by their GP to the hospital. This is known as the medical take. The take through this area was planned to lighten the pressure on the emergency department. However, when this area was full or blocked because there were no admission beds available, the medical take reverted to the emergency department. This area was led by nursing staff and was supported by doctors from the hospital and the co-located GP service. There were no administrative staff available at the weekends and the unit closed at 8pm each day.

Another area developed was the Medical Assessment Area located on the Acute Medical Unit (AMU). This was a bay with eight trolleys and was used to draw patients through the emergency department on their way to inpatient admission. We saw this area became blocked by patients on beds pending admission and so prevented its use to promote flow through the hospital.

A further impact was the lack of seven day working in all areas of the hospital. This meant that each week the hospital treatment and discharge facility slowed down at the weekends because there were less decision-making staff and less therapy staff available. Staff told us that each Monday to Wednesday there was a backlog of patients waiting to be discharged.
The trust tried to avoid the movement of patients from ward to ward but inevitably this occurred due to the pressures on the hospital. Transfers, whenever possible, took place between 8am and 8pm. Although the trust did not advocate the transfer of patients between wards out of hours, there were occasions when this was unavoidable, and patient transfers and discharges at night did take place. Discharging patients out of hours was undertaken in both day and night time. These discharges included patients living with dementia or who lived alone.

**West Cornwall Hospital**

Most patients were transferred from the Royal Cornwall hospital. Patients were also admitted directly from home through their GP or from the urgent care department. Discharge planning started on the patient’s arrival to the wards. Each ward had a discharge coordinator to ensure discharges, especially complex discharges, were planned and timely. Discharge dates were discussed at the weekly multidisciplinary meeting.

Some patients stayed in hospital past their discharge date even though they were medically fit to be discharged. At the time of our inspection, eight of the 28 patients were medically fit for discharge but had been delayed. These patients were waiting for packages of care in the community or placement in a residential or nursing home. Staff told us, due to the rural setting, discharges were routinely delayed waiting for care in the community. A ward manager told us that residential and nursing homes frequently did not have capacity to review patients on the wards for some time, delaying their discharge. In response, the trust was going to temporarily release two band six nurses to work as assessors for residential and nursing homes in the area. This was a secondment until March 2019 and was expected to reduce waiting time for residential and nursing assessments for patients, therefore speeding up discharge times.

**St. Michaels Hospital, Marie Therese House**

Patients were routinely assessed as suitable for admission by the consultant. Discharge planning started on admission. As discharges were usually complex, staff planned them carefully and for daytime only. Patients were not discharged out of hours. They were only transferred out of hours if there was a deterioration in their clinical condition, to the acute hospital. Discharge dates were discussed at the weekly multidisciplinary meeting and revised according to the patient’s progress.

However, some patients stayed in the unit past their discharge date even though they were medically fit to be discharged. At the time of our inspection, two of the 12 patients were medically fit for discharge but had been delayed. These patients were waiting for suitable accommodation. The extended delays to discharge meant that patients could not get on with their lives and beds were not available to support new patients needing rehabilitation.

All the patients on the unit required neurological rehabilitation and there were no outlying patients of any other speciality on the unit.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From June 2017 to October 2017 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was similar to the England average. However, from November 2017 to May 2018, performance was consistently below the England average.

In the latest period, May 2018, 78.7% of this group of patients were treated within 18 weeks versus the England average of 89.3%.
Referral to treatment (percentage within 18 weeks) – by specialty

Five specialties were above the England average for admitted RTT (percentage within 18 weeks) from June 2017 to May 2018.

In August 2018 the referral to treatment times had adjusted to show gastroenterology was at 79%, cardiology was at 69% and respiratory was at 71%. The overall total was 81% which was an improvement on July 2018 of 69%. This demonstrated that cardiology referral to treatment times had improved but gastroenterology had declined. Governance minutes showed that plans were considered to undertake extra gastroenterology clinics to meet demand.

Harm reviews had been implemented to mitigate the risks to patients of delays to treatment.

The departmental risk register noted that there was a risk that patients may not receive a new or follow up appointment in the consultant requested timeframes, with 700 patients currently over timeframe. This was caused by a lack of current capacity and historic impact of two locums for outpatients which created large number of follow ups.

The trust had requested a review of their cardiology services from the Royal College of Physicians. The review was completed in March 2018 and the trust had been provided with immediate recommendations, but the final report was not yet available. Areas of concern included waiting times for patient required implants, concerns about medical devices and how the consultant rota, work plans and routines were being managed. But an overall action plan was not yet in place. Some of the recommendations had begun to be implemented.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>100%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100%</td>
<td>94.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>98.5%</td>
<td>93.8%</td>
</tr>
<tr>
<td>General medicine</td>
<td>96.4%</td>
<td>96.3%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>93.8%</td>
<td>97.5%</td>
</tr>
</tbody>
</table>

Three specialties were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic medicine</td>
<td>88.9%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>78.6%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>58.7%</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

Patient moving wards per admission
From April 2017 to March 2018, 90.8% of individuals did not move wards during their admission, and 9.2% moved once or more. A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Patient moves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>3,623</td>
</tr>
<tr>
<td>West Cornwall Hospital</td>
<td>52</td>
</tr>
<tr>
<td>St Michael’s Hospital</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Ward moves)

Patient moving wards at night

From April 2017 to March 2018, there were 1,255 patients moving wards at night within medicine. Patients and staff told us that patients consistently moved at night with the emphasis put on avoiding the four-hour time breach in the emergency department. Patients could be moved at any time and to any outlying ward. Staff told us they tried hard not to move patients, especially at night.

The clinical decisions unit had the highest number of patients moving wards at night with 224 (18.3%), followed by the coronary care unit with 181 (14.8%) and Roskear ward with 138 (11.2%). A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Patient moves at night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>1,241</td>
</tr>
<tr>
<td>West Cornwall Hospital</td>
<td>14</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Ward moves at night)

Learning from complaints and concerns

Summary of complaints

Complaints were not consistently managed in a timely manner. From May 2017 to April 2018 there were 135 complaints about medical care. The trust took an average of 62.6 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 25 days.

One hundred and thirty complaints (96.3%) occurred at Royal Cornwall Hospital and five (3.7%) at West Cornwall Hospital. There were no complaints received relating to medical care at St Michael’s Hospital.

The most prevalent types of complaints were those relating to communication (22.2%), clinical treatment (20%) and patient care (18.5%).

There was information displayed for patients and their relatives about how to make a complaint. Patients knew how to make a complaint if they needed to and felt they could raise concerns with the clinical staff they met. Patients, carers and relatives could complain via the dedicated web links, by letter, email, telephone or in person to any member of staff or directly to a member of the Patient and Family Experience (Complaints) Team.

Staff were aware of actions to take if patients and/or relatives wished to make a complaint. Staff described the process they would follow to try and resolve any issues locally and directly and advise patients of how to escalate their concerns if not satisfied.

The ward manager and matron for the ward reviewed received complaints and worked with the Patient and Family Experience (Complaints) Team to respond appropriately.

Learning from complaints were shared on wards through staff safety briefs and an overview of complaints was reviewed through the medical services governance board.
Number of compliments made to the trust
From May 2017 to April 2018 there were 2,532 compliments within medicine.

A breakdown by site can be seen in the table below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>1,996</td>
</tr>
<tr>
<td>St Michael's Hospital</td>
<td>29</td>
</tr>
<tr>
<td>West Cornwall Hospital</td>
<td>507</td>
</tr>
<tr>
<td>Total</td>
<td>2,532</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

West Cornwall Hospital
The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. Five complaints (3.7%) occurred at West Cornwall Hospital. Information and leaflets about how to make a complaint were available on the ward which was an improvement from the last inspection in January 2016. Two patients we spoke to knew how to make a complaint. Both patients said they would speak to a senior nurse first before making a formal complaint.

Summary of complaints
Five complaints (3.7%) occurred at West Cornwall Hospital.

From May 2017 to April 2018 there were no complaints about medical care at Marie Therese house. Staff were proud of this achievement.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Complaints and their learning were displayed on the governance board on the ward. Senior staff showed us responses to complaints that had been resolved. We attended a nursing team meeting where they discussed two informal complaints about staff attitude and what could be done to improve this.

St Michael’s hospital, Marie Therese house
Summary of complaints
From May 2017 to April 2018 there were no complaints about medical care at Marie Therese house. Staff were proud of this achievement.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust
From May 2017 to April 2018 there were 2,532 compliments within medicine. A breakdown for by Marie Therese house was 507.

Number of compliments made to the trust
From May 2017 to April 2018 there were 2,532 compliments within medicine. A breakdown for by West Cornwall Hospital was 507.

From May 2017 to April 2018 there were 2,532 compliments within medicine. A breakdown for by Marie Therese house was 507.

Is the service well-led?

Leadership
Royal Cornwall Hospital
Leadership at a local ward and unit level was mostly strong and enabling. A minority of ward staff felt local leadership did not support them. Ward leaders had the skills, knowledge and experience to lead teams effectively. Leadership from the board was not evident to all staff we spoke with. Several staff expressed the wish for a consistent and visible board leadership, but after numerous changes the ward and unit level staff had developed a weariness of the instability. Staff felt their pride in the role and work undertaken was undermined by the higher-level management instability. All staff we asked did not know who the Chief Executive was and never saw members of the board on the wards. This meant that ward level staff were not all clear who was leading them and did not consider the board to be part of what they did on a day to day level.

All staff including leaders told us that the biggest challenges were staffing and operational pressures. However, they did not feel empowered to make changes and did not always feel listened to by the board.

The pharmacy service had a supporting leadership structure. In addition to clinical pharmacist services, there was support from the chief pharmacist and other senior pharmacists who had an overview of medicine optimisation/safety issues.

**West Cornwall Hospital, and Marie Therese House**

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Managers had recognisable or accredited leadership and management qualifications to enable them to do their job. Staff felt supported to do their jobs and felt they could raise concerns if necessary. The medical matron, based at the hospital, covered the two medical wards, the renal ward, the urgent care centre and Marie Therese House at St Michael’s hospital. The surgical matron covered the day-case unit, day treatment centre and the two theatres. The surgical matron was not based at the hospital and the medical matron provided immediate support to these areas when required.

Staff told us that the executive team had visited the hospital. During the inspection, a team talk was held for all staff to attend, led by the chief executive and chief nurse.

**Vision and strategy**

**Royal Cornwall Hospital**

Staff told us about their understanding of vision and strategy which included, working with each other, compassion, promoting integrity, trust and respect. Royal Cornwall Hospitals Trust vision and values were clear and easily accessible on the trusts website. We found that posters, leaflets, and newsletters had the vision on them. When we spoke to staff we found that they individually and collectively believed in the vision and strategy, but they found that due to the workloads, they were difficult to deliver.

The trust had a Service Level Agreement with a mental health trust for mental health liaison and Mental Health Act management. However, the trust did not have a mental health strategy appropriate for patients with mental illness that the trust board approved and reviewed annually. This meant that staff did not have a clear future direction for patients living with mental illness.

**West Cornwall Hospital**

West Cornwall Hospital had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
Staff were aware of the trust vision. The matron told us that West Cornwall hospital was working on their own individual vision which would be based on the trust vision and values. This was currently a work in progress. The matron told us about the launch of the nursing and midwifery strategy.

**St. Michaels Hospital, Marie Therese House**

Staff did not raise about the vision for the trust but explained that their own strategy for the unit was to “provide the best inpatient care for patients”. Staff we spoke to were aware of the trusts vision

**Culture**

**Royal Cornwall Hospital**

Staff felt that morale was varied within areas and departments. The stroke team felt morale was good with the strong points being teamwork, care, communication. They considered the patients benefited from extra staff training and an enthusiastic staff approach to developing the service. Staff on the cardiology ward told us that they were proud of their teamwork and considered the team to be “a family, working together to nurture good patient care”. They felt that the team was the whole ward from cleaners to consultants.

We were told of one ward incident which affected staff members. The leadership of the ward had not considered the impact of the incident on staff and as a result some staff were struggling to move forward. Consideration of input by occupational health was not considered to support staff until it was requested. The ward did not have staff meetings to provide group support. This meant that for some time staff were not supported as they should have been.

**West Cornwall Hospital**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff told us they felt valued and supported in their work. They told us that the senior staff were supported and listened to their concerns and there were no concerns about bullying in the workplace. Many of the staff had worked at the hospital for many years and were proud of their hospital. Staff turnover at the hospital was below the trust target.

The ward performance assurance framework was shared with staff and publicised on the ward. This included hand hygiene results, financial status of the ward, patient feedback and staff sickness rates.

**St. Michaels Hospital, Marie Therese House**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Many of the staff had worked at the hospital for many years and were proud of their unit. One staff member said it was a “really good unit, best place I have worked in the trust. Everyone supports each other”

As patients stayed for longer periods than in an acute setting, patients and relatives told us they developed good relationships with staff.

**Governance**

**Royal Cornwall Hospital**
There were assurance systems implemented to ensure that monitoring of the services provided was undertaken and appropriate action put in place. The information gathered was used to monitor and manage quality and performance.

There was a governance structure within the medical care group, with reporting lines from ward level to board level. Staff were clear about their roles and responsibilities and understood to whom they were accountable to.

Each medicine speciality had its own meeting to review its own governance. The meetings reviewed risk registers and audits, dashboards, incidents and learning. All the specialities fed into a monthly divisional governance meeting which considered business cases and actions to take forward for planning. We reviewed minutes from the medical services management governance meetings and saw that concerns were raised about the deterioration of some areas without an action plan to address them.

The trust completed an overall quality review to identify areas which were trending upwards or downwards. This identified a downward trend for gastroenterology. Elderly care and respiratory medicine, with targets for achievement not met. Discussion with consultants confirmed this met with their view of the services being provided. Some of the areas identified included increased demand and difficulty recruiting.

We spoke with clinicians and ward leaders in different specialties about national audit results and action plans to improve practice. Each told us that a governance overview helped to identify the areas where more work was needed, but that did not mean they all had the resources and support to change them.

Stroke ward governance was discussed at elderly care meetings as part of the stroke operational and governance monthly meeting. Ward staff felt this worked well as it developed a wider learning. The meeting was an opportunity to discuss incidents, falls, serious incidents, complaints, compliments, audits and governance updates.

The Medication Safety Committee met every two months. It reviewed medicine incidents and adverse events and looked at learning themes and trends. This was fed back to the relevant ward teams. The medicines management optimisation group had published a monthly newsletter which was circulated via e-mail. Safety bulletins were also circulated following medicine incidents.

The Accountable officer for Controlled Drugs was aware of their responsibilities. All incidents involving controlled drugs were investigated. Three monthly reports were made to the NHS England controlled drugs officer and the Controlled Drug Local Intelligence Network (CDLIN) meetings were attended.

There was a medicines management policy/strategy and business plan. The chief pharmacist also reviewed incidents involving medicines (including controlled drugs), adverse events, non-medical prescribing and the prescribing of medicines on external prescription forms. They were also involved in the development of medicine policies and procedures.

**West Cornwall Hospital**

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The medical wards were part of the medical division governance structure. Local governance meetings fed into the division then up to board level. Governance meetings took place monthly for the whole hospital. Incidents and risks were discussed and learning shared. The hospital performance framework was also discussed. This identified areas of concern in performance and
quality ratings. These meetings fed into the medical division governance system and up to the board.

Each ward had a large governance notice board which displayed information. For example, an incident would be highlighted and the learning from it. It also featured trust wide incidents and learning.

St. Michaels Hospital, Marie Therese House

The trust used a systematic approach to continually improve the quality of its services and safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.

The unit was part of the medical division governance structure. Unit management meetings discussed governance issues which fed into the division then up to board level. Governance meetings took place monthly for the unit. Incidents and risks were discussed and learning shared.

Marie Therese House had a large notice board which displayed quality assurance information. August results were:

- Communication with compassion. Target 98% Result 98%
- Assisting with toileting, ensuring dignity. Target 98% Result 98%
- Direct Care time for registered nurses. Target 60% Result 70%
- Hand Hygiene 100%

Management of risk, issues and performance

Processes were used to look at risks and manage issues and performance.

All risks were categorised as red, amber or green, with red being the higher priority. At divisional level the risk register was reviewed through the medical services governance board which met monthly.

We spoke with ward leaders and ward staff for the medical care group and found their perception and concerns about risks were aligned with those risks added to the risk register.

The medicine divisional risk register has 134 identified risks. Each was risk rated and had actions to reduce the risk. There were no identified timescales for delivery on the risk register.

There was a risk register for all aspects of the pharmacy service which was updated monthly. The Drug and Therapeutics Committee (including a medicines practice committee and joint formulary committee with Cornwall CCG) met every two months. It reviewed formulary issues, prescribing trends, Patient Group Directions and safe medication practices.

The three highest risks identified on the stroke unit were the higher risk of mortality for stroke patients, the environment as one bed space was not fully equipped so a risk assessment for its use was in place, and the risks of falls. The ward risk register was reviewed and discussed at the governance meetings and the timescales for completion were decided by senior ward staff.

An assurance framework was used to present an overview of findings and mapped to see if the service was improving or declining. The safety dashboard, in use identified and included audit data. The dashboards were used to inform divisional governance meetings.

There was a pharmacy dashboard which compiled performance information monthly, this included time for dispensing discharge medicines, the rate of reconciliation of patient’s medicines on admission, the number of missed doses and monitoring of the in-hospital community pharmacy service. There are weekly storage audits completed when the pharmacy staff top up the ward
stocks, this serves as an early warning system if standards are not being met. The information was reported back to the wards by their pharmacist.

St. Michaels Hospital, Marie Therese House

Processes were used to look at risks and manage issues and performance. Risk registers described current risks faced by the unit. Marie Therese house had its own risk register which senior staff were aware of. The main risks were the inability to recruit senior therapists and the carpet in the dayroom and dining room. Risks were monitored at governance meetings and actions decided to reduce risk. This was then escalated up to the medical division and further to the board.

Information management

Real time data around performance, quality and safety was used to review the service provided and to identify areas where further work was required. Governance meetings provided an overview of service provided to the board. Patient feedback information was also discussed to identify areas of good practice and those areas which required improvement. Action plans were put into place at ward level to address any issues.

Patients individual care records were stored securely. Medical records were stored in locked trolleys with key pads and at no time did we see records unsecured or unattended.

Notice boards at entrances to wards showed information for patients, for example, results from hand hygiene audits, level of falls and a cleaning analysis. Information for patients was easily available to patients on all wards. Information leaflets were available on all wards.

The trust had business continuity/recovery plans in the event of loss of wireless internet connection for electronic observations and medicine prescribing systems. This meant that systems were in place should network be lost but were not part of the issue of connectivity across the hospital site.

All staff we asked had secure access to relevant electronic information. All staff secured computers when not in use and these were password protected to prevent unauthorised access. There were electronic boards on each ward, which displayed the patients name in full. Information regarding the patients care and treatment. When not being used by staff these had a screen saver to prevent unauthorised persons accessing patients secure information. Screen savers were used for education information for patients and relatives.

The trust had a Service Level Agreement with a mental health trust for mental health liaison and Mental Health Act management. This enabled information to be moved safely to support patients being transferred.

Engagement

Royal Cornwall Hospital

The views of patients and relatives were gathered and used to develop the service. However, feedback to staff was not consistently used for learning or celebration opportunities. The medical care group collected information about patients’ and their relatives’ views about care and their experiences. All patients were encouraged to complete the friends and family test when they were discharged. Staff were not all aware of any feedback from these surveys. This was a missed opportunity for learning or celebration.
Systems were being developed to engage with staff in some areas. Small events to promote communication were used, for example a divisional lunch was taking place near the acute medical unit this was to enable staff from all areas to meet and discuss any issues.

Some wards held regular staff meetings, however staff told us some wards for example Tintagel ward had not had a meeting for some time. This opportunity for staff to raise issues for collective discussion was a good means of engagement but was not consistently undertaken.

In both Wellington ward and in cardiac wards sisters issued regular newsletters for their teams. Issues raised included both learning and recognition of success but also included areas for development and further training opportunities to develop the service.

No staff could describe a consistent message from the trust board. This meant that staff were not aware of the trust boards strategy, view of the future and plans for the trust. Staff could not describe very little engagement with the board and a few staff commented that they didn’t feel involved in any trust wide communication.

Not all staff were aware of the role of the Freedom to Speak Up Guardian within the trust. This role is there to support staff and enable staff to raise concerns. This was a wasted resource for staff if they were unaware of this opportunity.

The medical care group received complements about the service provided. We saw many ‘thank you’ cards displayed throughout the wards. The staff were not aware of complements made indirectly via the board and so did not always know they were doing well.

Staff told us that they had access to occupational health and the chaplaincy should they feel the need for support and further advice outside of the ward.

**West Cornwall Hospital**

West Cornwall Hospital engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The hospital league of friends was very active within the hospital. They had raised £750,000 to re-develop the physiotherapy and occupational therapy outpatient areas. This aimed to provide improved privacy and dignity for patients attending.

The memory café held on MED 2 ward was a registered charity and had raised funds to establish the sensory garden.

**St Michaels Hospital, Marie Therese House**

The unit engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The unit had a board which displayed the ‘you said, we did’. Patients, relatives and carers had asked for pre-admission information about the unit. Staff had compiled a handbook for patient, relatives and carers.

Relatives told us they felt involved in the rehabilitation process on the unit.

The unit engaged with various outside organisations such as the Spinal Injury Association.

**Learning, continuous improvement and innovation**

**Royal Cornwall Hospital**

Staff felt able to raise ideas for the development of the service.
To improve communication between the emergency department and the Medical Assessment area staff had recently implemented a dedicated telephone line, they were finding this helpful.

A dedicated frailty pathway area had been implemented in the Acute Medical Unit (AMU). This enabled all patients identified as meeting the frailty criteria could be co-horted together and receive the specific care and attention needed. This included an increase in therapy staff to meet their assessment and rehabilitation early and so reduce their needed length of stay in hospital.

Wellington ward had developed a pathway to take chest trauma patients, staff had received further training to support this development. Wellington had also undertaken to work with the Cystic Fibrosis team to include them in the MDT working.

Trials were taking place for patients to discharge with continuing antibiotic treatment at home using the hospital at home service. The trust had started sending selected patients for continuing antibiotic treatment at home using the hospital at home service. This had not been adopted routinely as a strategy. There was an ongoing discussion with the patient flow team and a formal policy was being discussed. At present only carefully selected low risk patients were being selected for this specific early discharge.

**West Cornwall Hospital**

West Cornwall Hospital was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

The trust was about to trial an initiative to help with delayed transfers of care. Two nurses were to be seconded into the community. Their role was to review and assess patients in hospital for their suitability for residential and nursing care homes. This aimed to reduce the amount of time patients waited for these assessments and improve patient flow through the hospital.

Nursing recruitment continued to be an ongoing concern. The matron told us about recruitment strategies they were exploring. This included ‘growing your own’ staff. Development of staff through education, apprenticeships and trainee assistant practitioner nurses. They currently had two qualified assistant practitioner nurses at band four.

**St. Michaels Hospital, Marie Therese House**

The unit was proud of their proactive approach. For example, they were a pilot site for the electronic prescribing system adopted by the trust.

The multidisciplinary team had all contributed to change their paperwork to make it more user friendly for staff. This had proved popular with staff.

Marie Therese House was a pilot site for “Always events” This was a complete opposite to ‘Never Events’ and planned to be a celebration of things that had gone well.

Staff on the unit were involved in a trust wide working group. The object of the group was to develop a trust-wide strategy for the care of a patient with a spinal injury. This also included two patients from Marie Therese house.

The unit had taken part in a national challenge from NHS England to ‘End pyjama paralysis’ whereby patients were encouraged to get up and dress in day clothes to as part of their rehabilitation.

**Surgery**

**Facts and data about this service**
The surgical division operates across the three hospital sites: Royal Cornwall Hospital, St Michael’s Hospital and West Cornwall Hospital.

The division is split into four different directorates; theatres and anaesthetics, general surgery, head and neck, and trauma and orthopaedics. This covers 14 surgical specialties: theatres, pre-operative assessment, gastrointestinal, vascular, urology, breast, trauma & orthopaedics, ears nose and throat, dermatology, audiology, ophthalmology, oral maxillary facial, pain services & anaesthetics.

The service has 19 theatres (of which two are available for use 24 hours a day), seven inpatient wards with 182 beds, and three day case units (7am-10pm).

(Source: Routine Provider Information Request (RPIR) – Context Acute)

At the main site Royal Cornwall Hospital there are 13 theatres, two of which are available for use 24 hours a day. Elective admissions are managed through three admitting areas; surgical admissions lounge, theatre direct and the Newlyn unit. Emergency non-elective patients are managed through the St. Mawes unit, trauma unit or the emergency department.

There are two peripheral sites. St Michael’s Hospital, for orthopaedic and breast surgery, this includes one ward and an admitting/day case area, with four theatres. West Cornwall Hospital has a day case area and two theatres, predominantly for ophthalmology, urology, gynaecology and general surgery day case activity.

Sterile services are also part of the division and provides sterilisation and decontamination services for theatre and wards equipment and sundries.

The specialties within the division provide over 9,000 emergency operations and over 29,000 elective operations each year. Operating takes place across all three hospital sites:

- Royal Cornwall Hospital: 69% of elective and all emergency operations
- St Michael’s Hospital: 17% of elective operations
- West Cornwall Hospital: 14% of elective operations

The trust had 34,294 surgical admissions from April 2017 to March 2018. Emergency admissions accounted for 9,787 (28.5%), 20,248 (59.0%) were day case, and the remaining 4,259 (12.4%) were elective operations.

(Source: Hospital Episode Statistics)

Royal Cornwall Hospital

During this inspection we:

- Spoke with 22 patients and one relative to gain their feedback on the services being provided.
- Spoke with 109 staff including; divisional and ward/theatre management, nursing staff on wards, theatre nursing staff, surgeons and anaesthetist medical staff, therapy staff and support staff.
- Reviewed 11 patient records.

St Michael’s Hospital

During this inspection we:

- Spoke with five patients to gain their feedback on the services being provided.
• Spoke with 33 staff including; ward nurses, healthcare assistants, theatre and recovery nurses, operating department practitioners, therapy staff, managers, reception staff, a resident medical officer, cleaning staff, surgeons and anaesthetists.

• Reviewed five patient records.

**West Cornwall Hospital**
During this inspection we:
• Spoke with three patients to gain their feedback on the services being provided.
• Spoke with 20 staff to including; ward nurses, healthcare assistants, assistant practitioners, theatre and recovery nurses, operating department practitioners, reception staff, cleaning staff, treatment centre nurses, surgeons and anaesthetists.
• Reviewed six patient records.

### Is the service safe?

#### Mandatory training

Staff received training in safety systems, processes and practices, although compliance with training modules was variable. All staff were required to complete mandatory training and had access to face to face mandatory training and e-learning modules, they were alerted when mandatory training was required or was due for renewal. However, staff told us about difficulties to complete this training due to staffing pressures.

Managers had oversight of staff performance with mandatory training and showed an understanding of the areas that needed to be focussed on. The surgical division recognised poor compliance for manual handling, safeguarding adults and children safeguarding training for level two, and level three. These training modules were being prioritised to bring compliance up to trust targets.

##### Mandatory training completion rates

Training compliance was not meeting trust targets in several training modules.

The trust set a target of 95% for completion of mandatory training. A breakdown of compliance for mandatory courses from September 2017 to August 2018 for medical/dental and nursing staff in surgery is shown in the tables below. This includes trust wide and the split by the three locations.

#### Trust wide

**Medical and Dental Staff**

Trust wide the 95% target was met for four of the 11 mandatory training modules for medical staff. A module was not specified in the training data, which had the lowest completion rate of 52.2%. Conflict resolution training had the next lowest completion rate with 63.6%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>176</td>
<td>178</td>
<td>98.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (incl. Privacy &amp; Dignity standards)</td>
<td>174</td>
<td>178</td>
<td>97.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>174</td>
<td>178</td>
<td>97.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>174</td>
<td>178</td>
<td>97.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>154</td>
<td>173</td>
<td>89.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in surgery trust wide had a completion rate of 83.8% for mandatory training. Medical staff met the target of 95% for four of the 12 applicable modules. Three members of medical staff had completed the adult immediate life support module although none were indicated to have been eligible during this reporting period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>238</td>
<td>243</td>
<td>97.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>238</td>
<td>243</td>
<td>97.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>237</td>
<td>243</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>236</td>
<td>243</td>
<td>97.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>209</td>
<td>238</td>
<td>87.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>208</td>
<td>243</td>
<td>85.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>206</td>
<td>243</td>
<td>84.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>205</td>
<td>243</td>
<td>84.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>197</td>
<td>238</td>
<td>82.8%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>198</td>
<td>243</td>
<td>81.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>148</td>
<td>238</td>
<td>62.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year</td>
<td>4</td>
<td>120</td>
<td>3.3%</td>
</tr>
<tr>
<td>Adult Immediate Life Support</td>
<td>3</td>
<td>-</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Nursing Staff

Trust wide the 95% target was met for five of the 11 mandatory training modules for nursing staff. A module was not specified in the training data, which had completion rate of 67.9%. Manual handling - people training had the lowest completion rate with 64.5%.
(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in surgery trust wide had a completion rate of 87.4% for mandatory training. Qualified nursing staff met the target of 95% for five of the 12 applicable modules. Twenty-seven members of nursing staff had completed the adult immediate life support module although none were indicated to have been eligible during this reporting period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>352</td>
<td>352</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>276</td>
<td>276</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>352</td>
<td>352</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>347</td>
<td>352</td>
<td>98.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>336</td>
<td>352</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>309</td>
<td>352</td>
<td>87.8%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>305</td>
<td>356</td>
<td>86.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>305</td>
<td>352</td>
<td>86.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>304</td>
<td>352</td>
<td>86.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>255</td>
<td>352</td>
<td>72.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>241</td>
<td>352</td>
<td>68.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year</td>
<td>12</td>
<td>118</td>
<td>10.2%</td>
</tr>
<tr>
<td>Adult Immediate Life Support</td>
<td>27</td>
<td>-</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Royal Cornwall Hospital

Medical and Dental Staff

At the Royal Cornwall Hospital, the 95% target was met for four of the 11 mandatory training modules for medical staff. A module was not specified in the training data, which had the lowest completion rate of 51.7%. Conflict resolution training had the next lowest completion rate with 63.1%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>171</td>
<td>173</td>
<td>98.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (incl. Privacy &amp; Dignity standards)</td>
<td>169</td>
<td>173</td>
<td>97.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>169</td>
<td>173</td>
<td>97.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>169</td>
<td>173</td>
<td>97.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in surgery at Royal Cornwall Hospital had a completion rate of 83.2% for mandatory training. Medical staff met the target of 95% for four of the 12 applicable modules. Three members of medical staff had completed the adult immediate life support module although none were indicated to have been eligible during this reporting period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (incl Privacy &amp; Dignity standards)</td>
<td>224</td>
<td>229</td>
<td>97.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>224</td>
<td>229</td>
<td>97.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>223</td>
<td>229</td>
<td>97.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>222</td>
<td>229</td>
<td>96.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>197</td>
<td>224</td>
<td>87.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>195</td>
<td>229</td>
<td>85.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>193</td>
<td>229</td>
<td>84.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>192</td>
<td>229</td>
<td>83.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>184</td>
<td>224</td>
<td>82.1%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>185</td>
<td>229</td>
<td>80.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>137</td>
<td>224</td>
<td>61.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year</td>
<td>4</td>
<td>120</td>
<td>3.3%</td>
</tr>
<tr>
<td>Adult Immediate Life Support</td>
<td>3</td>
<td>-</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Nursing Staff

At the Royal Cornwall Hospital, the 95% target was met for five of the 11 mandatory training modules for nursing staff. A module was not specified in the training data and this had a completion rate of 62.3%. Manual handling - people training module had the lowest completion rate with 60.6%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (incl. Privacy &amp; Dignity standards)</td>
<td>160</td>
<td>160</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>160</td>
<td>160</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>100</td>
<td>100</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>157</td>
<td>160</td>
<td>98.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>155</td>
<td>160</td>
<td>96.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in surgery at Royal Cornwall Hospital had a completion rate of 86.5% for mandatory training. Qualified nursing staff met the target of 95% for four of the 12 applicable modules. Twenty-three members of nursing staff had completed the adult immediate life support module although none were indicated to have been eligible during this reporting period.

### Course Coverage

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>267</td>
<td>267</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>198</td>
<td>198</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>267</td>
<td>267</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
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<td>267</td>
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<td>95%</td>
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<tr>
<td>Conflict Resolution</td>
<td>252</td>
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<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>234</td>
<td>267</td>
<td>87.6%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>230</td>
<td>267</td>
<td>86.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>230</td>
<td>267</td>
<td>86.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>229</td>
<td>267</td>
<td>85.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>192</td>
<td>267</td>
<td>71.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>179</td>
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<td>67.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year</td>
<td>12</td>
<td>110</td>
<td>10.9%</td>
</tr>
<tr>
<td>Adult Immediate Life Support</td>
<td>23</td>
<td>-</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

### St Michael's Hospital

**Medical and Dental staff**

At St Michaels Hospital the 95% target was met for five of the 11 mandatory training modules for medical staff with 100% in each. The remaining six mandatory training modules had a completion rate of 80%. A module was not specified in the training data and this had a completion rate of 80%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (incl. Privacy &amp; Dignity standards)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
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<tr>
<td>Equality and Diversity</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in surgery at St Michael’s Hospital had a completion rate of 93.5% for mandatory training. Medical staff met the target of 95% for four of the 11 modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS[CSTF][Resuscitation - Level 2 - Adult Basic Life Support - 1 Year]</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>11</td>
<td>14</td>
<td>78.6%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Nursing Staff)

At St Michaels Hospitals the 95% target was met for five of the 11 mandatory training modules for nursing staff. Manual handling (people) training module had the lowest completion rate with 52.5%. There was a module that was not specified in the data and the completion rate for this was 87.5%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (incl. Privacy &amp; Dignity standards)</td>
<td>40</td>
<td>40</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>40</td>
<td>40</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>40</td>
<td>40</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>37</td>
<td>37</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>39</td>
<td>40</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Module not specified</td>
<td>35</td>
<td>40</td>
<td>87.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>32</td>
<td>40</td>
<td>80.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>32</td>
<td>40</td>
<td>80.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>32</td>
<td>40</td>
<td>80.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in surgery at St Michael’s Hospital had a completion rate of 87.4% for mandatory training. Qualified nursing staff met the target of 95% for five of the 11 applicable modules. Three members of nursing staff had completed the adult immediate life support module although none were indicated to have been eligible during this reporting period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>37</td>
<td>37</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>43</td>
<td>43</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>43</td>
<td>43</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>43</td>
<td>43</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>42</td>
<td>43</td>
<td>97.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>35</td>
<td>43</td>
<td>81.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS/CSTF/Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>35</td>
<td>43</td>
<td>81.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>35</td>
<td>43</td>
<td>81.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>35</td>
<td>43</td>
<td>81.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>33</td>
<td>43</td>
<td>76.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>24</td>
<td>43</td>
<td>55.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Immediate Life Support</td>
<td>3</td>
<td>-</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

West Cornwall Hospital

There are no medical staff in surgery at West Cornwall Hospital, medical staff will attend the hospital site to perform day surgery.

Nursing Staff

At West Cornwall Hospital he 95% target was met for eight of the 11 mandatory training modules for nursing staff. Information governance had the lowest completion rate with 71.4%. There was a module that was not specified in the data and the completion rate for this was 82%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>42</td>
<td>42</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (incl. Privacy &amp; Dignity standards)</td>
<td>42</td>
<td>42</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>42</td>
<td>42</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>42</td>
<td>42</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>41</td>
<td>41</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>38</td>
<td>42</td>
<td>90.5%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in surgery at West Cornwall Hospital had a completion rate of 93.4% for mandatory training. Qualified nursing staff met the target of 95% for nine of the 12 applicable modules. One member of nursing staff had completed the adult immediate life support module although none were indicated to have been eligible during this reporting period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>42</td>
<td>42</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>42</td>
<td>42</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>42</td>
<td>42</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>42</td>
<td>42</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>41</td>
<td>42</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year]</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>38</td>
<td>42</td>
<td>90.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>30</td>
<td>42</td>
<td>71.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year]</td>
<td>0</td>
<td>8</td>
<td>0.0%</td>
</tr>
<tr>
<td>Adult Immediate Life Support</td>
<td>1</td>
<td>-</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Safeguarding

There were clear processes for identifying safeguarding concerns and making referrals. Staff spoken with could describe the processes they would follow and provided examples of safeguarding cases. Staff could access the trust safeguarding team and were positive about the support and advice they offered.

Safeguarding concerns and the input from teams was clearly recorded in patient records. We saw evidence of visits from teams relevant to safeguarding the individual to include a; homeless patient advisor, mental health team, psychiatry liaison.

The electronic system included safeguarding flags, so staff were aware of safeguarding concerns for patients. We were told the safeguarding team would also be alerted if there was a patient on a ward with a safeguarding concern.

Safeguarding training completion rates

There was poor compliance with safeguarding training level two, particularly for medical staff. The trust set a target of 95% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from September 2017 to August 2018 for medical/dental and nursing staff in surgery is shown in the tables below. This includes trust wide and the split by the three locations.
Trust wide

Medical and Dental Staff

Trust wide the 95% target was met for two of the four safeguarding training modules for which medical staff in surgery were eligible. Safeguarding children (level 2) did not meet the target with a completion rate of 45.1%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>173</td>
<td>178</td>
<td>97.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>172</td>
<td>178</td>
<td>96.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>144</td>
<td>173</td>
<td>83.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>78</td>
<td>173</td>
<td>45.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that medical staff in surgery trust wide had a completion rate of 80.1% for safeguarding training. Medical staff met the 95% target for two of the four modules. Compliance did not improve for any modules when compared to the earlier time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>234</td>
<td>243</td>
<td>96.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>233</td>
<td>243</td>
<td>95.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>198</td>
<td>238</td>
<td>83.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>106</td>
<td>238</td>
<td>44.5%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Nursing Staff

Trust wide the 95% target was met for three of the five safeguarding training modules for which nursing staff in surgery were eligible. Safeguarding adults (level 2) had the lowest completion rate with 84.3%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>242</td>
<td>242</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>239</td>
<td>242</td>
<td>98.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>205</td>
<td>242</td>
<td>84.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>204</td>
<td>242</td>
<td>84.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in surgery trust wide had a completion rate of 92.9% for safeguarding training. Qualified nursing staff met the 95% target for three of the five modules. Compliance improved for two modules when compared to the earlier time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Royal Cornwall Hospital

Medical and Dental Staff

At Royal Cornwall Hospital, the 95% target was met for two of the four safeguarding training modules for which medical staff in surgery were eligible. Safeguarding children (level 2) did not meet the target with a completion rate of 45.8%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>168</td>
<td>173</td>
<td>97.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>167</td>
<td>173</td>
<td>96.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>140</td>
<td>168</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>77</td>
<td>168</td>
<td>45.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Nursing Staff

At Royal Cornwall Hospital, the 95% target was met for three of the five safeguarding training modules for which nursing staff in surgery were eligible. Safeguarding adults (level 2) had the lowest completion rate with 83.8%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>160</td>
<td>160</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>157</td>
<td>160</td>
<td>98.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>135</td>
<td>160</td>
<td>84.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>134</td>
<td>160</td>
<td>83.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) –Mandatory and Statutory Training tab)
Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in surgery at Royal Cornwall Hospital had a completion rate of 92.8% for safeguarding training. Qualified nursing staff met the 95% target for three of the five modules. Compliance improved for two modules when compared to the earlier time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>269</td>
<td>270</td>
<td>99.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>262</td>
<td>267</td>
<td>98.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>232</td>
<td>267</td>
<td>86.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>231</td>
<td>267</td>
<td>86.5%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

St Michael’s Hospital
Medical and Dental Staff
At St Michael’s Hospital, the 95% target was met for two of the four safeguarding training modules for which medical staff in surgery were eligible. Safeguarding children (level 2) did not meet the target with a completion rate of 20%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
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(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that medical staff in surgery at St Michael’s Hospital had a completion rate of 85.7% for safeguarding training. Medical staff met the 95% target for two of the four modules. Compliance improved for two modules when compared to the earlier time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
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(Source: Updated data provided by the trust)

Nursing Staff
At St Michael’s Hospital, the 95% target was met for two of the four safeguarding training modules for which nursing staff in surgery were eligible. Safeguarding children (level 2) and safeguarding adults (level 2) both had the lowest completion rate with 77.5% each.

Staff told us low compliance was partly due to staffing changes on the wards and in theatres and managers had oversight of the training completion and addressed this as part of performance reviews.
Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in surgery trust wide had a completion rate of 89.5% for safeguarding training. Qualified nursing staff met the 95% target for two of the four modules. Compliance improved for two modules when compared to the earlier time period.

### West Cornwall Hospital

There are no medical staff permanently based at West Cornwall Hospital. Medical staff attend the hospital site to perform day surgery and their safeguarding training records are held at the Royal Cornwall Hospital.

**Nursing Staff**

At West Cornwall Hospital, the 95% target was met for two of the four safeguarding training modules for which nursing staff in surgery were eligible. Safeguarding adults (level 2) and safeguarding children (level 2) did not meet the trust target with 92.9% in each module.
At West Cornwall Hospital a member of the ward clinical team told us they had recently identified a potential vulnerable adult through the pre-operative assessment process and had alerted the safeguarding team to their concerns. They described the issue as a good opportunity for learning and as a result had developed a safeguarding information board within the department. The safeguarding board displayed information for staff, patients and visitors on how to escalate concerns and the contact details for relevant safeguarding teams.

**Cleanliness, infection control and hygiene**

Standards of cleanliness and hygiene were maintained across all three sites and there were systems to protect people from healthcare associated infections.

Surgical and ward areas were visibly clean and tidy. Staff used ‘I am clean’ stickers to show the date equipment was last cleaned. Contracted cleaning staff and trust nursing staff were responsible for cleaning. Staff followed cleaning schedules and maintained records of cleaning activities. Cleaning audits were carried out on the wards monthly and in theatres weekly. We saw some examples of completed audits.

In theatres we observed good infection control practice with the use of disposable, curtains drapes and gowns. Theatre equipment was decontaminated and sterilised between uses. Sterile services were based at the Royal Cornwall Hospital and there was a system of packaging, transfer and receipt of all reusable equipment. All items were tagged electronically, and staff told us they checked the security of the packaging when receiving equipment to ensure it was intact and sterility maintained.

We observed staff following national guidance on infection control. For example, staff with long hair tied back and all staff were ‘bare below the elbows’ at all times to enable effective hand washing and minimise the risk of contamination. We observed staff following NICE QS61: Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. Personal protective equipment and hand sanitiser gel were readily available, and we observed staff regularly washing their hands.

Infection control environmental audits were being completed. Matrons monitored these audits and following some failed audits were completing weekly spot checks. We saw in the surgery business and governance minutes infection control was being discussed and monitored.

Hand hygiene compliance was monitored. In June 2018 results showed most wards and theatres were compliant. There were a few non-compliant areas and some areas which did not report their compliance for the month.

Infection control risk assessments were completed for patients on admission. Patients were routinely screened for methicillin-resistant Staphylococcus aureus (MRSA) before surgery. Data was collected monthly to review the total number of admissions for surgical patients and the number of patients screened for MRSA. In June 2018 the trust reported some missed opportunities for screening; 32 out of 125 at St Michael’s hospital, and six out of 59 on the surgical admission unit/theatre direct. Missed opportunities for emergency screening included 16 out of 144 in the trauma unit, 11 of 26 for Wheal Coates, 16 of 171 at St Mawes and seven of 32 for surgical admissions lounge/theatre direct.

Staff followed surgical site infection bundles to reduce the risk of infection. This included the preoperative phase, intraoperative phase and postoperative phase. Surgical site infections were
monitored for knee and hip replacements and fractured neck of femur. Audits were completed each quarter. The infection prevention and control team were responsible for contacting the patient to review outcomes and produce the data set.

**Royal Cornwall Hospital**

The service managed infectious patients well. We saw wards had enough side rooms to isolate infectious patients. Side rooms were labelled to warn staff and visitors of the infection risk. Reminders about safe management of infections were displayed on wards.

All theatres were cleaned between 10pm and 6am, it was the theatre staff’s responsibility to complete the clean unless a deep clean was required. The surgical wards were cleaned throughout the day and deep cleaned as requested or on a rolling programme. Staff contacted the emergency cleaning service was contacted for any deep cleans that were required.

Disposable curtains were in use and replaced in line with a six-month replacement schedule. All disposable curtains had visible dates on them, indicating they had been changed during the last six months.

Some infection control practice at the Royal Cornwall Hospital could have been improved. We did see some instances of poor infection control practice where staff did not wear aprons when carrying bowls of urine to the sluice.

Theatre staff were concerned about the red tag policy and how this impacted infection prevention control. A transparent pouch was stuck to the wall which contained red tags for the current case. Staff were concerned the tags could be contaminated when they were taken off the pack of swabs and then they were passing the tags out.

In theatre, staff used multiple sterile drapes of different sizes to cover the x-ray c-arm. This did not cover the equipment appropriately. The drapes were secured with tape and the scrub nurse had to continually change their gloves to ensure they maintained the sterile field.

Most patients were happy with the cleanliness of the ward, however two patients spoken with commented how they thought the cleaning could be improved. One patient observed the area was only swept once a day and not done to a high standard as there was still debris under their bed. Another patient on a different ward was not impressed by the standards of cleaning and thought the floor was dirty.

**St Michael’s Hospital**

Disposable curtains were in use, although had not been replaced in line with the replacement schedule. At our last inspection we found curtains on the wards were made of reusable fabric rather than disposable, and there was no evidence showing when they were last cleaned. At this inspection we found disposable curtains were in use. However, some of these curtains had replacement dates on them of up to 10 months ago, indicating the six-month replacement schedule had not been complied with. We raised this issue with the ward manager and when we returned to the hospital two days after we found all the disposable curtains had been replaced.

Wards and public areas were cleaned daily, and theatres were deep cleaned every evening. Cleaning audit performance on the wards for July 2018 was between 96% and 99% compliance against a 90% target. Audit results for theatres for the four months before our inspection were between 98% and 100%.

Nursing staff on the wards maintained daily equipment cleaning checklists were maintained by. This was an improvement from our 2017 inspection where daily cleaning checklists for equipment on the wards were not consistently maintained. At this inspection we found records of daily
cleaning of equipment such as commodes, manual handling and emergency equipment were completed.

**West Cornwall Hospital**

Disposable curtains were in use and replaced in line with a six-month replacement schedule. Following our inspection in 2017 all reusable fabric curtains had been replaced with disposable curtains. All disposable curtains had visible dates on them, indicating they had been changed during the last six months.

Wards and public areas were cleaned daily, and theatres were deep cleaned every evening. Cleaning audit performance as displayed on the ward for July 2018 was at 98%.

At our 2017 inspection, due to vacancies in the contracted cleaning team, cleaning staff were not always available, and cleaning of theatres fell to the nursing and theatre staff. At this inspection staff told us this situation had improved. We spoke with one member of cleaning staff who told us they had the time to follow their planned cleaning schedule. We saw completed cleaning schedules were maintained.

**Environment and equipment**

Facilities and surgical equipment, including resuscitation and anaesthetic equipment were available, fit for purpose, and checked in line with professional guidance. The trust provided training to staff on use of new equipment. For example, the trust had introduced new defibrillators to all areas from June 2018. Staff were positive about the training they received for this.

Instruments, equipment and implants complied with the medicines and healthcare products regulatory agency on management of medical devices. There were processes for providing feedback on product failure to report to the appropriate regulatory authority.

Sterile services were part of the surgical division and provided sterilisation and decontamination services for theatre and wards equipment and sundries. This was in accordance with EU standards through the quality management ISO and SGS who completed audits. Each item leaving sterile services had a unique barcode on it to ensure tracking and traceability. We saw evidence these stickers were placed in patient records. The manager of the clinical sterile services department visited theatres to ensure sterilised packaged equipment was being stored correctly following incidents where packaging had holes.

Waste was well managed, including classification, segregation, storage, labelling, handling and disposal. Clinical waste was disposed of in appropriate clinical waste bags and stored securely for collection. Sharps were disposed of in sharps bins and labelled appropriately. All waste we saw was stored safely.

**Royal Cornwall Hospital**

The equipment used was fit for purpose. However, it was not always clear whether the servicing of equipment was in date as stickers showed dates had expired. For example, in Tower theatres recovery stickers showed the equipment was overdue for servicing, but the theatre manager followed this up and confirmed servicing had been completed. We also noted several other equipment with stickers to show they were out of date on wards and in theatres. For example, the ultrasound system (asset number 1225926) in St Mawes lounge which indicated next test due July 2016.

Staff told us they had access to the equipment needed, both in and out of hours. This included equipment to safely manage bariatric patients and equipment to manage pressure ulcers.
Occupational therapists were not involved with the preoperative assessment process for patients. This sometimes delayed the ability to get the most appropriate equipment to safely meet the needs of patients. The therapy team were reviewing how they could improve the preoperative pathway.

Emergency equipment was available and ready for use on wards and theatres we visited. Emergency equipment was stored on tamper-evident trolleys to ensure it was stored securely. Most records showed staff completed daily and weekly checks of emergency equipment. Although there were some gaps in recording.

Each theatre had an airway trolley and a separate difficult airway intubation trolley. The trolley was sealed with a tamper tag. Staff checked this daily and recorded they had checked the external contents and the tamper tag intact. We did identify some gaps in the completion, in particular in Newlyn theatre. There was not a clear record held of the expiry dates of the equipment stored in the trolley.

On Pendennis ward we found chlorine tablets in a keypad lockable cupboard which had not been locked, the sluice door was also not secured.

The Newlyn unit, a day case area, was used for inpatients at time of escalation and was not fit for purpose. We saw two incidents reported in November 2017 where patients with a radiologically inserted gastrostomy were inpatients overnight on Newlyn. Normally this patient group would be on Wheal Coates ward. When visited by the dietician it was identified the patient’s radiologically inserted gastronomy tube had not been flushed, this should be flushed 12 hours after insertion. It was also found staff were not trained for this. Learning outcomes were for the Newlyn unit to not accept these patients going forward.

During our inspection theatre 10 had been having issues with the flooring which had been reported to estates a week before our inspection. The red tape, used to zone off the sterile area directly under the laminar flow screens, had lifted. Staff had temporarily put tape over to hold it down, but this had also lifted, which was a trip hazard. When staff tried to pull off the tape it in turn pulled up the red tape leaving adhesive on the floor. Staff were observed using scalpel blades and acetone to remove the adhesive strip. We escalated the issue to the theatre matron who advised staff to stop and place temporary tape over the adhesive strip, close the doors and allow a 20-minute air change before sending for the patient. We were told estates would be reviewing this.

In Trelawny theatre 10 and 11 the theatre floors had a thin black strip all the way around which was integrated into the floor and had a thin metal trim. The strip was damaged in multiple areas and small parts of the floor had crumbled to reveal tiny cracks and gaps around the edges of the black strip. Coving and corners of the theatre floor were also chipped, and small cracks could be seen. This meant the environment was an infection control risk. We were told theatre six, seven, eight and nine had been refurbished to include the flooring, but 10 and 11 had not. The theatre matron said they would talk to estates about this issue.

Bariatric equipment for patients was available in theatres, to include a bariatric operating table, appropriate attachments and a hover mattress.

We observed an ophthalmic theatre list and all laser safety was complied with to include locked doors when laser in use, blinds pulled down over windows and doors, laser warning lights on external door and laser goggles were available.

**St Michael’s Hospital**

Equipment was seen to be in good working order and labelled with the date of service. All equipment we viewed was within date for servicing. Faulty equipment was taken out of service and
clearly labelled so as not to be used. We viewed a faulty item of manual handling equipment that had been reported to the medical physics department a month ago, in August 2018. The ward manager told us generally equipment reported as faulty would be reviewed and repaired within one to two weeks. They told us in the case of essential equipment this would be prioritised.

Resuscitation equipment was available. Resuscitation trolleys were kept on St Michael’s ward, St Joseph’s ward and in theatres. Trolleys were tamper evident and subject to daily and weekly checks. We saw records of these checks with minimal gaps in recording. For example, on St Joseph’s ward there had been five occasions in six months when the daily checks were not recorded as having been carried out. All weekly checks were seen have been completed. We found emergency equipment was in good condition and in date.

The sterilising department at the Royal Cornwall Hospital provided sterile instrument packs to St Michael’s Hospital. Theatre staff ordered equipment in advance, based on the theatre lists taking place. Equipment in theatres was stored using a modular storage system which made accessing and monitoring it more efficient. Prosthesis implants were recorded in patient records using labels provided for this purpose.

Random checks of stock consumables confirmed most stock was in good condition and within its expiry date. However, on St Joseph’s ward there were more than 10 non-needle access syringes which were out of date. We raised this with staff at the time of inspection and the expired stock taken out of service.

The hospital did not routinely admit patients with a body mass index above 40. This was due to the hospital admission criteria, a lack of bariatric equipment and some accessibility issues throughout the hospital relating to the use of bariatric wheelchairs and trolleys where there were narrow doorways. The ward manager told us they would occasionally take a patient who had bariatric needs. However, this was subject to a risk assessment and the relevant equipment being available to borrow from the Royal Cornwall Hospital.

**West Cornwall Hospital**

Equipment was in good working order and clearly labelled with the date of service. At our inspection in 2017 the maintenance of equipment did not keep people safe, the date of service labels on some equipment showed it had gone past its service date. During this inspection all equipment we viewed was within its servicing date.

Resuscitation equipment was available. Resuscitation trolleys were kept on the ward, in theatres and in the treatment centre. Trolleys were tamper resistant and subject to daily and weekly checks. We saw records of these checks that showed they were carried out consistently.

The sterilising department at the Royal Cornwall Hospital provided sterile instrument packs to West Cornwall Hospital. Theatre staff ordered equipment in advance, based on the theatre lists taking place. Equipment in theatres was seen to be stored securely. However, we were told some items of equipment transported back from sterile services were not always returned securely, risking damage to the equipment. For example, one item of ophthalmology equipment had been returned in sterile flexible packaging rather than a hard-case box that had also been sterilised. This meant equipment had the potential to be damaged in transit. The theatre/ward manager told us they were liaising with sterile services to address this issue. Prosthesis implants were recorded in patient records using the labels provided for this purpose.

Random checks of stock consumables confirmed most stock was in good condition and within its expiry date. However, in the clinical room on the ward there were single use forceps which had
passed their expiry date. This was raised with staff at the time of inspection and the expired stock taken out of service.

The hospital did not routinely admit patients with a body mass index above 40. This was due to the hospital admission criteria and a lack of bariatric equipment. Patients with bariatric needs had their surgery at the Royal Cornwall Hospital.

Assessing and responding to patient risk

Patient risk was considered and there were processes to assess and respond to potential or presenting risks.

Trust wide national early warning scores (NEWS) were used to record patient observations, this was captured electronically. Observations were completed, and an escalation pathway was initiated dependent on the scoring. Data could be reviewed to assess the response times to NEWS.

There were clear guidelines for sepsis management. The trust referred to this care bundle as BUFALO, as a reminder to staff of the process to follow: blood cultures, urine, output measurement, IV fluids, antibiotics, lactate measurement and oxygen. Wards had access to a sepsis box to ensure quick access to medication, equipment and information for managing patients with sepsis. Sepsis care was delivered within one hour and the patient was reviewed, escalation to medical staff or the outreach team was completed as appropriate. Staff we spoke with were aware of the signs of sepsis and the processes to follow.

Handovers were completed between shifts for nursing staff. This included an overarching safety briefing for the whole nursing team covering key concerns such as falls risks, pressure ulcer risks, and resuscitation decisions. Then individual handovers were completed. We observed two handovers which were clear and ensured the receiving team were informed of all details about the patients they would be caring for.

The World Health Organisation (WHO) Surgical Safety Checklist and NHS Five Steps to Safer Surgery were being completed in full and recorded on the paper record and electronically. The electronic completion could be audited. We reviewed patient records and confirmed the WHO checklist was completed and signed in all cases where patients underwent surgery.

Audits were completed to monitor the compliance with the WHO Surgical Safety Checklist and NHS Five Steps to Safer Surgery. The WHO audits for the previous three months showed:

<table>
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<th>Area of five steps</th>
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<th>June 2018</th>
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<td>Safety Huddle</td>
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<td>100%</td>
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<td>Theatre Brief / De-Brief</td>
<td>100%</td>
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Elective patients attended a pre-operative assessment. Patients had a pre-operative assessment before surgery. Nurses triaged patients and carried out assessments face to face or by telephone depending on the patients’ health. All patients were screened for methicillin-resistant Staphylococcus aureus (MRSA) before their operation.

Anaesthetists assessed patient's fitness for surgery was assessed using the American Society of Anaesthesiologists (ASA) classification system.
A theatre scheduling policy was in use and supported how patients were risk assessed prior to surgery, including last minute changes. There was an audit trail of the decisions made confirming the theatre, staffing and equipment were appropriate. Theatre lists were locked down and unable to be changed seven days before surgery. Theatre managers could unlock lists to add patients, this ensured the right staff and equipment were available at short notice, and the list could be confirmed by the operating surgeon.

The trust had a process to manage the risk of patients coming to harm where the 52-week wait for surgery was breached. Clinicians completed desk-based harm reviews, to assess the risk and prioritise patients, for patients waiting more than 52 weeks for surgery. Please see the outpatient evidence appendix for further information.

Surgical medical staff did not have a mandatory requirement for resuscitation Advanced Life Support and Advanced Paediatric Life Support, so the trust was unable to provide compliance. The anaesthetic trainee is Advanced Life Support trained and carries the cardiac arrest bleep. A cardiac arrest team was available 24 hours a day in all hospital sites and could be called to theatres.

Royal Cornwall Hospital

There was no formalised process or system used to accurately calculate and risk stratify patients receiving surgery and their requirement for the intensive care unit. Therefore, the percentage of risk for mortality and morbidity was not calculated for patients undergoing surgery to determine the needs of their postoperative care. We were told this was being reviewed. There was a preoperative assessment service which did review patients and identify any requirements for intensive care or high dependency postoperatively, although these were not always recorded.

There was limited capacity for level one care for high dependency patients. The identified area for level 1b patients was in the high dependency unit (critical care) for their post-operative care, but due to high level three occupancy in the high dependency unit there wasn’t sufficient capacity to accommodate these patients. This meant level one patients needed to be held in recovery.

There was a critical care outreach team available to support the wards with patients who were acutely unwell. Staff told us the outreach team were readily available.

Staff risk assessed emergency patients’ wellbeing to determine the urgency of their surgery. There was real-time oversight of the patients waiting for emergency surgery and data was captured to review performance against targets.

There was a machine for cardiopulmonary exercise (CPET) tests in one preoperative treatment room. This machine assesses the performance of heart and lungs to assess a patient’s fitness for surgery and the body’s likely response to the increased demands it will experience during surgery. It helps to form a patient-specific measure of risk. We discussed the use of this test, this was not regularly used but there were plans for this to be used routinely for high risk gastrointestinal and vascular patients, to enable effective consent and guide the post-operative care.

Staff were aware of how to manage aggressive patients and could contact security and the mental health liaison team if necessary. Staff were informed of potentially aggressive patients during nursing handover.

Concerns were raised to us on Pendennis ward about admission to the ward from the intensive care unit. There was an example of a patient with a NEWS of 10, although this was not reported as an incident. We were told there was work being done with the critical care outreach team to clarify admission criteria.
We observed one patient who was collected from the ward for their surgery. The surgeon’s preoperative checklist had not been completed and the ward doctor had to complete this before the patient could be taken to theatre.

Staff did not discharge day case surgery patients until they were stable. For example, one patient who was last on the list was kept overnight in recovery as they had a high pain score post operatively.

We observed three theatre safety briefings during our inspection. Each patient and their case were discussed in turn, to include equipment, positioning of patient, allergies and antibiotics.

We observed patient details being checked thoroughly before taking them to theatre, to include full name, date of birth, last time they ate and drank, allergies, any loose teeth caps or crowns, hearing aids or contact lenses.

The full theatre team were not always present for the WHO surgical safety checklist. We observed a timeout was started without the second scrub nurse, the scrub nurse had left the theatre and returned after the timeout. We also observed two staff members were not present for the safety briefing for the emergency theatre due to last minute changes with staffing.

There was a 24-hour blood bank. Staff told us blood products arrived quickly in an emergency.

**St Michael’s Hospital**

Staff followed admission criteria to ensure only patients with stable medical conditions were treated at St Michael’s Hospital. The criteria were based on the American Society of Anaesthesiologists (ASA) physical status classification system. Patients could receive their elective treatment at St Michael’s if they were classed as a normal health patient (ASA I) or a patient with mild systemic disease (ASA II). At the time of our inspection St Michael’s hospital did not have a high dependency unit or the staffing structure to treat patients outside of these criteria.

A pre-operative assessment was carried out for each patient prior to admission. For patients having elective orthopaedic procedures this included a multidisciplinary assessment, to include physiotherapy and occupational therapy requirements. Assessments included weight, height, temperature, blood pressure, bloods, electro cardiogram (ECG) and methicillin-resistant Staphylococcus aureus (MRSA) screening. Medical staff reviewed the patient records, checked their consent forms and the site of the surgery before transfer to theatre.

We observed the use of the five steps to safer surgery, World Health Organisation (WHO) surgical checklist. Staff used the WHO checklist appropriately. We reviewed five WHO checklists and found forms were fully complete, signed and dated. In theatres we observed the checklist being followed and read out loud so all staff caring for the patient were involved in ensuring compliance.

Staff used the National Early Warning System (NEWS) for all patients. Nurses monitored patients post-operatively in recovery and on the ward. We saw NEWS scores were routinely recorded for all patients. Staff told us the resident medical officer was available to report any concerns to.

On the day of surgery, nursing staff undertook an admission assessment where they assessed risks, this included; falls, pressure ulcers, venous thromboembolism, manual handling and nutrition. Nurses took to review and mitigate the risks during the admission. For example, anti-embolism stockings were given to patients at risk of venous thromboembolism (VTE). Patient information leaflets were also given to patients on how to reduce the risk of VTE during admission and on discharge home.
We observed safety huddles in both theatre and on the ward. This included a discussion about risk in general and those relating to individual patients receiving treatment. In the anaesthetic room safety briefings were held before each surgery. We observed staff in this situation discussing patient allergies and where relevant the results of patient pregnancy tests.

There were ‘stop before you block’ signs in theatres to reduce the risk of wrong side nerve blocks being undertaken. During procedures we saw the anaesthetist double checking the limb site before administering the nerve block.

Staff we spoke with had a good understanding of sepsis pathways. Sepsis grab boxes were available on the wards with equipment for sepsis screening such as blood bottles. A sepsis care bundle was in use and nursing staff could describe their assessment and the action they would take in the event of suspected sepsis.

There were clear processes in place to manage patients who were deteriorating or becoming clinically unwell. The resident medical officer provided medical input on a 24-hour rotational shift basis with senior medical support available from the on-call trauma surgery team at the Royal Cornwall Hospital. Staff told us resuscitation simulation training was regularly carried out in theatre and on the wards and the resident medical officer and senior nursing staff within the hospital were bleep holders for resuscitation. Patients who were physically unstable were transferred to the Royal Cornwall Hospital by emergency ambulance.

All clinical staff undertook training in managing the deteriorating patient. Staff we spoke with told us this training had recently been enhanced due to plans to expand the admission criteria at St Michael’s so more patients could have their elective surgery at the hospital.

**West Cornwall Hospital**

Staff followed admission criteria to ensure only patients with stable medical conditions were treated at West Cornwall Hospital. The criteria were based on the American Society of Anaesthesiologists (ASA) physical status classification system. Patients could receive their elective treatment at West Cornwall Hospital if they were classed as a normal health patient (ASA I) or a patient with mild systemic disease (ASA II).

A pre-operative assessment was carried out for each patient prior to admission. Assessments included weight, height, temperature, blood pressure, bloods, electrocardiogram (ECG) and methicillin-resistant Staphylococcus aureus (MRSA) MRSA screening. Medical staff reviewed the patient records, checked their consent forms and the site of the surgery before transfer to theatre.

We observed the use of the five steps to safer surgery, World Health Organisation (WHO) surgical checklist. The WHO checklist was used appropriately, and we observed completed forms were signed and dated in the records we reviewed. All seven records we reviewed had forms completed comprehensively.

Staff used the National Early Warning System (NEWS) for all patients. Nursing staff monitored patients post-operatively in recovery and on the ward. We saw NEWS scores were routinely recorded for all patients.

On the day of surgery, nursing staff undertook an admission assessment where they assessed risks, this included; falls, pressure ulcers, venous thromboembolism, manual handling and nutrition. Nurses acted to review and mitigate the risks during the admission.

We observed safety huddles in both theatre and on the ward. This included a discussion about risk in general and those relating to individual patients receiving treatment. In the anaesthetic room safety briefings were held before each surgery. We observed a briefing as part of a urology list where issues such as patient allergies, the use of antibiotics and the equipment the surgeon would
need for the procedure. We also saw safety checks being carried out in ophthalmology theatres. We saw the site/side for the surgery was recorded and checked, however this was not written out in full within the patient record which had to potential to lead to mistakes. For example, the record showed L/R rather than left/right.

There were safety checklists in place for different procedures. These included basic safety checklists and additional speciality checklists. These were routinely audited in theatre and we were told there were plans to start auditing these in the treatment centre for the coming month.

Staff we spoke with showed a good understanding of sepsis pathways. Sepsis grab boxes were available on the wards with equipment for sepsis screening such as blood bottles. A sepsis care bundle was in use and nursing staff could describe their assessment and the action they would take in the event of suspected sepsis.

At our 2017 inspection concerns about potential risks to patient safety had been raised by staff. This was due to the lack of medical staffing structure should a patient deteriorate post operatively. At this inspection staff told us this was an ongoing issue in relation to a lack of consultant cover when their lists had finished, where patients were still in recovery or on the ward. Staff told us while the surgeon would usually check on patients before going home, the arrangements for responding to deteriorating patients had still caused them concern. For example, we were told of a situation where a patient had not passed urine following a urology procedure and another who had bled post-operatively. Staff told us in both situations the surgeons had already left the hospital when the complications became apparent. Staff told us some surgeons were happy to be contacted once they had left the hospital, but this was not consistent. They also told us while some surgeons checked on patients before leaving and handed over any potential issues to the medical or urgent care doctors on-site, this was not always consistent. As a result, staff told us while deteriorating patients would always be transferred to the Royal Cornwall Hospital, there would sometimes be uncertainty about how to access support in the meantime. However, there were no reported incidents relating to these concerns recorded. Staff we spoke with told us patients would regularly be transferred to the Royal Cornwall Hospital post-operatively. Data provided by the trust showed nine patients had been transferred between 1 September 2017 and the 31 August 2018.

All clinical staff undertook training in managing the deteriorating patient. The theatre/ward manager also told us staff could participate in simulation training within the urgent care centre that took place regularly. However, there were no records available to demonstrate how many staff had participated in this.

We visited the treatment centre where patients were a day case for medical treatments and minor surgical procedures. The recovery area was mixed sex and staff told us there had been discussions about building a divide to create single sex bays within recovery. However, we were told there were still no solid plans or a timeline to address this. Staff reported they had been told to use a side room, next to the recovery area, to separate male and female patients post-procedure and protect their privacy and dignity. However, staff told us they believed this compromised patient safety as they would not be able to closely monitor the patient’s recovery.

Reception staff told us they had received training in basic life support and instruction in how to recognise when a patient is unwell. We spoke with one receptionist who told us they had experienced situations where a patient has arrived for surgery when they were unwell. They told us in this situation they would initially call nursing staff to provide support and would suggest to relatives going with the patient that they stay with them.

Nurse staffing
Nursing staffing in the surgical division was a challenge and had been for some time. There were a high number of vacancies which were being mitigated using agency staff. This had not improved since our last inspection of the service in July 2017. There were difficulties in ensuring a well-established and sustainable workforce.

In June 2018 the division reported 63.05 WTE registered nursing vacancies, which was a vacancy rate of 11.22%. The high-risk areas for nursing vacancies were the surgical admission lounge/theatre direct (9.85 WTE), trauma unit (11.22 WTE) and operating department practitioners (7 WTE).

Nurse recruitment days were being held as part of the trust generic recruitment days with rolling adverts and interview dates. Specific surgical recruitment days were also being held and the trust were involved in a programme for international nurses to come to the UK for placements of between 12 weeks and one year.

The safer nursing care tool was used to record the numbers and acuity of patients and calculate the number of nurses or hours of nursing required. The nurse in charge would add three times a day. Trust wide this was reviewed, and staff were moved to achieve the safest skill mix across the hospital.

**Royal Cornwall Hospital**

At the time of our inspection most surgical wards were staffed as planned. We spoke to nurses in charge of the surgical wards and they spoke about the escalation processes to manage safe staffing levels. Staff we spoke with knew how to escalate their concerns if there was not enough staff to care for patients safely.

Staff shortages at the Royal Cornwall Hospital were covered by bank and agency use, to ensure surgical wards were safely staffed. There was therefore a high agency usage. However, block booking agency staff helped to ensure some consistency with the agency used. Employed staff felt the pressures of high agency usage as agency staff required closer supervision until they were confident and competent in the environment. We were told there were more incidents reported at times when agency numbers were higher on wards, although we were unable to corroborate this.

There were difficulties with staffing in theatres at Royal Cornwall Hospital due to vacancies and high sickness rates. Although staffing did not impact on the safety of patients, as lists were only run with adequate staffing, there were times when lists may be cancelled.

The trust had appointed their first surgical consultant nurse for the gastrointestinal service.

**St Michael’s Hospital**

At St Michael’s Hospital extra nursing staff had been recruited in preparation for the changes to the admission criteria from October 2018. The ward manager told us most of these staff were currently working on Constantine ward at Royal Cornwall Hospital but would be transferring over in October when the Constantine ward closed and the new orthopaedic project was up and running at St Michael’s Hospital.

The ward manager told us they had been recruiting staff since April 2018 to ensure the higher care bay could be safely staffed. This included the recruitment of eight band 5 nurses and 2.29 band 6 nurses. In total nine of the eleven whole time equivalent additional staff had been appointed. Recruitment had included travelling overseas to appoint appropriately qualified theatre staff.

Ward nurses told us they regularly had to be moved for shifts to support the Royal Cornwall Hospital. Staff reported they were sometimes asked to go to non-surgical clinical areas and this did not always feel match their skills. However, staff we spoke with told us they felt able to speak
up about this and were supported by ward managers in this matter. The ward manager told us staff had been flexible in meeting the needs of patients across the trust and relocated shifts across the surgical division gave them the opportunity to develop their skills.

Staffing levels and skill mix was planned and reviewed using relevant tools to identify the appropriate staffing numbers for theatre lists and the acuity of patients on the wards. Theatre staff told us they adhered to the association for perioperative practice (AFPP) guidelines for the number of staff in theatres. We saw this in practice during our inspection. We observed staff discussing the skill mix in theatre during their safety huddle and as a result changes were made to staffing of each theatre to ensure the optimum skill mix was used.

**West Cornwall Hospital**

The theatre/ward manager told us the skill mix and overall staffing numbers were based on service needs. The surgical nursing team at West Cornwall Hospital covered theatres, the ward and the treatment centre. Bank and agency staff were used minimally. Theatre and ward staff worked flexibly to meet the needs of patients. For example, the ward was covered from 7 am to 8pm, however if a patient deteriorated post operatively then nursing staff would sometimes have to stay beyond the end of their shift.

Nursing staff worked in theatres, the ward and the treatment centre. Staff told us they regularly worked in the same area, although cross cover was also possible during times of staff shortages. Staff we spoke with told us they believed there were staff shortages across the surgical services at West Cornwall Hospital. However, they had been told by managers staffing numbers were close to as planned. The theatre/ward manager told us staff did have to work long days sometimes, particularly if a patient had deteriorated. However, they also told us there were times when lists finished early and patients were discharged ahead of schedule and staff could take time back.

**Planned vs actual**

The trust has reported their staffing numbers below as at April 2018 for nursing staff in surgery, with an overall staffing rate of 96.5%.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Planned WTE Staff</th>
<th>Number in post as at April 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>314.7</td>
<td>302.6</td>
<td>96.1%</td>
</tr>
<tr>
<td>St Michael’s Hospital</td>
<td>39.6</td>
<td>38.3</td>
<td>96.8%</td>
</tr>
<tr>
<td>West Cornwall Hospital</td>
<td>41.2</td>
<td>41.0</td>
<td>99.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>395.5</strong></td>
<td><strong>381.9</strong></td>
<td><strong>96.5%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

**Vacancy rates**

From May 2017 to April 2018, the trust reported a vacancy rate of 11.5% in surgery, compared to a target of 10% at March 2018 and 6% at March 2019. A site breakdown is below:

- Royal Cornwall Hospital: 12.0%
- St Michael’s Hospital: 11.9%
- West Cornwall Hospital: 7.6%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 8.4% in surgery, compared to a target range of 10-14%. A site breakdown is below:
• Royal Cornwall Hospital: 9.5%
• St Michael’s Hospital: 9.7%
• West Cornwall Hospital: 0.0%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From May 2017 to April 2018, the trust reported a sickness rate of 5.8% in surgery, compared to a target of 3.8%. A site breakdown is below:
• Royal Cornwall Hospital: 5.9%
• St Michael’s Hospital: 6.3%
• West Cornwall Hospital: 4.5%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

Trust wide
From May 2017 to April 2018, the trust reported 2,910 bank shifts and 38 agency shifts were filled by nursing assistants in surgery trust wide. There were 31 shifts that were unfilled.

During the same period, the trust reported 1,422 bank shifts and 1,688 agency shifts were filled by qualified nurses. There were 215 shifts that were unfilled.

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>2,910</td>
<td>1,422</td>
<td>4,332</td>
</tr>
<tr>
<td>Agency</td>
<td>38</td>
<td>1,688</td>
<td>1,726</td>
</tr>
<tr>
<td>Not filled</td>
<td>31</td>
<td>215</td>
<td>246</td>
</tr>
</tbody>
</table>

Royal Cornwall Hospital
From May 2017 to April 2018, the trust reported 2,700 bank shifts and 38 agency shifts were filled by nursing assistants in surgery at Royal Cornwall Hospital. There were 31 shifts that were unfilled.

During the same period, the trust reported 1,392 bank shifts and 1,556 agency shifts were filled by qualified nurses. There were 207 shifts that were unfilled.

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>2,700</td>
<td>1,392</td>
<td>4,092</td>
</tr>
<tr>
<td>Agency</td>
<td>38</td>
<td>1,556</td>
<td>1,594</td>
</tr>
<tr>
<td>Not filled</td>
<td>31</td>
<td>207</td>
<td>238</td>
</tr>
</tbody>
</table>

St Michael’s Hospital
From May 2017 to April 2018, the trust reported 210 bank shifts and no agency shifts were filled by nursing assistants in surgery at St Michael’s Hospital. There were no shifts that were unfilled.

During the same period, the trust reported 30 bank shifts and no agency shifts were filled by qualified nurses. There were no shifts that were unfilled.

<table>
<thead>
<tr>
<th>Bank/ agency</th>
<th>Nursing Assistant</th>
<th>Qualified nurse</th>
<th>Total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>210</td>
<td>30</td>
<td>240</td>
</tr>
<tr>
<td>Agency</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not filled</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

West Cornwall Hospital
From May 2017 to April 2018, the trust reported 137 agency shifts were filled by qualified nurses in surgery at St Michael’s Hospital. There were seven shifts that were unfilled.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurse</th>
<th>Total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Agency</td>
<td>132</td>
<td>132</td>
</tr>
<tr>
<td>Not filled</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

The trust had medical vacancies, and this fluctuated between the specialties. In June 2018 the division reported 36.31 WTE medical vacancies, which was 11.77% vacancy rate.

Six new anaesthetists had been appointed to join the trust between September and October 2018. Although this bridged a gap there were still vacancies.

The deanery removed all foundation two medical posts to redistribute to general practice. Since August 2018 the division has been using first physician associates and the trauma coordinator has trained as a trauma specialist nurse.

**Royal Cornwall Hospital**

There were arrangements for each specialty to ensure medical cover was available both in and out of hours on weekdays and weekends. Nursing teams spoken with were positive about the level of medical cover on surgical wards. The junior medical team felt they worked in a supportive environment and out of hours could contact consultants on their mobile phone for advice.

Following a serious incident, which was being investigated at the time of our inspection, anaesthetic cover out of hours was being increased to ensure clinicians were available to manage airways in the event of an emergency. The anaesthetic on-call group now attended the hospital at 8pm for a handover with critical care and anaesthetic colleagues, to determine and meet the airway competent provision for the evening, and to plan for the emergency 24-hour theatre and trauma. This same group attended the hospital post 11pm if the registrar anaesthetist took a patient to theatre, in the absence of an airway competent provision from critical care within the hospital.

A trauma ward round was completed by the medical team seven days a week. The team meet in the morning to discuss all patients and review scans before visiting the patient on the ward.

An elderly care team was available to visit patients post operatively for hip fractures.

**St Michael’s Hospital**

There were three resident medical officers in post and one locum at St Michael’s Hospital. The resident medical officers were trust grade doctors working in the NHS in a non-training post, at senior house officer level. The resident medical officers worked 12-hour shifts covering a 24-hour period. We spoke with one resident medical officer who told us generally their work level was manageable, however at busy times the workload could be difficult. Staff told us it had been recognised there needed to be better cover and support for resident medical officers, in particular with the planned changes to patient acuity and the addition of the higher care bay within the hospital.

Senior medical support was provided by the surgical consultants and out of hours support was provided by the trauma consultant on call. Staff we spoke with told us consultants were supportive, however when new medical staff start in post they aren’t always aware of the role of the resident.
medical officer which can lead to the post holders having to explain their role when asking for additional support.

**West Cornwall Hospital**

Medical cover at West Cornwall Hospital was provided by the trust wide surgeons and anaesthetists during theatre lists. They would review patients pre- and post-operatively. However, they would regularly leave the hospital while patients were still in recovery or on the wards. This meant should a patient deteriorate after this then medical support had to be sought from other doctors within the hospital.

Additional medical support was provided by a junior doctor on the medical wards at the West Cornwall Hospital and staff working within urgent care. Nursing staff could obtain surgical advice from the on-call team at the Royal Cornwall Hospital and staff told us some surgeons were happy to be contacted directly once they had left the hospital.

**Planned vs actual**

The trust has reported their staffing numbers below as at April 2018 for medical staff in surgery, with an over-established staffing rate of 1.4%.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Planned WTE Staff</th>
<th>Number in post as at April 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>284.8</td>
<td>287.7</td>
<td>Over-established by 1%</td>
</tr>
<tr>
<td>St Michael’s Hospital</td>
<td>4.2</td>
<td>5.5</td>
<td>Over-established by 30.2%</td>
</tr>
<tr>
<td>Total</td>
<td>289.0</td>
<td>293.2</td>
<td>Over-established by 1.4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From May 2017 to April 2018, the trust reported a vacancy rate of 15.2% in surgery, compared to a target of 10% at March 2018 and 6% at March 2019. A site breakdown is below:

- Royal Cornwall Hospital: 15.0%
- St Michael’s Hospital: 30.3%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 16.1% in surgery, compared to a target range of 10-14%. A site breakdown is below:

- Royal Cornwall Hospital: 16.3%
- St Michael’s Hospital: 0.0%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From May 2017 to April 2018, the trust reported a sickness rate of 2.2% in surgery, compared to a target of 3.8%. A site breakdown is below:

- Royal Cornwall Hospital: 2.2%
- St Michael’s Hospital: 0.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**
Please note we were unable to calculate locum usage as a proportion of the total number of shifts available due to the fact the trust was unable to provide the total number of available shifts including those covered by permanent staff. In addition, no site level breakdown was provided.

From May 2017 to April 2018, the trust reported that 1,525 shifts were filled by locum staff in surgery. There were 595 shifts unfilled by locum staff.

A breakdown of the shifts by staffing group is shown below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>365</td>
<td>152</td>
</tr>
<tr>
<td>Middle grades</td>
<td>58</td>
<td>78</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>1,102</td>
<td>365</td>
</tr>
<tr>
<td>Total</td>
<td>1,525</td>
<td>595</td>
</tr>
</tbody>
</table>

The trust stated in their RPIR that they do not keep information regarding bank shifts filled centrally and so do not have the information available, which has highlighted the need to collate this and will work on this for the future.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

From March 2018, the proportions of consultant and junior (foundation year 1-2) staff reported to be working at the trust were higher than the England averages.

**Staffing skill mix for the whole time equivalent staff working at Royal Cornwall Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>54%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>22%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>14%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

**Records**

Staff completed individual patient care records well. They were comprehensive, clear, legible, and were signed and dated for accountability. Records contained individual management plans, evidence of daily reviews, risk assessments and multidisciplinary care records.

Risk assessments included areas such as infection control, falls, pressure ulcers, nutrition, manual handling and venous thromboembolism. Pre-operative assessments were recorded and completed in full for the five patient records we viewed.
All records were observed to be stored securely across the surgical wards and units. Records were held in key pad lockable cabinets.

**Royal Cornwall Hospital**
We viewed 11 patient records. Records clearly showed the input from the multidisciplinary team and these were clearly in one place in a contemporaneous order.

**St Michael’s Hospital**
We viewed five individual patient records and saw these were accurate and complete.

The multidisciplinary team including nursing, therapy and medical staff recorded the care and treatment delivered in the shared care record. There were clear records to ensure care and treatment was communicated and information easily accessible to members of the multidisciplinary team.

The resident medical officers completed discharge summaries as part of their daily ward round. The discharge summary was then posted to the patient’s GP and a copy given to the patient.

**West Cornwall Hospital**
We viewed six individual patient records and saw these were accurate and generally complete.

**Medicines**
Medicines were well managed and stored securely. We randomly sampled medicines across surgical wards and within theatres. The clinic rooms were clean, and medicines stored safely. All medicines checked were in date.

Medicines were stored at the correct temperature as per the manufacturer’s recommendations. Fridge temperatures and clinic room temperatures were monitored remotely by pharmacy department and action was taken if they were outside the required temperature range.

Controlled drugs were stored securely, and stock levels monitored on a twice daily basis by two registered nurses. Records of stock levels were maintained and those we viewed were accurate and recorded completely. There was only one controlled drug key in use for each controlled drug cupboard, this was in line with trust policy and only authorised staff could access the key.

Patient’s own medicines followed the patient around the hospital and were kept securely whilst patients were on the wards, patient’s own controlled drugs were stored separately in the controlled drugs cupboard.

There was an electronic prescribing and administration system in use and only trained staff could access this system. This system would flag if any medication was not recorded as administered or offered to the patient. Allergies were clearly recorded in patient records.

There was an open culture for reporting medicines incidents, these were investigated and were reported to the medicines safety committee. Learning from incidents was identified and the information disseminated across the organisation.

**Royal Cornwall Hospital**
Staff had good access to pharmacy support and an on-call arrangement out of hours. The service had an in-house pharmacy service which provided a supply function and a clinical pharmacy service. Audits were carried out of the management of controlled drugs and medicines storage.

**St Michael's Hospital**
Ward staff carried out medication expiry audit every month. All medicines we reviewed were within their expiry date except for a transparent film dressing spray which had expired. This was raised with staff at the time of inspection and removed from use.

As part of the admission process patient own medicines were logged and when the patient was transferred to theatre these were then taken to the inpatient ward in anticipation of the patient’s admission post operatively.

Pharmacy input at St Michael’s Hospital was provided on an ad hoc basis with some areas of activity monitored remotely. For example, staff kept records of the use of prescriptions for patient medicines to take home on discharge. These were then sent to pharmacy where they were monitored. Staff told us pharmacy input had been inconsistent. However, with the new development of the hospital to include more surgical patient throughput, dedicated pharmacy staff had been recruited for St Michael’s Hospital. These staff were due to start in post from October 2018.

West Cornwall Hospital
Ward staff carried out medication expiry audit every month. All medicines we reviewed were within their expiry date. The onsite pharmacy staff also monitored stock and provided support to staff around the management of medicines.

In ophthalmology theatres we observed syringes used as part of the procedure were not labelled to indicate what medicine or substance they contained. While the nursing staff who prepared the syringes was seen to have stayed with them, the lack of labelling posed an increased risk of mistakes happening. We spoke with the theatre/ward manager who told us they now had pre-prepared labels as part of their ophthalmology packs and these should have been used. Following this, the theatre/ward manager told us they were planning on raising the issue in theatre safety huddles to ensure the labels were consistently used.

Incidents
Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and to report them when necessary. Incidents were recorded on the trust’s incident system, each incident was reviewed and investigated as appropriate, co-ordinated by the surgical governance team. All staff we spoke with told us they felt confident reporting incidents to their managers. Staff also told us they received feedback from their manager and incidents were openly discussed and learning and changes to practice identified and shared.

Duty of Candour, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires a provider to be open and transparent with a patient or other relevant person when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.

Staff understood the term duty of candour and could provide examples of how they have or would apply this. The surgical governance team were responsible for confirming the duty of candour had been completed and providing any follow-up letters as required. Some staff were duty of candour champions, we met one during our inspection.

Mortality and morbidity meetings were held regularly for specialties, and we were told these were well attended by medical staff. We requested some example meeting minutes to review the content of these meetings and confirm attendance, however this was not provided to us.

Incidents were openly discussed at ward and theatre safety huddles. We observed good practice across all theatres where an incident relating to consent was shared with all staff, we observed this in both Trelawny theatre and West Cornwall theatre. Staff were reminded of the importance of
ensuring consent had been properly obtained and recorded before the patient goes to theatre and required checks were carried out by all staff. We were also told one of the anaesthetists had sent all band 7 nurses emails about the consent issue and the need to check the appropriate consent form was used, particularly when locum surgeons were working in theatres.

**Royal Cornwall Hospital**

Staff spoken with were aware of learning from recent incidents. For example, a focus on completing nursing observations in a timely way following an increase in pressure ulcers.

**St Michael's Hospital**

Ward and theatre managers told us they had access to incidents from other surgical sites across the trust. They told us this meant learning could be shared across locations. In addition, senior staff told us they would routinely share learning from incidents with all band seven nurses across the division via email. This ensured information was shared across the trust. Changes had been made because of incidents on other sites included tagging of prosthesis’ and changing the layout of storage within theatres. In addition, changes to the WHO surgical checklist had included the addition of the removal of all metal work and the number of pieces removed were now logged on the white board in theatres.

**West Cornwall Hospital**

Monthly audit meetings were held with a focus on staff learning. However, safety incidents were not consistently discussed or reviewed at these meetings. Staff told us incidents were generally discussed at the safety huddles and ward managers had an overview of the incidents across the trust and the learning to be shared. The theatre/ward manager told us they received a four-weekly report on action to be taken because of incidents and areas that need reviewing. Staff told us they believed the service had improved the way they managed incidents. There was a debrief at the end of each theatre list to discuss what went well and what could have been better.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported two surgical/invasive procedure incidents classified as never events for surgery. One incident was for an incomplete surgical procedure and the other was for wrong site surgery. The incomplete surgical procedure was identified during this reporting period but was not attributable to a surgical procedure within the last year.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 39 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from June 2017 to May 2018. The site at which the incident occurred was not specified in most cases.

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with 17 (43.6% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with nine (23.1% of total incidents).
- VTE meeting SI criteria with three (7.7% of total incidents).
- Slips/trips/falls incident meeting SI criteria with three (7.7% of total incidents).
Medication incident meeting SI criteria with three (7.7% of total incidents).

(Source: Strategic Executive Information System (STEIS))

**Safety thermometer**

The incidence of pressure ulcers, falls, catheters and UTIs, and Venous Thromboembolism (VTE) was monitored to review the level of patient harm.

Equipment was available to aim to reduce the level of harm caused to patients. For example, pressure relieving mattresses were provided to reduce incidence of pressure ulcer and sensor mats to alert to staff if vulnerable patients move out of bed to reduce the incidents of falls.

Pressure ulcers were incident reported and a root cause analysis was completed within 24 hours. The root cause analysis was an initial pressure ulcer investigation. It reviewed the information captured at admission, the preventative measures in place, the root cause of damage, service delivery problems and any immediate lessons learnt. Staff explained about lessons learnt from pressure ulcer incidents and how they had received further education to aim to prevent their occurrence.

There was a trust tissue viability team and link nurses for tissue viability on the wards. Staff told us the tissue viability team were available to support and would review patients as required.

All patients on admission received an assessment of VTE. VTE risk assessments were completed electronically for all patients, a patient could not progress with their surgery until this was complete.

**Safety Thermometer Data**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed the trust reported 21 new pressure ulcers, six falls with harm and three new urinary tract infections in patients with a catheter from May 2017 to May 2018 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Royal Cornwall Hospitals NHS Trust**

![Graph showing prevalence rates of pressure ulcers, falls, and UTIs](chart.png)
Total Falls (6)

3 Total CUTIs (3)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only
(Source: NHS Digital)

Royal Cornwall Hospital

Ward managers shared safety thermometer information with staff to encourage improvement. The service displayed safety thermometer safety crosses at the entrances to surgical wards we visited. The number of harm free days were marked with green crosses and the days with harm in red.

Trauma unit had seen a reduction in their number of patient falls. They worked collaboratively with the physiotherapists, who took patients lying and standing blood pressures, to help reduce their falls.

Enhanced care was provided to patients who were a high falls risks. We saw evidence of this on both the trauma unit and the surgical admission lounge at the time of our inspection.

St Michael's Hospital

The number of falls and pressure ulcers were recorded and displayed on St Joseph's ward for the days that had passed in September 2018. During this time the ward had reported no new pressure ulcers and no new falls. The overall number of harm free days was not displayed on the ward. However, the ward manager told us improving harm free care was a priority for the trust.

West Cornwall Hospital

Safety thermometer information was not displayed on the surgical ward at West Cornwall Hospital.

Is the service effective?

Evidence-based care and treatment

People's needs were holistically assessed, and their care, treatment and support delivered in line with legislation, standards and evidence-based guidance. Policies, procedures and standard operating protocols were based on national guidance from sources such as the National Institute for Health and Care Excellence (NICE) and the Association for Perioperative Practice (AfPP).

The service used the World Health Organisation (WHO) surgical checklists and these had been adapted for different surgical specialities. For example, a basic checklist was available to cover any procedure, plus speciality checklists were available for different types of surgery such as breast, ophthalmology and orthopaedic surgery.
The surgical division were reviewing and streamlining all surgical pathways to help improve delivery. For example, the fractured neck of femur, cholecystitis, glue ear and back pain.

**Nutrition and hydration**

Staff assessed patients’ nutrition and hydration needs on admission and regularly during a patient’s stay. The trust used the malnutrition universal screening tool, and nutritional care plans were completed for patients who were malnourished or at risk of malnutrition.

Food and hydration charts were used to monitor patient food and drink intake. Housekeepers were made aware of patient dietary requirements to ensure their nutritional needs were met.

Dietitians were available to support patients to meet their dietary needs. Dietary input was particularly important for patients in hospital for gastrointestinal diseases and disorders.

We saw nurses clearly explained fasting instructions for the day of surgery to patients during pre-operative assessments. Patients were nil by mouth before surgery. We observed nursing staff checking with patients when they last ate or drank as part of the pre-operative assessment processes. When patients were informed of their surgery they were told when to be nil by mouth from. However, nursing staff told us when patients arrived on the ward this was reviewed based on where the patient was on the theatre list. For example, we observed a patient who had been told to be nil by mouth from midnight but when they arrived nursing staff thought this was unnecessary as they were at the end of the theatre list. As a result, nurses spoke with the anaesthetist to review this and the patient was subsequently given a light breakfast and able to drink clear fluids until mid-morning.

After surgery staff provided patients with fluids and encouraged to drink. Light snacks were also available for patients post-operatively.

Patients were assessed for any signs of nausea or vomiting, and anti-sickness medicines were prescribed, administered and monitored for their effectiveness.

**Pain relief**

Staff regularly assessed and managed patient’s pain. Patients told us their pain was managed well and they received timely pain relief. Nurses regularly assessed pain levels and recorded on the electronic observation system.

Staff told us pain management started before surgery and we observed staff explaining the type and likelihood of pain to patients as part of the pre-operative assessment. We also observed staff discussing the ways they would support patients in managing their pain.

Handovers included discussions about patient pain and their pain relief needs. Patients were prescribed medicines to manage their pain, either on a regular basis or ‘as required’. We observed patients being encouraged to inform nursing staff of any pain they were experiencing. This was particularly the case for patients recovering from orthopaedic surgery where they were encouraged to take regular pain relief to ensure they could mobilise effectively to enhance their recovery.

The trust had a 24-hour consultant-led dedicated pain team. We confirmed they were working in line with the key pain management standards for surgery:

1. Acute pain management must be supervised by consultants and specialist nurses with appropriate training and competencies.
2. All patients with acute pain must have an individualised analgesic plan appropriate to their clinical condition that is effective, safe and flexible.
3. All in-patients with acute pain must have regular pain assessment using consistent and validated tools, with results recorded with other vital signs. There should be clear guidelines for communication with the acute pain service.

When reviewing patients record we saw notes inputted by the pain specialist team and record of the analgesia plan.

Therapy staff told us they worked closely with the pain team and could refer patients to this team.

**Patient outcomes**

The effectiveness of care and treatment was reviewed through local and national audit. Outcomes were collected and monitored, and they generally were within the expected range when benchmarked nationally.

Trauma and orthopaedics specialty were involved in several research projects to include; DRAFFT (Distal Radius Fractures), Trigen and HEALTH (NOF) and BOSS (SUFE and Perthes).

28-day readmissions were reviewed at weekly referral to treatment time meetings. In June 2018 there were 16 readmission breaches and in May 2018 there were nine readmission breaches.

The surgical services division was not accredited to the Anaesthesia Clinical Services accreditation (ACSA). This is a voluntary scheme for NHS and independent sector organisations that offers quality improvement through peer review. The strategy of the surgical services is to deliver the guidelines for the provision of anaesthetic services and then once fully addressed to participate in ACSA.

**Relative risk of readmission**

**Trust Level**

From February 2017 to January 2018, all patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.

- ENT patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

- Trauma & orthopaedics patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Graph showing relative risk of readmission for different specialties.](image)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

All patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average of 100.
- General surgery patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average of 100.
- Trauma & orthopaedics patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average of 100.
- Urology patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average of 100.

**Non-Elective Admissions – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Ratio of Observed to Expected Emergency Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>90</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>75</td>
</tr>
<tr>
<td>Urology</td>
<td>60</td>
</tr>
</tbody>
</table>

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*

**Royal Cornwall Hospital (Treliske)**

From February 2017 to January 2018, all patients at Royal Cornwall Hospital had a similar to expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at Royal Cornwall Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
- ENT patients at Royal Cornwall Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Upper gastrointestinal surgery patients at Royal Cornwall Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions - Royal Cornwall Hospital**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Ratio of Observed to Expected Emergency Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>100</td>
</tr>
<tr>
<td>Urology</td>
<td>90</td>
</tr>
<tr>
<td>Upper Gastrointestinal Surgery</td>
<td>85</td>
</tr>
</tbody>
</table>

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity*

All patients at Royal Cornwall Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average of 100.

- General surgery patients at Royal Cornwall Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average of 100.
- Trauma & orthopaedics patients at Royal Cornwall Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average of 100.
• Urology patients at Royal Cornwall Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average of 100.

Non-Elective Admissions - *Royal Cornwall Hospital*

![Graph](image)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

**St Michael's Hospital**

From February 2017 to January 2018, all patients at St Michael's Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average of 100.

• Trauma & orthopaedics patients at St Michael's Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average of 100.

• Breast surgery patients at St Michael's Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average of 100.

• Vascular surgery patients at St Michael's Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average of 100.

Elective Admissions - *St Michael's Hospital*

![Graph](image)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

All patients at St Michael's Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average of 100.

• Breast surgery patients at St Michael's Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - *St Michael's Hospital*
From February 2017 to January 2018, all patients at West Cornwall Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Upper gastrointestinal surgery patients at West Cornwall Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at West Cornwall Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Colorectal surgery patients at West Cornwall Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions - West Cornwall Hospital**

All patients at West Cornwall Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Trauma & orthopaedics patients at West Cornwall Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

**Non-Elective Admissions - West Cornwall Hospital**

(Source: HES - Readmissions (February 2017 – January 2018))
National Hip Fracture Audit

In the 2017 National Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.4% which was within the expected range. The 2016 figure was 8.0%.

The proportion of patients having surgery on the day of or day after admission was 79.8%, which failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 65.9%.

The perioperative medical assessment rate was 95.5%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 92.8%.

The proportion of patients not developing pressure ulcers was 97.7%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 98.2%.

The length of stay was 16.7 days, which falls within the top 25% of trusts. The 2016 figure was 16.7 days.

(Source: National Hip Fracture Database 2017)

National Bowel Cancer Audit

In the 2017 National Bowel Cancer Audit, 46.4% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate of 69.5%. The 2016 figure was 43.2%.

The risk-adjusted 90-day post-operative mortality rate was 4.3% which was within the expected range. The 2016 figure was 2.4%.

The risk-adjusted 2-year post-operative mortality rate was 21.8% which was within the expected range. The 2016 figure was 24.8%.

The risk-adjusted 30-day unplanned readmission rate was 15.6% which was worse than expected. The 2016 figure was 12.2%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 52.0% which was within the expected range. The 2016 figure was 55.5%.

(Source: National Bowel Cancer Audit 2017)

National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.2% for abdominal aortic aneurysms, which was as expected. The 2016 figure was 0%.

Within carotid endarterectomy, the median time from symptom to surgery was 16 days, which was worse than the audit aspirational standard of 14 days. The 2016 figure was eight days.

The 30-day risk-adjusted mortality and stroke rate was 3.3%. This was within the expected range. The 2016 figure was 3.1%.

(Source: National Vascular Registry 2017)

National Oesophago-Gastric Cancer Audit

In the 2016 National Oesophago-Gastric Cancer Audit, the age and sex adjusted proportion of patients diagnosed after an emergency admission was 2.1%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 4.4%.

The trust was not eligible for the metric relating to the 90-day post-operative mortality rate.
The proportion of patients treated with curative intent in the Strategic Clinical Network was 36.7%. This was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2016)

**National Emergency Laparotomy Audit**

The National Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2017 National Emergency Laparotomy Audit (NELA), Royal Cornwall Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 115 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 91 cases.

The site achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 71 cases.

The site achieved an amber rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 53 cases.

The risk-adjusted 30-day mortality for the site was within the expected range. This was based on 115 cases.

(Source: National Emergency Laparotomy Audit)

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting they feel worse can be viewed on the left.
In relation to performance on groin hernias in 2016/17, the trust’s performance did not worsen as much as the England average for EQ VAS and performance did not improve as much as the England average for the EQ-5D index.

For varicose veins, performance was about the same as the England average. However, for the EQ-5D index the trust did not improve as much as the England average did.

For hip replacements, performance was about the same as the England average for the EQ-5D index and the Oxford hip score. However, for EQ VAS, the trust worsened more and improved less than the England average.

For knee replacements, performance was about the same as the England average.

(Source: NHS Digital)

**Orthopaedic Enhanced Recovery After Surgery Programme**

An enhanced recovery after surgery programme was delivered at St Michael’s Hospital improving patient outcomes and post-operative recovery. This programme was not available at Royal Cornwall Hospital.

The therapy service at St Michael’s Hospital was based on the national Enhanced Recovery After Surgery (ERAS) model for orthopaedic patients. The model provided a multidisciplinary approach to improving patient outcomes and keeping the post-operative length of stay in hospital to a minimum. At the time of our inspection the average length of stay on St Joseph’s ward following hip or knee surgery was 3.3 days with 38% of patients being mobilised on the day of their surgery. Data provided by the trust showed over a 13-month period between July 2017 and July 2018 an average of 41.6% of patients mobilised on the day of surgery. At our previous inspection in July 2017 the percentage of patients mobilised on the day of surgery was 34%, therefore improvements continued to be made in this area.

This enhanced recovery after surgery programme included pre-operative input that included training orthopaedic patients to use crutches and identifying their equipment needs before surgery, so all equipment was available, and delays minimised.

The service ran a ‘joint school’ as part of their enhanced recovery programme. Weekly ‘joint schools’ were held on St Michael’s ward, one for patients having knee surgery and one for hip surgery. Patients were given the opportunity to meet other patients having similar surgery while providing multidisciplinary information, support and education around the surgery, recovery and rehabilitation.
As part of our inspection we observed part of a ‘joint school’ session for patients having hip surgery. The session provided patients with advice and practical information and was open to both patients and their relatives to attend. Information and advice included:

- Nursing input on what will happen on the day of surgery, including information about eating and drinking, medicines, pain relief and what to expect after surgery.
- The therapy staff gave advice on how to mobilise after the surgery, providing demonstrations on activities such as how to get in and out of a car without crossing their legs.
- The physiotherapist showed the patients how to use crutches and they were then given time to practice using crutches with practical support and advice. Also show some more movements and advice on mobilising.

Staff told us the joint school had been running for a couple of years and since January 2018 had been multidisciplinary. A physiotherapist we spoke with told us by providing a group session pre-operatively and encouraging patients to practice using crutches before surgery, they could focus their time post-operatively where it was most needed. They told us they were working on a case study to use it in presentations to demonstrate the effectiveness of the group approach.

One of the main aims of the enhanced recovery programme was to mobilise patients on the day of their surgery. Staff told us they continually reviewed their support of patients in relation to the outcome data they collected and collated. For example, they were reviewing barriers to achieving 100% of patients mobilising on their day of surgery, this included aspects such as access to x-ray and working to improve this.

Staff told us they focused on patient discharge as part of the admission process. The aim of this was to improve patient’s confidence post operatively and set goals that were focused on a speedy and effective recovery.

**West Cornwall Hospital**

We reviewed data for post-operative transfers of patients. Nine patients receiving surgery at West Cornwall Hospital were transferred to the Royal Cornwall Hospital between 1 September 2017 and 31 August 2018. These transfers were due to post-operative complications requiring an inpatient admission.

**Competent staff**

Staff spoken with were mostly positive about the support they received to ensure their competency in their role. Junior doctors consistently told us they had good support from the consultants. We did find differences across the three sites, with the level of formalised competency assessments.

**Appraisal rates**

There was an improvement plan to support increased compliance with appraisals. Most staff we spoke with had completed their annual appraisal in the past year. We were told annual appraisals were used to discuss staff areas of interest and identify skill gaps. This would allow training and support to be sought.

**Trust wide:**

Up to August 2018, 79.0% of medical staff and 65.2% of nursing staff within surgery at the trust had received an appraisal, compared to the trust target of 95%.

A split by location and staff group can be seen in the tables below:
### Royal Cornwall Hospital:
At Royal Cornwall Hospital, the completion rate for medical staff was 79.6% and nursing staff had a 66.4% completion rate.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff – Hospital</td>
<td>129</td>
<td>162</td>
<td>79.6%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>39</td>
<td>51</td>
<td>76.5%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>14</td>
<td>21</td>
<td>66.7%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>217</td>
<td>333</td>
<td>65.2%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>147</td>
<td>245</td>
<td>60.0%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff</td>
<td>51</td>
<td>86</td>
<td>59.3%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical staff</td>
<td>31</td>
<td>64</td>
<td>48.4%</td>
</tr>
</tbody>
</table>

### St Michael’s Hospital:
At St Michael’s Hospital, the completion rate for medical staff was 60% and nursing staff had a 46.9% completion rate.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff – Hospital</td>
<td>3</td>
<td>5</td>
<td>60.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>10</td>
<td>19</td>
<td>52.6%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>15</td>
<td>32</td>
<td>46.9%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>1</td>
<td>8</td>
<td>12.5%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff</td>
<td>1</td>
<td>14</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

### West Cornwall Hospital:
At West Cornwall Hospital, the completion rate for nursing staff was 71.8%. There are no medical staff in surgery at West Cornwall Hospital.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>28</td>
<td>39</td>
<td>71.8%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>18</td>
<td>27</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

*Source: Routine Provider Information Request (RPIR) – Appraisal tab*
agency staff, but this was more of a familiarisation and orientation rather than an in-depth induction. Agency staff confirmed they had received an induction to the ward and knew who to speak with if they had any concerns.

There were different levels of competency assessments dependent which specialty staff were working within. Some wards did not have formalised competency frameworks but were considering how to implement these. Staff also raised concerns about the number of medical outliers on the surgical wards and their competency to care for and treat these patients.

There were no formal arrangements for clinical supervision. Clinical supervision was done informally as part of team meetings.

Staff had good opportunities to develop in the trust and access to further training and development. For example, we spoke with newly qualified nurses who were completing their mentorship training and a band six nurse who had started at the trust as a healthcare assistant. There was access to simulation training, for example practising responding to a medical emergency.

Theatre assistants were signed off as competent by a trained person as part of their induction. This was completed within four to six weeks of starting in post. Some theatre assistants were progressing to do an apprenticeship, extended scrub skills or operating department practitioner training.

St Michael’s Hospital

Staff told us they were supported in their training and education to develop their skills and competencies. There was a competency framework which included competency passports being issued to staff when their competency assessments had been completed. This included competencies for different clinical activities and different staff groups, for example there were specific theatre competencies and those for newly qualified staff working at the hospital as part of the trust’s induction programme. Therapy staff told us they were in the process of developing a generic competency framework for band 3 and band 4 therapy staff with the involvement of the relevant staff. Staff told us competencies were reviewed as part of the annual appraisal process. One member of nursing staff who was new in post told us they had completed specific orthopaedic competency assessments as part of their induction, as well as competency checks of existing skills such as the administration of intravenous medicines and venepuncture.

Staff told us senior staff were very good at providing support and training during day to day working. For example, one nurse told us they had received support and training from the ward sister in the use of a pain buster (a local anaesthetic infusion to reduce pain after surgery).

With the development of enhanced higher care bay at St Michael’s Hospital due to start in October 2018, clinical staff had been provided with additional training and support to develop more acute care skills to care for less stable patients than were being cared for at the time of inspection. The St Michael’s development day training included additional training in recognising and caring for the deteriorating patient, recognising sepsis and the use of relevant protocols, transferring patients and intermediate as well as basic life support skills. In addition, staff were working at Constantine ward at the Royal Cornwall Hospital on a rotational basis to provide support and develop their skills.

West Cornwall Hospital

Appraisals and renewals of competency passports/assessments were managed by the deputy managers on the ward. A deputy manager we spoke with told us they received alerts for competency renewals 12 weeks in advance, so they could manage the update and renewal
process. Competency packs and training days were provided for staff, for example, relating to catheter care, undertaking an electro card iogram, venepuncture and cannulation.

Managers told us staff were encouraged to share learning with the unit and we saw evidence of this where a member of developed an information board for staff and visitors on safeguarding and how to raise safeguarding concerns.

**Multidisciplinary working**

Staff, teams and services within and across the organisation worked together to deliver effective care and treatment. All necessary staff were involved in assessing, planning and delivering care and treatment.

Arrangements for discharge were considered before elective surgery, on admission and throughout the patient’s stay in hospital. Key information was communicated to any onward care and the patient’s GP at discharge.

**Royal Cornwall Hospital**

At the Royal Cornwall Hospital, the multidisciplinary team were involved and worked together to deliver the most effective care and treatment to patients. Staff reported good working relationships between different teams and we observed this in practice.

Speaking to therapy staff they told us they had a lot of input and were part of the decision making of the discharge planning for patients.

Consultants spoken with spoke of a cohesive environment, and good links and working relationships with other departments and trusts, to deliver effective care and treatment to patients.

**St Michael’s Hospital**

Staff across a variety of disciplines worked together to deliver effective care and treatment. There was a multidisciplinary approach to assessing, planning and delivering care and treatment to patients. As part of the enhanced recovery programme for patients receiving elective joint surgery, there was a multidisciplinary approach involving input from medical, nursing, and physiotherapy and occupational therapy staff.

Staff we spoke with consistently told us the multidisciplinary approach worked very well at St Michael’s. We observed multidisciplinary support provided to patients as part of the enhanced recovery programme and saw this was both integrated and collaborative. Patients we spoke with reported the support they needed was there and staff worked well together to ensure their care was of a good standard.

We observed a multidisciplinary daily huddle on the ward where staff from medical, nursing and therapy disciplines reviewed the care of each patient on the inpatient ward. This ensured all staff had a comprehensive understanding of the issues and care needs of each patient and they worked together to provide cohesive care.

Collaborative working had a positive impact on the ability of the service to discharge patients home within a relatively short time after surgery.

There was good team working within theatres. Staff worked together to ensure the appropriate skill mix of staff was available for each theatre list. Consultant surgeons told us there was a cohesive, professional approach within theatres.

**West Cornwall Hospital**

Staff working within the surgical services at West Cornwall Hospital worked collaboratively to deliver care and treatment to patients. We observed good relationships and communication
between staff from different departments. There was a ‘one team’ approach across theatres, the ward and the treatment centre and staff told us there was flexibility to provide support across each department. For example, staff told us if a theatre list finished ahead of schedule then theatre staff were available to provide support to the ward or the treatment centre.

Treatment centre nurses worked with specialist staff when providing assessment and treatment to patients accessing the service. Staff working on the surgical ward could access support from medical staff on the medical wards or in the urgent care centre when there was no surgeon on site during the patient’s post-surgery recovery phase. Staff told us communication was very good across the hospital and there was a collaborative team approach.

**Seven-day services**

The NHS England’s seven-day services priority standards were mostly being met. The trust audited their seven-day services twice a year, autumn and spring. The spring 2018 audit included 16% cases from general surgery and 10% of cases from trauma and orthopaedics.

There was provision for seven-day consultant wards rounds for specialties. Consultants reviewed patients within 14 hours of admission. For the admitting specialty the spring 2018 audit showed general surgery at the weekend saw all nine cases (100%) within 14 hours, and on the weekday 19 out of 26 (73%) of patients were seen within 14 hours. For trauma and orthopaedic surgery all 15 weekday and all seven weekend patients were seen within 14 hours. Patients were made aware of diagnosis, management plan and prognosis within 48 hours of admission. Daily reviews of patients by consultants was achieved in 83% of audited cases for general surgery and 94% of audited cases for trauma and orthopaedics for patients who were delegated a review.

**Royal Cornwall Hospital**

Diagnostic tests and reporting was available on site at weekdays and weekends. To include; CT, microbiology, echocardiography, upper gastrointestinal endoscopy, MRI and ultrasound. Consultant directed interventions were available on site seven days a week to include critical care, emergency general surgery and interventional radiology.

Occupational therapy cover for the surgical wards was provided five days a week, there was no cover at the weekends. We were told there was not enough occupational therapy staff to meet the needs of surgical patients, and the team would need to see the medical outliers on the surgical wards.

Physiotherapy cover for surgical wards was provided Monday to Friday. If surgical patients needed physiotherapy input urgently at the weekends they were added to a list and seen by the hospital wide team. We were told there was not enough staff to meet the needs of surgical patients and there were always patients which were not able to be seen each day.

Pharmacy was accessible Monday to Friday 7am to 7pm, and at weekends and bank holidays between 8.30am and 5pm. Out of hours, staff had access to an on-call pharmacist.

Consultant ward rounds were completed seven days a week. There was cover for the care of the elderly five days a week, but this left a gap at weekends.

**St Michael’s Hospital**

Theatres operated Monday to Friday and on a Saturday morning. Medical cover was provided by surgeons when operations were being carried out and, by resident medical officers who provided 24-hour medical support to the surgical wards across the seven-day service.

Physiotherapy services were provided seven days a week between 7.30am and 8pm. Physiotherapists and physiotherapy assistants/technicians provided up to three sessions a day to
patients as part of the enhanced recovery programme following orthopaedic surgery. Occupational therapists were available Monday to Friday between 9am and 5pm.

There was access to on-site radiology Monday to Friday and a radiographer was on-call at the weekend. Pharmacy input was provided on an ad hoc basis; however, during our inspection we were told pharmacy staff had been recruited to be based at St Michael's Hospital as part of the development of the higher care bay and the provision of elective surgery for less stable patients from October 2018.

**West Cornwall Hospital**

Surgery was provided Monday to Friday between 9am and 5pm on a day surgery basis. The surgical ward was open between 7am and 9pm with flexibility in the case where patients required longer recovery time or were awaiting transfer to an acute bed. Staff we spoke with told us as part of development plans across the trust there had been discussions around expanding the use of West Cornwall Hospital. We viewed this as part of identified surgical service priorities for 2018-19, to better utilise the hospital as part of a broader aim to improve capacity and demand planning and reduce delays.

Pharmacy and radiology services were available on-site Monday to Friday between 8.00am and 5.00pm, with on call services available outside of these times.

**Health promotion**

The surgical service aimed to support people to be as fit as possible for surgery by providing information and guidance to educate patients ahead of their elective surgery. For example, eating the right food, stopping smoking, and reducing alcohol. Patients undergoing orthopaedic surgery were encouraged to mobilise their joints both before and after surgery. Early mobilisation on the day of surgery improved people’s outcomes, this was well embedded at St Michael’s Hospital with their enhanced recovery programme.

**Royal Cornwall Hospital**

We observed a pre-operative assessment at the Royal Cornwall Hospital. We saw stop-smoking information was displayed in the waiting area and patients were referred to services to support them to give up smoking during their pre-operative assessment.

**St Michael’s Hospital**

The service worked to support patients to be fit for surgery. The enhanced recovery programme provided a framework for patients to help prepare them for their joint surgery. All patients were assessed pre-operatively to assess their fitness for surgery and as part of the admission process this was reviewed by nursing and anaesthetic staff on the day of surgery.

Post-operatively patients were given information to support their recovery, and in many cases this process began prior to surgery as part of the enhanced recovery programme. Staff we spoke with told us it was common to begin the process of identifying patients’ needs on discharge at the point where they were admitted. This enabled staff to proactively identify potential issues and begin to address them during the patient’s admission.

**West Cornwall Hospital**

We observed staff assessing patients’ needs as part of their admission/pre-operative assessment processes. These assessments included identifying issues or concerns that may impact on a patient’s recovery. For example, we observed one pre-operative assessment where a patient was asked about their caring responsibilities at home. The staff member provided help and guidance to the patient on what to expect post operatively and what they could feasibly expect to achieve in
the days immediately following surgery. In addition, we observed a patient being asked about their smoking habits as part of a pre-operative assessment where they were also asked if they wanted information and support on stopping smoking.

There were information leaflets in the hospital for patients on several areas impacting health. This included information on areas such as stopping smoking and promoting healthy lifestyles.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood the relevant consent and decision-making requirements of legislation and guidance.

**Mental Capacity Act Training**

Training performance for the mental capacity act was above trust targets. The trust reported their Mental Capacity Act (MCA) level 1 training from May 2017 to April 2018:

- Trust wide they reported 99.0% of staff within surgery were compliant. Medical staff had 93.7% completion rate and nursing staff had a completion rate of 100%.
- For the Royal Cornwall Hospital site 98.8% of staff within surgery were compliant. Medical staff had 93.5% completion rate and nursing staff had a completion rate of 100%.
- For St Michael’s Hospital and West Cornwall Hospital sites 100% of staff within surgery were compliant.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated analysis for April to August 2018 of Mental Capacity Act (MCA) level 1 training found that:

- The trust reported that 99.5% of staff within surgery trust wide were compliant. Medical staff had 97.9% completion rate and nursing staff had a completion rate of 100%.
- For the Royal Cornwall Hospital site 99.5% of staff within surgery were compliant. Medical staff had 97.8% completion rate and nursing staff had a completion rate of 100%.
- For St Michael’s Hospital and West Cornwall Hospital sites, 100% of staff within surgery were compliant.

(Source: Updated data provided by the trust)

**Deprivation of Liberty Training**

The trust compliance in Deprivation of Liberty (Safeguarding Adults Level One), as recorded on the 31 August 2018 was:

- 94.12% compliant for medical and dental staff
- 99.66% compliant for nursing registered
- 99.23% compliant for additional clinical services

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated analysis for April to August 2018 of Deprivation of Liberty (Safeguarding Adults Level One) found that:

- The trust reported that 98.6% of staff within surgery trust wide were compliant. Medical staff had 95.9% completion rate and nursing staff had a completion rate of 99.7%.
- For the Royal Cornwall Hospital site 98.4% of staff within surgery were compliant. Medical staff had 95.6% completion rate and nursing staff had a completion rate of 99.6%.
• For the St Michael's Hospital and West Cornwall Hospital sites, 100% of staff within surgery were compliant.

(Source: Updated data provided by the trust)

Royal Cornwall Hospital

The week of our inspection there was one incident where an incorrect consent form had been completed for a patient’s surgery who was consented on the day of surgery. This resulted in the patient having an unnecessary general anaesthesia as they needed to be woken up to recomplete the consent form. The consent form used was a pre-printed consent form and the incorrect consent form had been used. This identified the consent form was not checked correctly before the patient underwent general anaesthesia, and it was not spotted until the time out of the WHO surgical safety checklist.

Staff were reminded of the importance to ask patients what surgical procedure they were undergoing. We observed good practice where an operating department practitioner asked the patient what operation they were having done and which side they were fixing.

Consent was obtained and recorded on consent forms for all surgical patients we reviewed. However, the completion of consent forms was variable. There were a few instances where elective patients were not consented prior to the day of surgery to allow the patient enough time to make an informed decision. Other times when the patient had been consented a significant time before to the day of surgery the consent form had not been resigned by the healthcare professional on the day of the surgery to confirm the consent.

One patient with a learning disability who had the capacity to consent to surgery was supported to do so by a member of the learning disability team.

Surgeons did not always complete the pre-operative checklist. When reviewing records this section of the perioperative documentation pack was not always complete. The surgeon was required to complete this section before the patient left the ward. This confirmed: the consent form corresponded with the operation list and case notes, the consent form was appropriately signed, the patient had been marked and this matched the operating list and patient notes, VTE prophylaxis considered, compression stockings considered, and blood cross matching considered.

Staff we spoke showed a good awareness of their role in gaining consent and their duties under the Mental Capacity Act 2005. Nurses gave examples of how they would always explain what they were doing to patients including the risks and benefits of procedures. Nurses understood how to support patients who lacked capacity.

There was not a culture of regularly discussing resuscitation decisions with patients. We saw few treatment escalation plans (TEP) completed. There was one example where it would be appropriate to have completed resuscitation decisions for a patient, we reviewed their medical record, this was an elderly patient who had spent some time in critical care, and whose nursing observations showed they were at times medically unstable. We asked a nurse why the patient did not have a TEP form and we were told the nursing staff had requested this, but it had not been completed by medical staff. From talking to staff, we found there was not a culture of regularly discussing resuscitation decisions with patients, and this tended to be done if a patient already had a TEP form in place or if they were particularly poorly. This impacted on patient and their families emotional and psychological wellbeing if this was only completed in line with a life-threatening diagnosis.

St Michael’s Hospital
The service obtained consent from patients through written consent forms and verbally. We observed medical and nursing staff discussing consent with patients and saw comprehensive information was given on the risks and benefits of the intervention.

Staff we spoke with showed an understanding of their responsibilities relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us while they rarely cared for patients living with dementia they had occasionally cared for patients with learning disabilities where decisions had been made in their best interest if they were unable to consent to surgery because of capacity issues.

West Cornwall Hospital
The service obtained consent from patients through written consent forms and verbally. We observed medical and nursing staff discussing consent with patients and saw comprehensive information was given on the risks and benefits of the intervention.

Staff could describe a consent incident at another location in the trust that had occurred during our inspection. They told us information about the incident had been shared during safety huddles and learning identified as a result. This included reminders to staff to double check consent forms used to make sure they were correct, particularly when locum surgeons were working at the hospital.

Is the service caring?

Compassionate care
People were treated with kindness, dignity, respect and compassion. The patients we spoke with during this inspection were mostly positive about the care and treatment they received. We observed positive interactions from the multidisciplinary team with their patients.

Royal Cornwall Hospital
We saw kind and compassionate interactions between staff and patients. Staff introduced themselves to patients in a friendly and professional way and spoke to patients with respect and encouragement. Curtains were always used to ensure patient privacy. There was a chaperone policy for the pre-assessment clinic, this was clearly displayed so patients were aware this was available to them.

Some examples of caring staff interactions included:

- One nurse on Wheal Coates ward told us how they try to get to know their patients, know their story and then work as a team to offer care and meet their needs.
- One patient on the trauma unit said they had excellent care and treatment and staff always came to them quickly, while another said nothing is too much for staff to help you with.
- A patient on the Newlyn unit felt valued by everyone they had interacted with and felt hospital staff understood the personal side of care as well as the clinical side.
- On St Mawes unit a patient attended regularly and felt the care was consistent and they could rely on a good service every time, they said staff were always incredibly friendly and respectful. Staff would apologise and communicate if there was any delay with treatment.
- One patient on theatre direct said the nurses were exceptional and were authentically caring and very responsive. Their all-round experience had been excellent.

St Michael’s Hospital
We observed staff communicating with patients with kindness and respect. Privacy was protected through use of privacy curtains on wards and patient’s dignity was respected throughout all stages
of their journey through theatres. Patients were cared for in single sex bays on both surgical wards within St Michael’s Hospital. Staff encouraged patients to bring dressing gowns into hospital with them to ensure their dignity when wearing hospital gowns in readiness for theatre.

Feedback from patients who used the service from the Friends and Family test survey was positive. In July 2018 100% of patients on St Michael’s and St Joseph’s wards would recommend the services to their friends and family. As well as the Friends and Family test, patients were encouraged to provide feedback through Care Opinion, an anonymous method for patients and visitors to provide feedback on the care and environment. Staff told us they valued the feedback they received and used it as an opportunity to learn and improve.

St Joseph’s inpatient ward regularly monitored the direct care time provided to inpatients using the productive ward direct care assessment tool. The target for direct care was set at 60% and on St Joseph’s ward this target was exceeded with results of 71%. Staff told us they believed this was because of the collaborative approach between nursing and therapy staff which helped to provide patients with ongoing support during their admission.

All patients we spoke with were positive about their experience of care, stating staff were kind and caring. A patient being cared for on St Joseph’s ward told us their privacy and dignity was always respected. They also told us their call bell was answered quickly and staff were very quick to provide help and support when needed.

Staff were seen to be friendly and open with patients, on both St Michael’s and St Joseph’s wards. Patients told us staff were approachable and the atmosphere was positive and relaxed. One patient who had day surgery at St Michael’s told us the care was wonderful.

Staff supported patients to be mobile and independent post operatively, ensuring they had the equipment and support needed to be as independent as possible. We observed both therapy and nursing staff spending time with patients to provide the support and encouragement they needed. For example, we observed physiotherapy staff taking time to walk with patients before and after surgery, teaching them how to use crutches and other walking aids as part of the support to promote their independence and get them home as soon as possible.

**West Cornwall Hospital**

We observed staff communicating with patients with kindness and respect. Privacy was protected using privacy curtains on the wards and patient’s dignity was respected throughout all stages of their journey through theatres. Patients were cared for in single sex wards on the surgical unit within West Cornwall Hospital. Staff encouraged patients to bring dressing gowns into hospital with them to ensure their dignity when wearing hospital gowns in readiness for theatre.

Patients receiving treatment and care in the treatment centre were provided with care in single rooms or bays. Some of these bays were mixed sex, particularly where patients were receiving intravenous therapy treatment, but where they could remain in their normal clothes. However, staff working in the recovery bay of the treatment centre told us as the recovery area was open it was not possible to provide care in single sex areas, however privacy curtains were seen to be used. Staff told us they had requested development of the recovery area to promote privacy and single sex care. However, this had not yet happened. One member of staff told us they had been told if they had a member of the opposite sex from the majority of patient in the treatment centre recovery they should consider caring for them in a separate room. However, staff expressed concern about this as it would be difficult to undertake the close observations required for a patient being cared for in recovery which led to safety concerns.
Surgical ward staff told us they encouraged patients to submit Friends and Family test feedback and results of this were collated centrally within the trust. However, ward staff were not receiving results of this to be able to display it on the ward or to make changes as a result.

**Friends and Family test performance**

**Trust wide**

From July 2017 to June 2018, the friends and family test response rate for surgery at the trust was 19%.

A breakdown of the friends and family test performance by ward for surgical wards at the trust from July 2017 to June 2018 with total responses over 100 is below. The monthly figures show recommendation rates.

**Friends and family Test – Response rate from July 2017 to June 2018 by ward**

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Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Note: Sorted by total response

All wards and departments had annual recommendation rates of above 90%.

Note: Although included in the chart above, the medical day case unit is not within the surgical division.

**Royal Cornwall Hospital:**

Royal Cornwall Hospital had a response rate of 21% (based on 4,264 responses).

A breakdown of the friends and family test performance by ward for surgical wards at Royal Cornwall Hospital from July 2017 to June 2018 with total responses over 100 is below. The monthly figures show recommendation rates.

**Friends and family Test – Response rate from July 2017 to June 2018 by ward**

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Newlyn ward had the lowest response rate with 14%. All wards and departments had annual recommendation rates of above 90%.
St Michael’s Hospital:
St Michael’s Hospital had a response rate of 22% (based on 797 responses).

A breakdown of the friends and family test performance by ward for the two surgical wards at St Michael’s Hospital from July 2017 to June 2018 with total responses over 100 is below. The monthly figures show recommendation rates.

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<th>Ward name</th>
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<tr>
<td>St Michael</td>
<td>227</td>
<td>11% 100% 100% 100% 100% 94% 100% 100% 100% 100% 100%</td>
<td></td>
</tr>
</tbody>
</table>

Highest score to Lowest score

Key
100% 50% 0%

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Note: Sorted by total response

St Michael’s ward had the lowest response rate with 11%, whilst St Joseph’s ward had a response rate of 37%.

West Cornwall Hospital:
West Cornwall Hospital had a response rate of 6% (based on 195 responses).

The friends and family test performance for the surgical day-case unit at West Cornwall Hospital from July 2017 to June 2018, which was the only department with total responses over 100, is below. The monthly figures show recommendation percentages.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical DayCase</td>
<td>192</td>
<td>10% 100% 100% 100% 94% 100% 100% 97% 98%</td>
<td></td>
</tr>
</tbody>
</table>

Highest score to Lowest score

Key
100% 50% 0%

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Note: Sorted by total response

The surgical day case unit had a response rate of 10%, with an annual recommendation rate of 98%.

(Source: NHS England Friends and Family Test)

Emotional support

Emotional support was provided to patients and their families. During handovers the nursing team discussed patient wellbeing and any support they may require enabling them to deliver the emotional support.

Royal Cornwall Hospital

Staff were observed communicating to patients with kindness and in a way which took in to account their emotional needs. We observed a nervous patient pre-operatively, the nurse assessing the patient had an awareness of the patient’s anxieties about their surgery and provided emotional support to put the patient at ease.

Patients provided us with examples where they were provided with emotional support, this included:
• One patient on Wheal Coates ward told us how staff ask how they are feeling and check if they look distressed or depressed.

• A patient on theatre direct told us how they had been put completely at ease by all staff throughout their time in hospital.

Staff told us how when they need to deliver bad news to patients they try and ensure family members and friends of the patient are present. We saw evidence in patient records that the palliative care nurse would visit patients and talk to them about their diagnosis and offer emotional support. There was a hospital chaplaincy to help provide support. A chaplaincy volunteer was visiting the trauma ward to chat to and support patients who did not get many visitors, at the time of the inspection.

Psychological support / counselling was not available to amputee patients, but staff could signpost to local peer support groups for amputees.

St Michael’s Hospital

We observed staff communicating with patients in a kind, patient and understanding way. When patients were seen to be nervous before surgery staff spent time reassuring them, answering their questions and giving them information to improve their understanding and address their concerns. Staff told us when patients were distressed they could take them to the quiet room on the ward. The quiet room had been designed in response to feedback from patients about a lack of private space on the wards.

Patients were positive about the support they received from staff. For example, one patient told us they felt supported by staff as a person rather than just as a patient. They told us staff had supported them with family and childcare concerns and spent time listening to concerns they had.

There was a prayer room available for patients and relatives to use adjacent to St Michael’s ward. Chaplaincy support could be accessed via the Royal Cornwall Hospital switchboard.

Thankyou cards were visible on notice boards on the wards. We viewed a number of these, providing positive feedback from patients and their relatives to staff that cared for them. Comments related to the high-quality care patients received and the attitude, support and kindness of staff.

West Cornwall Hospital

We observed staff communicating with patients in a kind, patient and understanding way. When patients were seen to be nervous pre-operatively staff spent time reassuring them, answering their questions and giving them information to improve their understanding and address their concerns. Staff told us when patients were distressed, or they wanted to speak in private they could take them to day rooms at the end of each ward.

We observed a member of staff taking time to speak with a patient who had concerns about their caring responsibilities at home and how this may be affected by their recovery. The staff member took time to identify what these concerns were and to provide support to patient.

Understanding and involvement of patients and those close to them

Royal Cornwall Hospital

Staff communicated with patients so they understood their care and treatment. However, the amount of communication and updates on what was happening and test results, particularly by doctors, was an area some patients we spoke with felt could be improved.
Patients spoken with provided variable thoughts on the communication they had received while in hospital. One patient felt they had been waiting around and were unsure of what was happening. Another patient felt they were very involved with the therapy input, but less so with the medical input and a second patient said they would appreciate more contact from doctors. One patient was able to explain how at this admission they had a much better experience and felt they were fully informed about their surgery, so they could prepare themselves psychologically. Another patient said the medical staff answered all questions.

Processes and treatment were explained to patients. We observed an admission assessment and the procedural options were fully explained to the patient, including potential risks. When the patient asked questions, comprehensive answers were given. We also observed a pre-operative assessment and saw the patient had an opportunity to discuss their concerns and asks questions. We observed patients undergoing surgery who were spoken through the process while they underwent anaesthetic.

At the time of the inspection surgical wards had recently introduced open visiting times between 10am and 8pm, to enable those close to patients to visit more easily. Some staff we spoke with raised concerns this had a negative impact on patient privacy and cleaner’s ability to clean all ward areas. Feedback from patients was mixed.

Patients’ social situations were discussed at nursing handover, so all staff were aware of the important people involved in the patient’s life and arrangements for returning home.

**St Michael’s Hospital**

We observed staff communicating with patients in a way they could understand their care, treatment and condition and any advice given. We observed staff taking their time to explain procedures to patients. Staff checked for understanding by asking patients questions about what they had already been told about their procedure and their recovery and rehabilitation.

Patients participating in ‘joint school’ as part of the enhanced recovery programme received information in an environment where they could access support from staff as well as peer support from other patients in a group setting. Family members and carers were also able to participate in ‘joint school’ to provide support to their loved ones as part of their rehabilitation. Patients were positive about this experience, telling us they felt involved in their care and treatment and they had a better understanding of what would happen to them during their admission, surgery and recovery as a result.

Patient’s told us they felt valued by the staff and listened to. One patient we spoke with told us staff had taken their personal circumstances into account as part of their planned recovery. Another patient told us staff had actively involved them in their treatment and care from their very first appointment through to their surgery. Another patient told us staff had explained everything to them in a way that helped them to be calm. They also told us staff had discussed pain relief, rehabilitation and exercise with them before surgery and this helped them to develop a better understanding of what to expect.

**West Cornwall Hospital**

We observed staff communicating with patients in a way they could understand their care, treatment and condition and any advice given. We observed staff taking their time to explain procedures to patients. Staff checked for understanding by asking patients questions about what they had already been told about their procedure and their recovery and rehabilitation.

Patients we spoke with told us they were encouraged to ask questions and we observed this in practice. We observed a trainee practitioner undertaking an admission assessment and saw they
took their time explaining things to the patient, allowing the patient time to ask questions and checking their understanding.

Family members accompanying patients to the ward for their surgery could be present during assessment processes and pre-operative discussions where appropriate and with the consent of the patient. Staff took time to answer their questions and we observed this in practice. Family members were also able to be with patients once they had returned to the ward from recovery.

Before surgery patients were visited by the consultant surgeon. They discussed the procedure, the plan of care and the likely recovery with the patient. We observed a discussion between a surgeon and a patient who had been admitted for a procedure normally undertaken under a general anaesthetic. The patient had requested the procedure using a local anaesthetic due to their caring responsibilities at home. We observed the surgeon discussing the decision with the patient where they informed them of what to expect and supported them to make the decision that was best for them and their circumstances.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The surgical division was regularly reviewing the service they provided to meet the needs of the local population.

A business case had been approved and finance made available for an orthopaedic transformation project to move more orthopaedic work to St Michael's Hospital. The infrastructure of St Michael's Hospital was being improved to ensure appropriate facilities and staffing to care for patients with an American Society of Anaesthesiologists (ASA) score of three or four. This aimed to support the delivery of improved patient care through reduced waiting times and cancellations. It would also allow development of the provision of the trauma service to deliver better emergency care, and free up theatres at Royal Cornwall Hospital to increase capacity for other specialties. St Michael's was planned to become the primary site for orthopaedic electives from 22 October 2018. The business plan also involved extending theatre times incrementally to increase capacity.

In June 2018 Constantine ward opened, at the Royal Cornwall Hospital site, for orthopaedic elective patients which could care for up to 14 patients. This enabled operating to resume for patients who could only have their operation at the Royal Cornwall Hospital. This was staffed by the St Michael's Hospital nursing staff who were specialised in caring for orthopaedic patients. It also enabled the staff to become more confident in caring and treating patients who had an ASA score of three or four.

In August 2018 a hand assessment and treatment service commenced to improve the management of open and infected hand injuries. Patients were now given general treatment and sent home, they then return via the fracture clinic for surgery with the hand surgeon specialist with a ring-fenced afternoon for these patients.

Winter pressures had affected the delivery of the surgical service and resulted in a high number of elective patients being cancelled, in line with the national directive. Admission areas were opened as inpatient wards to provide extra capacity which impacted on the delivery of the elective service and leading to poor referral to treatment time performance in all specialties.

Improving patient flow was a priority for the management team in preparation for the winter months. They were working with planned care partners in the community to manage demand and working with the clinical commissioning group to review capacity and demand.
There continued to be opportunity to increase the theatre activity at West Cornwall Hospital. A project group had been set up with stakeholders to review this.

**Royal Cornwall Hospital**

Medical outliers were regularly in the surgical bed space and this impacted on patient flow throughout the hospital. At the time of our inspection there were 44 medical outliers on surgical wards to include; the surgical admission lounge, Wheal Coates and Eden ward. Although these patients were reviewed by an arranged consultant and medical team, the nursing staff were required to look after medical patients rather than surgical patients. We were told of concerns this may not aid the retention of staff who wanted to work with surgical rather than medical patients.

Surgical outliers were only placed within the surgical bed base and therefore were well managed within the surgery division.

Newlyn unit, a day case admission and recovery area, was not an appropriate environment to be responsive to patient needs when used for inpatients. The Newlyn unit had been used at times of escalation for inpatients. Patients did not have access to shower facilities and the area was not fit for purpose. Patients would be taken to other wards for showers. There were also difficulties in accessing food. When used for inpatients it also meant surgical day case patients were discharged from first stage recovery as the admissions and second stage recovery area was full.

Pre-assessment clinic booking clerks prioritised urgent cancer patients over routine patients and managed bookings to make sure urgent patients were always seen in a timely way. The service ran dedicated pre-assessment clinics for urgent and cancer patients. Booking clerks told us cancellations were very rare.

**St Michael’s Hospital**

The surgical division had developed a business case to increase orthopaedic activity at St Michael’s Hospital. This included expanding the admission criteria to include patients with systemic disease and functional limitations. As a result, the service had invested in capital, staffing and equipment developments. These included the development of a higher care bay and training for staff in caring for patients with unstable health conditions. Staff told us the aim of the project was to carry out 95% of elective orthopaedic surgery at St Michael’s Hospital.

We viewed minutes of a theatre users group meeting dated September 2018 and saw the implementation of the project was to be undertaken in stages. Staff we spoke with on the wards at St Michael’s Hospital told us the project was due to start in October 2018. However, the minutes we reviewed showed full implementation may take longer than that as it was dependent on additional background work and additional medical cover being available. As part of the project a temporary ward had been opened at the Royal Cornwall Hospital which was staffed by St Michael’s staff as an interim until the project was implemented. The ward at the Royal Cornwall Hospital was planned to remain open until December 2018.

Patients we spoke with told us they were given the choice to have their surgery at St Michael’s Hospital. For example, one patient told us they had requested St Michael’s as it was closer to their home.

**West Cornwall Hospital**

The surgical service at West Cornwall Hospital was designed to provide elective day case surgery for patients in line with the trusts surgical admission criteria. Service delivery was based on the type of surgery provided each day and the individual consultant theatre lists. As part of the surgical services priorities for 2018-19 the trust aimed to increase the utilisation of West Cornwall Hospital. Staff we spoke with were aware of the aim to improve capacity and demand planning and a
reduction in surgery delays, however they weren’t aware of any confirmed plans and timelines at the time of our inspection. We viewed minutes of a theatre users group where it was recorded as recognised there was potential capacity at West Cornwall Hospital to increase capacity.

There was a treatment centre based at West Cornwall Hospital. Activities within the treatment centre included minor surgical procedures such as gynaecology and dermatology procedures. In addition, non-surgical interventions such as infusions and pain management interventions were undertaken.

**Average length of stay**

**Trust Level**

From March 2017 to February 2018, the average length of stay for all elective patients at the trust was 3.1 days, which is lower compared to the England average of 3.9 days.

- The average length of stay for trauma & orthopaedics elective patients at the trust was 3.4 days, which is lower compared to the England average of 3.8 days.
- The average length of stay for urology elective patients at the trust was 2.0 days, which is lower compared to the England average of 2.5 days.
- The average length of stay for ENT elective patients at the trust was 2.0 days, which is the same compared to the England average of 2.0 days.

**Elective Average Length of Stay – Trust Level**

The average length of stay for all non-elective patients at the trust was 4.1 days, which is lower compared to the England average of 4.9 days.

- The average length of stay for general surgery non-elective patients at the trust was 3.3 days, which is lower compared to the England average of 3.8 days.
- The average length of stay for trauma & orthopaedics non-elective patients at the trust was 6.1 days, which is lower compared to the England average of 8.7 days.
- The average length of stay for ENT non-elective patients at the trust was 2.1 days, which is similar compared to the England average of 2.2 days.

**Non-Elective Average Length of Stay – Trust Level**
Royal Cornwall Hospital

From March 2017 to February 2018 the average length of stay for all elective patients at Royal Cornwall Hospital was 3.3 days, which is lower compared to the England average of 3.9 days.

- The average length of stay for urology elective patients at Royal Cornwall Hospital was 2.0 days, which is lower compared to the England average of 2.5 days.
- The average length of stay for trauma & orthopaedics elective patients at Royal Cornwall Hospital was 4.7 days, which is higher compared to the England average of 3.8 days.
- The average length of stay for ENT elective patients at Royal Cornwall Hospital was 2.0 days, which is the same compared to the England average of 2.0 days.

Elective Average Length of Stay - Royal Cornwall Hospital

The average length of stay for all non-elective patients at Royal Cornwall Hospital was 4.1 days, which is lower compared to the England average of 4.9 days.

- The average length of stay for general surgery non-elective patients at Royal Cornwall Hospital was 3.3 days, which is lower compared to the England average of 3.8 days.
- The average length of stay for trauma & orthopaedics non-elective patients at Royal Cornwall Hospital was 6.0 days, which is lower compared to the England average of 8.7 days.
- The average length of stay for ENT non-elective patients at Royal Cornwall Hospital was 2.1 days, which is similar compared to the England average of 2.2 days.

Non-Elective Average Length of Stay - Royal Cornwall Hospital

St Michael's Hospital

From March 2017 to February 2018 the average length of stay for all elective patients at St Michael's Hospital was 2.7 days, which is lower compared to the England average of 3.9 days.
• The average length of stay for trauma & orthopaedics elective patients at St Michael's Hospital was 2.8 days, which is lower compared to the England average of 3.8 days.

• The average length of stay for breast surgery elective patients at St Michael's Hospital was 1.4 days, which is similar compared to the England average of 1.6 days.

• The average length of stay for general surgery elective patients at St Michael's Hospital was 221.0 days, which is much higher compared to the England average of 3.9 days. However, this is likely to be based on a small number of patients which has inflated the average.

**Elective Average Length of Stay - St Michael's Hospital**

The average length of stay for all non-elective patients at St Michael's Hospital was 24.5 days, which is higher compared to the England average of 4.9 days.

• The average length of stay for trauma & orthopaedics non-elective patients at St Michael's Hospital was 19.1 days, which is higher compared to the England average of 8.7 days.

• The average length of stay for breast surgery non-elective patients at St Michael's Hospital was 2.0 days, which is lower compared to the England average of 3.9 days.

• The average length of stay for general surgery non-elective patients at St Michael's Hospital was 162.0 days, which is much higher compared to the England average of 3.8 days. However, this is likely to be based on a small number of patients which has inflated the average.

**Non-Elective Average Length of Stay - St Michael's Hospital**

West Cornwall Hospital

From March 2017 to February 2018 the average length of stay for all elective patients at West Cornwall Hospital was 1.6 days, which is lower compared to the England average of 3.9 days.
• The average length of stay for urology elective patients at West Cornwall Hospital was 1.9 days, which is lower compared to the England average of 2.5 days.

• The average length of stay for upper gastrointestinal surgery elective patients at West Cornwall Hospital was 1.1 days, which is lower compared to the England average of 4.6 days.

• The average length of stay for colorectal surgery elective patients at West Cornwall Hospital was 3.0 days, which is lower compared to the England average of 7.1 days.

**Elective Average Length of Stay - West Cornwall Hospital**

![Elective Average Length of Stay Graph]

Note: Top three specialties for specific site based on count of activity.

The average length of stay for all non-elective patients at West Cornwall Hospital was 54.2 days, which is higher compared to the England average of 4.9 days.

• The average length of stay for trauma & orthopaedics non-elective patients at West Cornwall Hospital was 59.0 days, which is higher compared to the England average of 8.7 days.

• The average length of stay for general surgery non-elective patients at West Cornwall Hospital was 40.0 days, which is higher compared to the England average of 3.8 days.

**Non-Elective Average Length of Stay - West Cornwall Hospital**

![Non-Elective Average Length of Stay Graph]

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

**Meeting people’s individual needs**

Staff considered the needs and choices of different people and met their individual needs. We observed patient needs being discussed as part of handover discussions and documented within their patient records. Communication tools such as large print, were available to aid communication.

Where English was not a patient’s first language staff could access face to face or telephone interpreting. All staff groups were aware of the access to interpreters and translators.
Patients living with a diagnosis of a dementia or a learning disability were flagged to staff on their electronic system. Staff used the trust learning disability team for support and their dementia link nurses. For patients living with dementia a ‘this is me’ booklet was available to be completed and used, to ensure peoples wishes and choices were known to staff.

**Royal Cornwall Hospital**

Staff were aware of the importance of learning about individual needs to provide personalised care. Staff had access to a mental health liaison team and the trust learning disability team. Staff had good awareness of the needs of patients with learning disabilities and could access the trust learning disability team. During our inspection a patient with a learning disability was undergoing ophthalmic surgery. We saw they were prioritised and placed first on the theatre list to reduce anxiety. The patient was accompanied into the anaesthetic room by a learning disability liaison nurse, who was also present in the recovery area. The learning disability liaison nurse stayed with the patient and took them home later in the day, settling them at home and giving their first set of eye drops. Arrangements had been made for district nurses to then visit three times a day to give the eye drops, and a support agency would visit in the evenings.

The trauma unit had recognised a need for more patient dementia friendly bays on their ward. There were two bays, one for males and one for females. These were placed at the end of the ward to provide a quieter and calmer environment for patients living with dementia. Enhanced care was provided so patients had regular supervision. A healthcare assistant showed us the activities and resources they used to stimulate the patients. A table was in the middle of the ward which could be used for activities and for meal times. However, this was dependent on the patients in the bay and how they interacted. We were also told about plans to introduce monthly projects in the bay, for example the world wars.

Bay environments had not been adapted to make them more dementia-friendly. For example, there was no differences with colours and contrast, or the use of large clocks.

Relevant patient information leaflets were available on the wards. Leaflets had information on accessing information in other languages or Braille.

Some patients did feel there was a lack of stimulation and they were bored as there were no activities. One patient had asked for internet access the previous day, but this was not yet available, and another patient said the entertainment system was not working.

**St Michael’s Hospital**

People received personal care that was responsive to their needs. Individual patients had their needs assessed and planned for as part of the pre-operative assessment processes, including an assessment against the admission criteria for St Michael’s Hospital. Patient’s individual needs were also re-assessed as part of the admission process on their day of surgery.

Services took account of the needs and choices of different people. Staff we spoke with gave us examples of how the needs and choices of different people were well considered. For example, at the time of our inspection a young person with autism was admitted for surgery. Staff worked closely with the patient and their relatives to ensure the patient’s individual needs were met. Specific examples of this included enabling the patient’s mother to accompany them to the anaesthetic room and to then meet them in recovery so they were not alone when they woke up. The patient was given space in the ward quiet room and was admitted later in the day, so they could avoid being in a noisy, busy environment with other patients after surgery. The ward manager also told us of a patient whose admission they were planning for. The patient with a learning disability was due to be admitted in the coming weeks. Staff worked with the learning disability team to plan their admission. For example, staff told us of an instance where a patient
did not want to be cared for by male staff and would find this distressing. Staff arranged for female staff to be working the theatre list on the day of their surgery to meet the patient’s individual needs and reduce their distress.

The service identified and recorded the communication needs of patients. A hearing loop was available, and staff could access patient information including menus in different formats, including Braille.

Staff told us they did not routinely care for patients living with dementia having surgery at St Michael’s because of the limitations of the admission criteria. However, staff told us they had recently had a patient living with dementia transferred from the Royal Cornwall Hospital for rehabilitation. Staff told us they liaised with dementia specialist staff to get advice on how best to care for the patient. Staff identified activities such as colouring/drawing to help the patient settle and the multidisciplinary team worked together on the patient’s mobility rehabilitation.

Due to the admission criteria, bariatric patients were not likely to meet the criteria for surgery at St Michael’s Hospital, however staff told us there was the possibility patients could be transferred post-operatively from the Royal Cornwall Hospital. For example, the ward manager told us they had recently had a bariatric patient transferred and as a result had to request the appropriate equipment to come with them.

Patients having breast surgery at St Michael’s had access to a monthly breast care group held at the hospital. The group provided peer support and information and advice for patients following breast surgery to enhance the support received post-operatively and during their recovery.

There were information leaflets on the ward, providing information to patients about their surgery and what to expect during their recovery and rehabilitation. There were also information leaflets available on how patients could access further support if necessary. For example, there was information displayed on the ward about a breast care support group for patients having undertaken breast surgery.

**West Cornwall Hospital**

People received personal care that was responsive to their needs. Individual patients had their needs assessed and planned for as part of the pre-operative assessment processes, including an assessment against the admission criteria for West Cornwall Hospital. Patient’s individual needs were also re-assessed as part of the admission process on their day of surgery.

Services took account of the needs and choices of different people. For example, at the time of our inspection a patient on the urology day surgery theatre list had caring responsibilities at home. Staff worked with them to ensure support with their recovery, including the surgeon and anaesthetist who agreed to the surgery using a local rather than general anaesthetic.

Staff told us they did not routinely care for patients living with dementia having surgery at West Cornwall Hospital because of the limitations of the admission criteria. Patients with learning disabilities had their needs identified as part of the pre-operative assessment process. Staff told us when they had patients with learning disabilities they would liaise with the family and members of the learning disability support team to identify how best to meet the patient’s needs.

**Access and flow**

Patients did not always have access to care and treatment in a timely way. In June 2018 there were 11 specialties out of 14 failing to meet the referral to treatment time target. The specialties achieving target, with the percentage achieving under 18 weeks, included; breast surgery (92.5%), orthodontics (96.5%) and pain management (93.6%). The specialties well below target, with the percentage achieving under 18 weeks, included; urology (72.8%), colorectal surgery (55.4%),
upper gastrointestinal surgery (64.9%), vascular surgery (73%), trauma and orthopaedics (68.1%), and paediatric surgery (61.1%).

There was a recovery plan for improving referral to treatment time performance both at specialty level and trust wide. This was developed in conjunction and agreement with commissioners. There was an agreed trajectory that was being worked towards to reduce waiting times by April 2019. The trajectory was currently on track.

Daily theatre performance meetings were held to review the previous day activity and agree actions for improvement. Directorate managers were in post for all specialties to help focus on referral to treatment (RTT) recovery and improve theatre performance.

A divisional RTT performance meeting was held weekly to discuss the specialties, this included; 52-week pathways, 48-52-week pathways, diagnostics, same day cancellations, RTT performance, outpatients, data quality assurance, and cancer pathways.

The trust had been cancelling patient treatments but were unable to rebook these patients within 28 days. In April 2018 there were 121 cases cancelled on the day, in May 2018 145 cases and June 2018 184 cases. The reasons varied but the most common reasons included; 12.5% where a patient did not attend 11% where there was insufficient list time remaining, 11% where an emergency took priority 10.5% where the operation was no longer necessary, and 10.5% where the patient decided against surgery.

The trust had improved since our last inspection with the number of cancer cancellations and the timeliness of these patients being rebooked. We reviewed data for the last 12-month period. There had been 10 cancellations with reasons including: staff sickness, insufficient time, no high dependency unit or intensive unit beds, and no inpatient bed. All but one patient was appropriately rebooked within 28 days of the cancellation. On average from the 10 patients cancelled they were rebooked within 12 days. Additionally, during the inspection we were told of two patients who had been cancelled in the last three weeks based on no bed availability.

There were a high number of patients who had been waiting for 52 weeks or longer for their surgery for trauma and orthopaedics and urology. In June 2018 in trauma and orthopaedics there were 112 reported patients waiting 52 weeks compared to a target of 103. In urology in June 2018 there were 60 reported patients waiting 52 weeks or over against a target of 50. There were also 26 patients reported to be waiting over 52 weeks compared to a target of 18 in colorectal surgery.

The trust hoped the use of Constantine ward for orthopaedic elective patients would improve the throughput of patients. A urology locum started in August to focus on reducing the waits for patients who had already been waiting a long time.

There were good processes for monitoring the theatre efficiency. However, the trust was seeing a downward trend with an increased number of unused theatre sessions with 98 unused sessions in June 2018 compared to 73 in May 2018.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From June to September 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was similar to the England average. However, from October 2017 to May 2018, the rate was consistently below the England average.

In the latest period May 2018, 56% of this group of patients were treated within 18 weeks versus the England average of 67%.
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Of these, all six specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>72.5%</td>
<td>76.9%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>68.7%</td>
<td>70.0%</td>
</tr>
<tr>
<td>General surgery</td>
<td>60.2%</td>
<td>72.8%</td>
</tr>
<tr>
<td>ENT</td>
<td>60.1%</td>
<td>63.4%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>55.2%</td>
<td>61.3%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>55.1%</td>
<td>60.8%</td>
</tr>
</tbody>
</table>

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

From April 2016 to March 2018, the percentage of cancelled operations at the trust showed an upward trend, peaking in 2017/18 quarter 4 (January 2018 to March 2018) when this trust cancelled 335 surgeries. Of the 335 cancellations, 41% of the patients were not treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Royal Cornwall Hospitals NHS Trust
Over the two years, the percentage of cancelled operations at the trust was consistently above the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Royal Cornwall Hospital

Data for patients waiting for emergency surgery showed on average the trust were meeting their targets. Patients were classified based on urgency for their surgery and this was recorded and monitored. There were plans for Trelawny theatres to run five emergency theatres between 6pm and 9pm, to include a specific pathway for fractured neck of femur. At the time of inspection staffing arrangements needed to be confirmed to accommodate this.

During our inspection one patient underwent their surgery despite there being no available bed in the intensive care unit, which may have been required. A decision was made to continue to operate on the patient and keep them in recovery if needed. The theatre team were not aware the patient may need an intensive care bed and only found this information out when retrieving the patient from the ward. It had not been written on the theatre list and the anaesthetist was also not aware.

The service had an electronic referral system to arrange support for patients from GPs or the district nursing team on discharge. Staff told us discharge was generally timely and expected date of discharge was managed from the point of admission. However, there were instances where waiting for packages of care delayed the process and meant a patient who was medically fit for discharge was unable to be discharged. We saw patient discharge plans and goals to facilitate discharge were discussed during nursing handover.

The surgical wards could use the discharge lounge to help with patient flow. The discharge lounge included bed spaces and nurses continued to administer medication, so patients still requiring care and treatment could be moved to the discharge lounge. The lounge was open 7.30am to 8pm. Hot meals could be provided to patients while they were in the discharge lounge.

Occupational therapists and physiotherapists did initial assessments of patients to see if they could be rehabilitated in their home or another care environment. The trust had an early supported discharge team, who were available seven days a week. The team assessed patients and carried out home visits, with the aim of discharging patients home with a package of support from the hospital community therapy team. The early support discharge therapy could support patients in their home for a period of six weeks following discharge from hospital after surgery. Patients with complex needs were supported by occupational therapists to arrange necessary packages of care and adaptations to the home environment.

Bed managers visited the surgical wards regularly to manage patient flow into and out of the wards.
At the time of inspection, the time to theatre for patients with a fractured neck of femur (hip fracture) was improving. In June 2018 72% went to theatre within 36 hours, compared to 60% in May 2018. The trauma demand was being managed and maintaining neck of femur performance would be aided by moving elective orthopaedic work to St Michael’s Hospital.

One porter told us they felt there was not enough porters, and the number of porters had decreased since our last inspection. This sometimes caused a delay in moving patients from recovery to the ward. We were also told about multiple patient moves and patient moves at night. On Pendennis ward there had been four patients moved at night over the weekend before our inspection.

St Mawes Lounge received patients from the GP, 111 service or from the emergency department. The lounge only accepted medically stable patients with a national early warning score below four. The lounge was staffed by a nurse, healthcare assistant, ward clerk and doctor. Patients could be clerked and seen by the consultant before admitted to a ward or discharged home.

St Michael’s Hospital

Elective breast and orthopaedic surgery was routinely carried out at St Michael’s Hospital. Managers monitored waiting lists and cancellations and monthly meetings were held to review activity.

Theatre staff monitored compliance with theatre list times. Data at the time of our inspection showed there was 89% compliance with list start times.

Staff consistently told us there was capacity at St Michael’s to increase elective activity. For example, bed occupancy data showed in July 2018 surgical beds at the hospital were only 50% occupied.

The average length of stay at St Michael’s Hospital was three days. Therapy staff told us they had worked to review length of stay data and identify blocks to discharge to maintain and continuously improve patients’ length of stay. Specific action included recording dates when catheters and surgical drains were removed to help identify causes of delays as part of routine audits of data. In addition, therapy staff had reviewed patient data against the different types of anaesthetic, to identify any common themes as part of their review of delays to discharge.

West Cornwall Hospital

Elective day surgery was carried out at West Cornwall Hospital including urology and ophthalmology surgery. Staff we spoke with were aware of the trust wide issues of improving theatre utilisation and bed occupancy across the trust to reduce delays in elective surgery.

The theatre manager told us theatre utilisation improving. For example, data showed in May 2018, eight full sessions had been cancelled. In August 2018 this had reduced to two and a half sessions having been cancelled. Specific activity to improve this had included the recruitment of more anaesthetists, theatre lists had been extended to 5.00pm when they had previously finished by 3.30pm.

Learning from complaints and concerns

Complaints were being managed and learning shared, however the timeliness of response to complaints needed improvement. There was additional support in the division from August 2018 to help with the backlog of complaints.

We were told about local resolution meetings, which were being held more regularly in the division to provide face to face resolution with the complainants and ensure as much learning as possible was captured. Staff on the wards talked to us about their involvement in these meetings.
One example was provided of a compliment received by a patient but reading the compliment there were several issues raised which could be improved. The individual was invited in to talk about their experience.

Staff spoken with were aware of learning from recent complaints. We were told managers shared both positive and negative feedback from patients with staff.

The service encouraged feedback from patients. Leaflets on how to make a complaint and FFT surveys were available to patients on surgical wards.

Staff responded to patients wanting to complain or provide feedback by supporting them to do so. Patients were encouraged to share their experiences and concerns and there were a range of feedback methods available. Staff told us they were happy to support and guide patients who wished to make a complaint about any aspect of the service.

**Summary of complaints**

From May 2017 to April 2018 there were 98 complaints about surgery. The trust took an average of 55.4 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 25 days.

Ninety-one of the 98 complaints (92.9%) occurred at Royal Cornwall Hospital, four (4.1%) at West Cornwall Hospital and three (3.1%) at St Michael’s Hospital.

The most prevalent types of complaints were those relating to clinical treatment (31, 31.6%), patient care (16, 16.3%) and communications (12, 12.2%).

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

**Number of compliments made to the trust**

From May 2017 to April 2018 there were 1,531 compliments within surgery.

A breakdown by site is shown below:

- Royal Cornwall Hospital: 1,390
- St Michael’s Hospital: 68
- West Cornwall Hospital: 73

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

**Is the service well-led?**

**Leadership**

The leadership team felt supported to drive progress and make improvements. They had a good awareness of risks and the challenges to the service.

The surgical division leadership team included two clinical directors, an associate director, a deputy associate director and an associate director of nursing. Each specialty had a specialty lead, governance lead and directorate manager. The division was also supported by a finance manager and HR business partner.

The leadership team was quite new at the time of the inspection. The associate director of nursing had been in role for five months and interim director for surgery for eight weeks. The theatre matron and one surgical matron had only been in post for four months. They spoke of a plan for a triumvirate model with the directorate manager, matron and clinical all sharing responsibility for the management of the service.
There were two vacant clinical director posts for general surgery and head and neck surgery specialties. These had been vacant for some time and had previously been covered by one of the clinical directors who stood down from covering these in June 2018.

The theatre matron said once every two weeks they were off the main Royal Cornwall Hospital site visiting the locations at St Michael’s Hospital and West Cornwall Hospital. The theatre matron told us they were planning to standardise theatre practice across all theatres for the trust.

Matrons spoke of a management programme they were attending which was then due to be rolled out to band 7 staff. Management passports were available through learning and development for those with line management responsibilities.

**Royal Cornwall Hospital**

Staff spoken with said ward managers and matrons were visible and they felt well supported. Staff were not always clear who the current executive team were due to several changes within the trust. However, some staff told us the executive team had completed ward walk arounds.

**St Michael’s Hospital**

Staff told us hospital leaders were visible and approachable. The surgical ward manager was the lead for the site on day to day basis. They were supported by two deputy managers who worked across the inpatient and day wards. In addition, there was a theatre manager and pre-operative assessment manager based at St Michael’s Hospital.

The site manager told us they could get support from senior managers from head office when needed. Staff told us there had been positive changes to the leadership in the last 12 months.

Staff reported having seen the chief executive at the hospital and told us they were visible and approachable.

Ward staff were very positive about the leadership of the hospital and the trust. We were told the chief executive held ‘team talks’ on a regular basis were accessible to staff on site at the Royal Cornwall Hospital or remotely using social media and other sources.

Staff reported they felt well supported by managers and described St Michael’s as a nice place to work.

**West Cornwall Hospital**

At our 2017 inspection there was an acting ward manager and acting theatre manager in post. We were told the interim posts would be in place until August 2017 when new substantive posts would be established. However, during this inspection we found the ward and theatre manager post was being covered on an interim basis and the post holder had been in position for two months of a three-month initial post. Staff we spoke with told us they had some concerns the ward and theatre manager post was interim. They expressed frustration this impacted on an ongoing lack of stability due to from management changes over the last few years.

Not all staff we spoke with were aware of who the executive leads were. They reported receiving good support from the theatre/ward manager and the surgical division matron. However, one member of staff told us they felt like the team did not exist in the eyes of the wider trust executive team.

**Vision and strategy**

The leadership team were clear about the priorities for the division and were keen to make changes which were sustainable to ensure improvements.

The priorities for the surgical service for 2018/19 included:
• Safety culture
• Strong governance
• Tackling delay
• Attract, develop and retain excellent staff
• Offer integrated care, as close to home as possible
• Make the best use of all resources

Royal Cornwall Hospital
Staff spoken with were aware of the priorities for the surgical division and they key challenges which were faced.

St Michael’s Hospital
Staff were consistently aware of the key priorities for the trust in relation to areas such as reducing waiting lists and improving theatre and bed utilisation. Staff told us they felt clear the key strategy for the trust was to reduce waiting times for surgery in all areas. For example, staff told us the trust had an aim to reduce the orthopaedic 52-week wait to zero and ultimately to keep all elective surgery patients within the 18-week target.

West Cornwall Hospital
Staff told us a primary aim was to increase the turnover of surgery and the trust were looking at doing more at West Cornwall Hospital. However, staff told us there were no clear plans yet.

Culture
Royal Cornwall Hospital
Staff we spoke with were proud to work for the trust and serve the local community and felt valued. They spoke of good, supportive team working. Staff could see changes were happening and were generally positive about the future.

Staff we spoke with told us they were confident to raise concerns with managers or more senior staff. Staff who had raised concerns told us they had been listened to and appropriate action taken.

There had previously been a lack of leadership in Trelawny theatres which had impacted on the culture and morale. Staff spoke highly of the new theatre matron and were hopeful they would see improvements. However, some of the historic issues meant staff felt undervalued. There were examples of having to continually stay late to accommodate the theatres but no reward or thanks for this.

St Michael’s Hospital
A positive culture was clear across surgical services at St Michael’s Hospital. Staff and patients told us they enjoyed the atmosphere of the hospital and there was a good sense of community and teamwork across all services. Staff said they felt they could provide good quality care and had the time to do so.

Staff told us they felt valued and were supported by colleagues and managers. For example, staff were encouraged and supported to take uninterrupted breaks during their shift where colleagues would provide cover to ensure this happened. We saw a cohesive team approach between the two wards where staff worked as a single team to provide care for inpatients and day surgery patients.

Action was taken to address issues with performance and staff told us any concerns they raised were dealt with in a supportive way.
Patients were encouraged to provide feedback on the services and there was a genuine desire across all disciplines to improve the patient experience, achieve identified goals and develop the service.

Staff and managers told us the culture within the service was open and honest and staff consistently felt able to voice their views, knowing they would be listened to.

Staff told us they felt there was a good culture of learning across the service. They had been given the opportunity to develop their skills and knowledge in caring for more acutely unwell patients through development sessions aligned with the plans to expand elective surgery at the hospital.

**West Cornwall Hospital**

There was a positive culture at West Cornwall Hospital, and staff worked well as a team. However, some staff told us they believed their goodwill was stretched. For example, while staff told us they felt supported by immediate line managers, they did not feel the executive team and senior leaders across the division had a good understanding of the issues they faced. Some staff told us they did not feel valued and supported as a result. Staff were aware of current developments across the division but felt these were focused at the other hospital sites across the trust and plans for West Cornwall Hospital were still unclear.

**Governance**

There were improved governance processes and oversight in the surgical division. People were clear of their responsibilities, roles and accountability within the governance framework. The new governance arrangements were still in the process of embedding, however leaders felt this was gathering pace and they were seeing positive change.

The trust had commissioned a review of its governance arrangements earlier in the year, and actions were being progressed to improve the structure and capacity to deliver the quality improvement plan and a strong governance agenda. The aim was to improve ward to board accountability, escalation and reporting.

Staff said they felt engaged and involved with surgical governance at an appropriate level relevant to their role. Band 6 nurses had been identified to take on the role of governance links to provide leadership on the ground floor. The surgical matrons were engaged with governance and spent time with the governance lead. Weekly the two clinical directors reviewed complaints and incidents on a dashboard with the governance team. This enabled them to pick up themes and trends.

Key meetings for the surgical service included the divisional business and governance meeting, and the senior management team meeting. There were monthly division performance meetings.

Daily and weekly governance meetings called 'comm cells' were held to ensure the early escalation of any patient safety incidents and the sharing of information.

A monthly mortality review and oversight committee monitored and shared learning from deaths. The outcomes of specialty mortality and morbidity meetings fed into this committee. We requested mortality and morbidity meeting minutes for surgery as part of our data request, but these were not provided.

The governance team felt the route to board was working well, but some work needed to be done to make sure information was cascaded back down to the ward. This was being done through ward themes and trends.

Senior managers recognised the workload and capacity impacted on the ability to deliver the governance, at the time of the inspection the new governance processes meant they were mostly reactive but were aiming to be proactive once processes embedded and backlogs were removed.
The surgical division sisters held weekly meetings to share best practice and learning. Monthly this was held with the medical division sisters to enable trust wide learning.

The trust held audit days, and these were used for shared learning amongst the division. These audit days were open to all staff and well received by the staff.

At St Michael’s and West Cornwall Hospital there was a clear governance structure within the surgical division and staff at these sites were clear on who they reported to and the structure that supported the service. Governance meetings were held monthly and were either division specific or site specific. For example, there was an overarching surgery governance meeting attended by staff working across all locations of the surgical division. Site specific meetings were held at St Michael’s Hospital where quality and performance and service development issues were discussed within a multidisciplinary framework, and at West Cornwall Hospital where cross divisional and service representatives reviewed hospital specific quality, performance and development issues.

**Management of risk, issues and performance**

The management and oversight of the risk register was not clear. Although staff could talk to us about the risks, when reviewing the risk register we weren’t always able to see the risks discussed, which we had been told had been signed off. This was likely due to an error with how the risk register was being recorded and stored electronically. It was not clear what were the business as usual risks, the recurrent risks and the new risks. We were told there was a plan for specialty level ownership of risks in a manageable way.

We were provided with the surgical service risk register, this included 271 risks, but did not include any high-level risks. The risk rating did not go higher than nine. We did not see evidence of nursing staffing and high use of agency on the risk register despite senior managers identifying these as the top risks to the service.

A quality, experience, workforce and safety dashboard was produced monthly to review; nursing workforce, safety, falls, pressure ulcer, infection control, staff and patient experience, and deaths.

There was no focus on sepsis as part of surgical governance, although the governance team felt this should be an upcoming focus and audit programmes to be arranged. Improvements to the electronic observations would help to audit this process.

There was participation in clinical audit and outcome programmes, to include mandatory national audits, mandatory internal audits, divisional priorities and clinical interest. The surgical division were in the process of carrying out a review of the audit programme, meeting with each specialty clinical audit lead to review their programmes. This would enable a review of those audits which had expired their anticipated end date.

**Royal Cornwall Hospital**

Noticeboards were used to share performance for incidents, falls, harms, complaints and serious incidents.

**St Michael’s Hospital**

The ward manager ran monthly team meetings where information was shared, including learning from incidents and divisional updates. Daily huddles were held in theatre and on the wards where quality and safety issues were discussed.

Risk assessments were undertaken by band 6 and band 7 and were reviewed as required or annually as a minimum. Risks were added to a central divisional risk register. However, the way
risks were recorded did not include clarity on oversight, management and the specific site that the risks related to.

Performance data was collated and displayed within the ward environments. This included safety thermometer data, audits, therapy performance, patient length of stay and post-operative performance.

**West Cornwall Hospital**

Risk assessments were not available on the surgical ward during our inspection. Risk assessment folders dated back several years and the ward manager who was new in post was unable to locate more up to date records. A divisional risk register was held centrally. However, it was not clear how risks were managed and monitored.

Staff working within surgery at West Cornwall hospital told us they did not routinely receive performance data, despite submitting information centrally. Performance boards within the ward did not have up to date performance information recorded and staff were unaware of audit results such as hand hygiene audits and friends and family test results for the service.

**Information management**

There was a developed programme to measure theatre performance, and there were plans to further improve using robust data.

Notices were displayed on wards informing patients of how their information was used by the hospital in line with general data protection regulations.

We spoke with one consultant who was leading on IT for surgery, they had been in their chief clinical information officer role for two weeks. They were working on the trust digital strategy, whereby there had been no digital strategy in the previous years. This looked at the multiple clinical systems used, for example; separate systems for blood results, radiology reporting, and drug charts. There was an aim to move all information to one system. They were also working on patient status at a glance (PSAG) project which will have live bed information and allow ward managers to book patients in. PSAG was currently running in a test environment. The system will be clinically oriented and will have observations, length of stay, NEWS and handover information.

**Engagement**

The trust engaged with staff through multiple channels. Staff we spoke with were aware of trust wide communication emails and bulletins.

**Royal Cornwall Hospital**

The service encouraged feedback from patients and relatives. ‘You said, we did’ boards were displayed at the entrance to surgical wards. Changes made following feedback from patients included making every effort to treat patients as individuals.

**St Michael’s Hospital**

Staff working in the surgical division received regular communication updates via email. Staff we spoke with were aware of the upcoming changes to the surgical services at St Michael’s. Staff told us they attended regular meetings and training sessions where updates were openly discussed, and staff had the opportunity to ask questions and share their thoughts.

The service encouraged feedback from patients and relatives using the friends and family test and ‘care opinion’ feedback processes. We viewed ‘You said, we did’ boards and saw these were displayed along the corridors of the surgical wards. Changes recorded on the board at the time of
our inspection included creating a wet room showering facility to ensure this was accessible to all patients.

St Michael’s staff worked closely with the local community to share updates on developments within the hospital and the services. A summer fete had been held to raise funds for an improved outside space for patients. The trust was working with the local historical society to obtain archived photos of the hospital. They were also engaging with the public over sharing photos and raising awareness about the developments.

**West Cornwall Hospital**

Staff reported they did not receive collated friends and family test data, however, patients were encouraged to complete the feedback. The 'you said, we did' board was blank because of this.

Staff told us they could complete the staff survey, however one staff member told us they had concerns about what they included as the survey was not anonymous. Staff told us they had been visited by freedom to speak up guardian and encouraged to speak up if they had concerns.

**Learning, continuous improvement and innovation**

The surgical division had been concentrating on the improvements needed to the service and their transformation project, therefore they had not spent time on any innovative practice.

A ward accreditation process had been introduced and all wards had gone through this accreditation peer review process. We were told this had facilitated shared learning between the surgical wards and between different divisions. Staff we spoke with were positive about the ward accreditation scheme.

The St Michael’s team had received a national enhanced recovery audit certificate of recognition from the NHS National Institute for Health Research for the quality of their work.

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**Critical care**

**Facts and data about this service**

The trust has a total of 26 critical care beds. A breakdown of these beds by type is below:

**Breakdown of critical care beds by type, Royal Cornwall Hospitals NHS Trust and England**

<table>
<thead>
<tr>
<th></th>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric, 15.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal, 26.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult, 57.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paediatric, 7.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neonatal, 23.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult, 68.2%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: NHS England)

The critical care unit (hereafter referred to as the ‘unit’) offers both intensive and high dependency care for the 15 adult beds. It admits approximately 1,000 patients each year with all forms of medical and surgical conditions (planned and emergency). The critical care service (hereinafter
referred to as the ‘service’) treats a wide range of patients but this does not include major trauma
patients, cardiothoracic patients, paediatric patients, neurosurgery patients, complex burns
patients or very advanced respiratory care patients. These patients are transferred to the nearest
specialist hospital for treatment.

The majority (36%) of admissions come from the emergency department, 25% from ward areas,
15% from emergency surgery, and 15% from planned surgery. An average of 89 patients were
treated each month in 2018. An average of 78 patients were admitted and discharged each month
in 2018 with a median average age of 65.

The unit is divided in two distinct areas, the North Side and the South Side. Wherever possible,
The North side usually accommodates level three patients, and the South side usually
accommodates level two patients. Level two care describes patients requiring more detailed
observation or intervention. This includes support for a single failing organ system or post-
operative care, and those 'stepping down' from level three care. Level three care refers to patients
requiring advanced respiratory support or monitoring and support for two or more organ systems.
This level includes all complex patients requiring support for multi-organ failure.

The critical care outreach team (hereafter referred to as the ‘outreach team’) provide a nurse-led
outreach service 24 hour a day, seven days a week. This is a highly skilled team of senior nurses
who work with staff on the wards to ensure the early detection of the deteriorating patient and
follow-up of patients who have been discharged from critical care

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

Is the service safe?

Mandatory training

Staff were offered mandatory training and regular updates. The training was presented as a
combination of online training and two face-to-face days that included critical care specific training.
The staff we spoke with valued this content.

Clinical staff received mandatory training on patients with mental health needs, learning
disabilities, autism and dementia. Staff also relied on specialist teams (such as psychiatric liaison)
for support in these areas.

The systems to monitor mandatory training compliance were not reliable. Leaders of the service
did not have accurate data regarding the mandatory training compliance of the staff who worked
there. Mandatory training compliance submitted to the Care Quality Commission prior to our
inspection, was inaccurate. The original data included 16 medical staff who no longer worked on
the unit. The medical trainees showed as non-compliant, but they had completed all the modules
during their induction. However, there was a time lag between completion of the training and the
data being logged onto the central recording system.

There was a risk staff working on the unit might not be knowledgeable regarding essential safety
systems, processes and practices. This was because not all staff had completed their mandatory
training. Staff told us their mandatory training was cancelled when they were required to provide
nursing cover elsewhere in the hospital. This was raised at the theatres and anaesthetic
operational governance meeting in May 2018. Mandatory training compliance was identified as a
risk on the specialty risk register. However, there was no evidence of a plan to address this risk.

The data for mandatory training compliance of medical staff given to us as part of our provider
information request is displayed in the table below. This showed the 95% target was met for just
three of the 12 mandatory training modules shown above for medical staff. Conflict resolution training module had the lowest completion rate with 40.9%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>20</td>
<td>22</td>
<td>90.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>20</td>
<td>22</td>
<td>90.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>19</td>
<td>22</td>
<td>86.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>19</td>
<td>22</td>
<td>86.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>18</td>
<td>22</td>
<td>81.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>17</td>
<td>22</td>
<td>77.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>17</td>
<td>22</td>
<td>77.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>9</td>
<td>22</td>
<td>40.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>3</td>
<td>0</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in critical care at Royal Cornwall Hospital had a completion rate of 90.5% for mandatory training. Medical staff met the target of 95% for four of the 11 modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>20</td>
<td>20</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>20</td>
<td>20</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>20</td>
<td>20</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>20</td>
<td>20</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>18</td>
<td>20</td>
<td>90.0%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>18</td>
<td>20</td>
<td>90.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>17</td>
<td>20</td>
<td>85.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>17</td>
<td>20</td>
<td>85.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>17</td>
<td>20</td>
<td>85.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>16</td>
<td>20</td>
<td>80.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>16</td>
<td>20</td>
<td>80.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

During our inspection, leaders of the critical care team told us the mandatory training data for medical staff was inaccurate. The trust submitted revised data whilst we were on site. This evidence showed medical staff were compliant in the following modules: dementia awareness; equality diversity and human rights; medicines management; mental capacity act; moving and handling level one. The team did not meet the trust target for compliance for fire safety; health and safety; infection prevention and control; information governance; moving and handling level two; conflict resolution; basic life support.
The data for mandatory training compliance of nursing staff, given to us as part of our provider information request, is displayed in the table below. This showed the 95% target was met for just five of the 12 mandatory training modules shown above for medical staff. Fire safety training module had the lowest completion rate with 75.9%. There were an additional 18 staff who completed the resuscitation training module although were not eligible during this reporting period and have been included in the overall total.

### Course name

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>87</td>
<td>87</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>87</td>
<td>87</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>80</td>
<td>80</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>86</td>
<td>87</td>
<td>98.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>86</td>
<td>87</td>
<td>98.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>86</td>
<td>87</td>
<td>98.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>81</td>
<td>87</td>
<td>93.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>77</td>
<td>87</td>
<td>88.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>74</td>
<td>87</td>
<td>85.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>74</td>
<td>87</td>
<td>85.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>66</td>
<td>87</td>
<td>75.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>18</td>
<td>0</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in critical care at Royal Cornwall Hospital had a completion rate of 94.7% for mandatory training. Qualified nursing staff met the target of 95% for four of the 11 applicable modules. Five members of nursing staff had completed the adult immediate life support module although none were indicated to have been eligible during this reporting period.

### Name of course

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - People</td>
<td>86</td>
<td>86</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>86</td>
<td>86</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>86</td>
<td>86</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>86</td>
<td>86</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>86</td>
<td>86</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>76</td>
<td>76</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td></td>
<td>79</td>
<td>86</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>77</td>
<td>86</td>
<td>89.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>76</td>
<td>86</td>
<td>88.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>73</td>
<td>86</td>
<td>84.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>70</td>
<td>86</td>
<td>81.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Immediate Life Support</td>
<td>5</td>
<td>-</td>
<td>N/A</td>
<td>95%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
During our inspection, leaders of the critical care team told us the mandatory training data for nursing staff was inaccurate. The trust submitted revised data whilst we were on site. This evidence showed nursing staff were 100% compliant in eight courses. These were: dementia awareness; equality and diversity; medicines management; mental capacity act; moving and handling level one; conflict resolution; safeguarding adults level one; safeguarding children level one. Safeguarding training data is reported elsewhere in this report.

**Safeguarding**

There were processes to safeguard adults and children from abuse and neglect. Staff we spoke with understood how to recognise a safeguarding concern and were knowledgeable of the processes to follow in the event of them identifying a safeguarding concern. There was a safeguarding lead who could be contacted for further advice when required.

Staff were offered mandatory training and regular updates regarding safeguarding systems. Staff in the critical care team were required to complete mandatory training in the systems and processes around safeguarding vulnerable adults and children. This training included reference to female genital mutilation and human trafficking.

However, there was a risk staff might not have up to date knowledge regarding safeguarding safety systems processes and practices. This was because not all staff had completed their mandatory training in safeguarding children level two and safeguarding adults level two. Compliance with this training was below the trust standard of 95%.

The data for mandatory training compliance of nursing staff, given to us as part of our provider information request, is displayed in the table below. A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for medical/dental and nursing staff in critical care is shown below. The 95% target was met for two of the four safeguarding training modules for which medical staff in critical care were eligible. Safeguarding children (level 2) had the lowest completion rate with 31.8%.

**Safeguarding training completion by module – medical and dental staff - Royal Cornwall Hospital**

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>12</td>
<td>22</td>
<td>54.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>7</td>
<td>22</td>
<td>31.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab**

During our inspection, leaders of the critical care team told us the safeguarding training data for medical staff was inaccurate. The trust submitted revised data whilst we were on site. This data is shown below. However, it remained that the 95% target was met for two of the four safeguarding training modules for which medical staff in critical care were eligible.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>8</td>
<td>11</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>7</td>
<td>11</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Updated data provided by the trust for the period April to August 2018 indicated that medical staff in critical care at Royal Cornwall Hospital had a completion rate of 90.0% for safeguarding training. Medical staff met the 95% target for three of the four modules. Compliance improved for all four modules when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>20</td>
<td>20</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>20</td>
<td>20</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>19</td>
<td>20</td>
<td>95.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>13</td>
<td>20</td>
<td>65.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

The data for mandatory training compliance of nursing staff, given to us as part of our provider information request, is displayed in the table below. The 95% target was met for two of the four safeguarding training modules for which nursing staff in critical care were eligible. Safeguarding adults (level 2) had the lowest completion rate with 26.4%.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>87</td>
<td>87</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>86</td>
<td>87</td>
<td>98.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>61</td>
<td>87</td>
<td>70.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>23</td>
<td>87</td>
<td>26.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

During our inspection, leaders of the critical care team told us the mandatory training data for nursing staff was inaccurate. The trust submitted revised data whilst we were on site. The 95% target was met for safeguarding adults level one and safeguarding children level one. It remained not met for safeguarding children level two and safeguarding adults level two.

<table>
<thead>
<tr>
<th>Course name</th>
<th>Critical care nurse’s completion rate</th>
<th>Outreach nurse’s completion rate</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>67.1%</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>79%</td>
<td>71.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in critical care at Royal Cornwall Hospital had a completion rate of 86.9% for safeguarding training. Qualified nursing staff met the 95% target for two of the four modules. Compliance improved for three of the modules when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 1)</td>
<td>86</td>
<td>86</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>86</td>
<td>86</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>67</td>
<td>86</td>
<td>77.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>60</td>
<td>86</td>
<td>69.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
All band five and band six nursing staff were encouraged to complete safeguarding children level three training. Medical staff were also invited to participate in this training. Completion of the training was not mandatory. At the time of our inspection, 66.7% of eligible nurses and no medical staff had completed this training.

Cleanliness, infection control and hygiene

The unit appeared visibly clean. The hospital contracted the cleaning of the ward areas to a private company. This company allocated a regular cleaner to the unit. The cleaner was responsible for completing daily checklists of all the work undertaken. Cleaning standards were jointly audited on a weekly basis by the ward sister and the cleaner’s line manager. The critical care team were proud their cleaner had achieved 100% for this audit during the three weeks preceding our inspection.

There were reliable systems to prevent and protect patients from healthcare associated infection. Critical care staff followed national guidance with regards to decontamination of their hands. Staff decontaminated their hands immediately before and after every episode of direct patient contact. There were sufficient hand wash sinks and equipment and alcohol gel was available in each bed space. Hand hygiene audits were completed every month. This audit looked at whether staff were bare below the elbows and whether they decontaminated their hands for the NHS’s ‘five moments of hand hygiene’. In the six months preceding our inspection the results of this audit were 100% for March to July 2018 and 90% for February 2018.

Doctors and nurses wore personal protective equipment such as gloves and aprons where appropriate to avoid risk of cross contamination. There were systems to ensure good practice. For example, aprons were colour coded for each bed-space.

Disposable curtains between bed-spaces were changed at fixed intervals or earlier if they became soiled or if there was the risk of infection. However, the date of changing the curtains was not displayed on two of these curtains. Nursing staff were responsible for cleaning medical equipment within the patient’s bed-space. Team members used checklists and ‘I am clean’ stickers to confirm when cleaning had taken place.

The unit had not developed Local Safety Standards for invasive procedures (LocSSIPs). However, staff followed standard safety protocols when they carried out an invasive procedure for a patient such as inserting a chest drain (a small plastic tube inserted into the chest). This minimised the risk of hospital acquired infections.

Leaders completed regular audits to check staff consistently followed safe procedures. The intravascular line audit looked at the documentation of 10 patients every month to check team members had given the recommended care at the time of insertion and thereafter. In the six months preceding our inspection, the results of this audit were 100% for April, June and July 2018, 95% for May 2018, 94% for March 2018 and 85% for February 2018. The indwelling catheter audit looked at the documentation of 10 patients every month to check team members had given the recommended care at the time of insertion and thereafter. In the six months preceding our inspection, the results of this audit were 100% for February, March, April, June and July 2018. Results for May 2018 were 87%.

Rates of hospital-acquired infection were low. Leaders of the service monitored the safety of the service using a critical care dashboard. This displayed monthly figures for a range of metrics including unit acquired MRSA and unit acquired Clostridium difficile. There was only one case of
acquired MRSA during the eight months preceding our inspection, and no instances of acquired *Clostridium difficile*.

Every three months, the specialty lead submitted data to the Intensive Care National Audit and Research Centre (ICNARC). This included data regarding the number of patients who acquired an infection whilst they were an inpatient on the unit. This report showed during April 2017 to March 2018, there were six infections of this type, which equated to 1.5 per 1000 patient days. This was slightly higher (worse) than similar units who had an average of 1.0 but below (better) than the average of 1.6 for all units participating in the audit.

**Environment and equipment**

The unit was built to a safe standard. Some aspects of the critical care environment complied with Health Building Note 04-02 (2013), although the unit was built before this guidance was issued. The critical unit was centrally located close to imaging facilities and operating theatres with easy access from the Emergency Department. Each bed-space had an electric bed capable of attaining Trendelenburg positions (to give patients many different positions in which to rest). All beds were fitted with a pressure relieving mattress. Each patient had a high-backed chair with foot elevation and tilting facility. The North area of the unit had ceiling mounted twin armed pendants to accommodate a range of equipment and for the provision of medical gases and electrical and data connectivity. Each bed space had a call bell system with a separate switch for an emergency call. Curtains in multi-bed spaces closed to ensure 100% privacy and could be pulled back to the wall when not in use. There were toilet and shower facilities for patients.

Some aspects of the environment did not comply with Health Building Note 04-02. On the South area of the unit, ceiling mounted pendants were not available and clinical wash hand basins were shared between patients. Not all bed spaces had easy visibility of an analogue clock to help patients be orientated by the time. The visitors waiting area was not separated from the clinical areas by a door. The reception desk did not have surveillance of the visitors’ entrance. However, as required by critical care national guidance, these risks were recorded on the critical care risk register.

These shortfalls did not impact significantly upon the safety of patient care. The environment was used safely, and leaders allocated the bed space locations according to patient risk. Bed spaces without view of a clock were rarely used. Closed circuit television was in operation which gave visual oversight of the front door and the corridors leading to the unit. Access to the unit was controlled by door intercom and a member of staff met all relatives at the entrance to show them to the waiting area or to the patient’s bedside.

There was a designated area for the respiratory isolation of patients with a transmittable infection. However, due to space limitations, the team used the area for training and for storage when it was not in use for patients. There were clear processes for ensuring the area was cleaned and made ready for clinical use when required.

There were safe systems for the management of clinical waste. The risk of cross contamination was reduced because nurses and doctors used disposable equipment. We saw staff disposing of equipment safely in sharps bins or clinical waste containers.

Staff ensured emergency equipment was available and ready for use. Nurses checked emergency trolleys at the beginning of each nursing shift. Defibrillator trolleys had tamper-evident drawers. All disposable items on the trolleys were in date at the time of our inspection. Difficult airway trolleys were compatible with the requirements of the Difficult Airway Society. Staff checked these trolleys once a day and followed clear guidance to ensure all necessary stock was available. Emergency
medicines such as a hypoglycaemia kit and reversal medicines were kept in stock. Equipment for transferring adult and paediatric patients within the hospital and to offsite locations was stored in specific transfer bags. Staff in the outreach team used a checklist to review these bags every day to ensure they were ready for immediate use.

Not all equipment risks were adequately assessed. Bed rails were routinely used for patients on the unit and none of these patient records showed evidence of adequate assessment of the risk related to use of this equipment. The Medicines and Healthcare Products Regulatory Agency issued a directive in December 2013. This identified the need for a careful and thorough risk assessment of combinations of bed equipment including beds, rails, mattresses and bed occupants to avoid the risk of patients becoming trapped by the bed equipment. The trust document ‘Policy for prevention and management of falls in hospital and the safe use of bedrails with adult patients’ (August 2015) stated bedrail assessments must be undertaken for all patients where bedrails are being considered. The trust-wide documentation did not include the tools recommended in the policy and did not provide prompts for detailed risk assessment. During our inspection we raised this concern with the matron who acted immediately to escalate the risk to the deputy chief nurse and to reinstate the use of a bed rail matrix tool as an interim measure.

Staff used medical equipment that was not regularly maintained. There was a backlog in the routine servicing and maintenance of medical equipment such as patient monitors, suction pumps, beds, respiratory equipment and hoists. There were 33 items of high risk equipment that did not meet the key performance indicator for routine servicing and maintenance, 15 of these were out of date by over 12 months. There were 17 items of medium risk equipment that did not meet the key performance indicator for routine servicing and maintenance, five of these were out of date by over 12 months. There were a further 38 items of high risk equipment and 24 items of medium risk equipment for which there was insufficient data to determine whether the key performance indicator for routine maintenance had been met.

Following the previous CQC inspection in July 2017, the trust implemented a recovery plan for medical equipment maintenance which focused on improvement, sustainability and corporate level governance of medical devices. A medical equipment board was set up in May 2018. The trust-wide plan for mitigating this risk included prioritising high-risk equipment for maintenance, interim outsourcing of servicing and maintenance, making additional space for the maintenance workshop, purchasing additional test equipment, providing “swap-out” equipment to improve technician access to highly utilised equipment, replacing equipment overdue for service with new equipment where possible. Data showed there had been a sustained improvement in the compliance rate for medium and high-risk items and a trust-wide recovery trajectory ahead of dates endorsed by the medical equipment board.

The plan to mitigate the risks specific to critical care included: prioritising the maintenance of pipeline suction and flow meters, removing decommissioned respiratory machines from the unit, cleansing data and physically auditing the remaining items to confirm their existence on the unit. The critical care leads planned to alert technicians when equipment was not in use. These actions were to be completed by the end of October 2018.

At the time of our inspection, completion dates for equipment training had not been logged on to the electronic database so nursing team leaders were not able to readily monitor individual or team compliance. However, paper records showed nursing staff were trained in the use of equipment on the unit. All nursing staff told us they felt confident to use the medical equipment. Junior doctors told us they were trained in the use of equipment as part of their induction and felt at ease to ask for help.
Where patients required specific equipment, such as a self-turning bed, the team had secured this funding and purchased the necessary equipment for the patient’s stay. Staff also hired specialist equipment to trial which brand was most suitable for individual patients. This included, for example, home ventilator systems.

**Assessing and responding to patient risk**

The unit had the facilities and experience to safely care for level two and level three patients. The hospital used the Intensive Care Society ‘Levels of care’ to categorise patients according to their clinical needs. Level zero care described patients whose needs could be met through normal ward care. Level one care referred to patients recently discharged from a higher level of care, patients in need of additional monitoring, input or advice, or patients requiring critical care outreach support. Level one patients could also be cared for on general wards. Level two care described patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those ‘stepping down’ from higher levels of care. Level three care referred to patients requiring advanced respiratory support alone or monitoring and support for two or more organ systems. This level included all complex patients requiring support for multi-organ failure.

Nursing staff completed a holistic assessment for each patient on the unit. This assessment identified the individual risk factors applicable for each patient. The nursing documentation directed staff to implement specific management plans to reduce unsafe outcomes, for example, risks of developing venous thromboembolism, falls, pressure ulcers and delirium. There were also management plans to promote healthy physiology such as bowel and bladder function, nutrition and hydration. We checked patient records and saw the holistic assessments and management plans were consistently completed. However, the nursing assessment did not focus on mental health. If mental health/learning disability/dementia needs were identified there was not a corresponding care plan.

There was a hospital-wide standardised approach to detecting patients who were deteriorating. Ward staff completed patients’ vital observations and used a nationally recognised tool, the National Early Warning System (NEWS), to record this for all patients. Staff inputted individual patients’ NEWS scores onto networked devices. As the patients’ NEWS score increased, for example, if the patient had onset of sepsis, a referral to the outreach team was automatically triggered. Sepsis is a life-threatening illness caused by the body’s response to an infection. Sepsis develops when the chemicals the immune system releases into the bloodstream to fight an infection cause inflammation throughout the entire body instead.

The outreach team was available 24 hours a day. We visited the hospital at night time and saw the outreach nurse visiting wards to provide advice for ward staff and to monitor patients who might be at risk of deterioration. The outreach team attended the consultant medical handover, so they were prepared for patients who were identified as at risk of potential deterioration.

Members of the critical care team and outreach team were competent and confident to recognise and treat sepsis. The hospital wide plan for treating sepsis began with the ward staff using an observation system to trigger the automatic referral to the outreach team. The outreach team implemented the sepsis six care bundle. This is a recognised evidence-based treatment plan for early onset of sepsis. Staff used a recognised tool as a reminder of the essential tasks required to complete for the sepsis pathway. The critical care team used a sepsis-related organ failure assessment score to track patients’ status during their stay in the unit to determine the extent of their organ function or rate of failure.
Current patient risks were communicated to staff during handovers. For example, the nursing shift leader identified when patients had treatment escalation plans, highlighted patients who were under a section of the Mental Health Act, and emphasised caution where patients had similar first names. We saw medical handovers were structured and comprehensive. Junior doctors confirmed they had all relevant information communicated to them at the start of every shift. Staff felt confident to seek advice and support from senior staff when a patient’s condition deteriorated. Contact with senior doctors was always supportive.

There was an effective system to ensure all members of the critical care team had a clear and accurate overview of safety risks on the unit at the beginning of each nursing shift. We saw up-to-date risks assessed which affected patient care. These were posted onto ‘hawk-eye’ at every shift handover. Hawk-eye was a visual display board in the staff meeting room where shift leaders posted snapshot data and briefings regarding infection control, patients who were at risk of airway difficulties, falls, pressure sores and delirium. The leaders also highlighted any patients with safeguarding concerns, any patients with decreased or variable mental capacity, patients with treatment escalation plans and patients who had a diary to complete. Any patient deaths that had occurred during the previous shift were communicated to staff at handover and listed on hawk-eye.

There were systems to minimise risk of harm to patients during surgical procedures carried out on the unit. The critical care team ensured current safety recommendations communicated at a national level were incorporated into everyday practice. For example, in response to the National Tracheostomy Safety Project, the critical care team implemented use of the World Health Organisation (WHO) safety checklists. They positioned signs above patient’s beds indicating the type of tracheostomy and the specific care required in the case of an emergency. However, the use of the WHO checklist was not audited, so compliance with this protocol could not be assured.

Staff did not routinely complete risk assessments for patients with mental health needs. There was no risk assessment form for staff to complete. Staff explained that they would consider risks for patients based on patient presentation and experience. This should be documented in a patient’s clinical notes. However, we found no examples of this. Critical care was, however, provided with round the clock access to mental health liaison (covering the age range of the unit) and/or other specialist mental health support if staff were concerned about risks associated with a patient’s mental health.

The critical care team were prepared to respond to emergency situations. Once a year the critical care team participated in evacuation training. This involved using the teaching mannequin and included removal/set up of all relevant equipment. Fire officers attended these events for support and training.

**Nurse staffing**

**Planned vs actual**

The nursing team was not fully staffed. The trust reported their staffing numbers below as at April 2018 for nursing staff in critical care at Royal Cornwall Hospital, with an overall staffing rate of 93.3% of planned levels.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Planned WTE Staff</th>
<th>Number in post as at April 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>84.7</td>
<td>79.0</td>
<td>93.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
The unit ensured nursing staff to patient ratios complied with the Faculty of Intensive Care Medicine Core Standards for Intensive Care (hereinafter referred to as the Core Standards) recommendations for safe provision of critical care. The nurse to patient ratio for level three patients was a minimum of one nurse to every one patient. The nurse patient ratio for level two patients was a minimum of one nurse to two patients. The duty rosters demonstrated this ratio was met.

Nursing staffing included one supernumerary nurse per shift who was available to respond to patient emergencies, as detailed in the Core Standards. Many of the admissions to critical care were unpredictable and for this reason the unit required enough staffing to provide a prompt response for very sick patients.

There were systems to ensure adequately trained critical care nursing staff were available to respond to emergency admissions and deterioration in existing patients. The matron used a measure of care contact time as another tool to achieve safe nursing staffing in critical care. Care contact time refers to the time that staff spend with patients. Locally collected care contact time can be analysed to show the proportion of nursing time spent on direct care, indirect care, associated work or unproductive time and can be related to factors such as patient need and dependency, and overall nursing staff available. Staffing levels and direct care time data were displayed on the unit.

The matron or sister attended the hospital-wide staffing review meeting twice daily. Representatives from all wards attended this meeting to determine nursing staffing requirements across the hospital. In the past, critical care nurses were sometimes redeployed elsewhere in the trust to cover staff shortages and could not be retrieved from these wards at short notice. There was a standard operating procedure to moderate this risk. This directed the site team to redeploy temporary nurses before critical care substantive nurses, identify a redeployment area suited to each nurse’s competence and ensure nurses could return to the unit within an hour if required. A standard operating procedure also stipulated the process for redeployment of critical care outreach staff which could only be used as a last resort. The ward sister planned to present a skills refresher day for critical care trained nurses who now worked elsewhere in the trust, the aim being these nurses could be called on in the future to respond to surges in demand.

Vacancy rates
The nursing team were affected by staff vacancies. From May 2017 to April 2018, Royal Cornwall Hospital reported a higher (worse) vacancy rate of 13.8% in critical care when compared to a target of 10% at March 2018 and reduced target of 6% at March 2019.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Band seven team leaders told us they did not have time to complete all the management aspects of their role. At the time of our inspection, there were eight band five nursing vacancies, with a further two to four vacancies anticipated considering predicted retirements and secondments. The service had recently advertised for a further band seven nurse who would lead on patient experience.

Turnover rates
There was a low rate of staff turnover. Staff turnover refers to the number of staff who leave an organisation and are replaced by new employees. From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 6.5% in critical care, which was lower (better) than the trust target range of 10-14%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates

From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 3.7% in critical care, which was lower (better) than the trust target of 3.8%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The use of bank and agency staff complied with the Core Standards for Intensive Care Units. The unit did not use more than 20% bank or agency staff on any one shift when those nurses were not their own staff.

Bank and agency staff filled all vacant shifts in the 2017/18 year. From May 2017 to April 2018, the trust reported 99 bank shifts and 285 agency shifts filled by qualified nurses. There were no shifts unfilled. Agency nurse cover was limited to a maximum of two per shift and team leaders always attempted to fill with either substantive or bank nurses first.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

Planned vs actual

There was good coverage by medical staff. In April 2018, there were more medical staff in critical care than the planned levels. This is shown below:

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Planned WTE Staff</th>
<th>Number in post as at April 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>23.4</td>
<td>28.2</td>
<td>Over-established by 20.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

There were enough consultant staff on duty in relation to the number of patients in the critical care unit. The Core Standards state the consultant to patient ratio should not exceed a range between 1:8 and 1:15 and the junior doctor to patient ration should not exceed 1:8.

Consultant work patterns allowed for continuity of care as mandated in the Core Standards. A consultant in intensive care medicine was available 24 hours a day and could attend patients within 30 minutes. There was a consultant for each side of the unit during the daytime. At 5pm, these consultants handed care over to a night consultant who was available in the hospital until approximately 10pm then on-call from home during the rest of the night.

Medical staff were suitably trained to provide safe care. Care was led by a consultant in intensive care medicine. Foundation year doctors were never left as the sole resident doctor on the unit. There was immediate access to a practitioner who was skilled with advanced airway techniques.

Consultants participating in the duty roster were not responsible for delivering other services while covering the unit. This included when they were working in the evenings and at weekends. At the time of our inspection, the establishment of medical staff on the unit did not provide fall back cover on a Saturday morning if the doctor on call on Friday evening had been seeing patients all night.

The critical care clinical lead recognised this risk and submitted a business case to provide capacity for two consultants at weekends. Meanwhile other consultants in the team provided cover on an informal basis.

Vacancy rates
From May 2017 to April 2018, Royal Cornwall Hospital reported an over-establishment of 4.8 whole time equivalent medical staff in critical care. At the time of our inspection, there were no medical staffing vacancies.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**
From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 24.8% in critical care, which was higher (worse) than the trust target range of 10-14%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**
From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 0.1% in critical care, which was lower (better) than the trust target of 3.8%.

(Source: Routine Provider Information Request (RPIR) – Sickness)

**Bank and locum staff usage**
From May 2017 to April 2018, the trust reported no shifts filled by locum staff in critical care and there were no shifts unfilled. There was no data available for use of bank medical staff.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Allied Health Professional Staffing**
Occupational therapy staffing levels did not meet the recommendations of the Guidelines for Provision of Intensive Care Services (GPICS). The guidelines suggest 0.22 whole time equivalent (WTE) occupational therapists per bed, which equates to 3.3 WTE occupational therapists for a critical care unit with 16 beds. There was no occupational therapy for the critical care unit.

Dietitian staffing levels did not meet GPICS recommendations. The guidelines recommend 0.05 WTE per bed which equates to 0.75 WTE dietitian for a critical care unit with 16 beds. There was 0.1 WTE dietitian for the unit.

Physiotherapy staffing levels did not meet GPICS recommendations. The guidelines suggest 1 WTE per four beds which equates to four WTE for a critical care unit with 16 beds. There were 3.2 WTE physiotherapists for the unit and their remit was respiratory therapy only. There was no dedicated speech and language therapy or psychology input for the critical care unit.

All therapists we spoke with confirmed they were unable to meet the rehabilitation needs of patients on the unit and post discharge. Leaders recognised there were gaps in the multidisciplinary team but there had been no audit of the impact on patient experience.

**Records**
Individual care records were written and managed in way that kept patients safe. The critical care team used a records system designed to meet the needs of critically ill patients. The critical care team used a specific electronic records system not used elsewhere in the hospital. The system included prompts for a holistic patient assessment and evidence-based care plans for generic needs such as prevention and management of pressure ulcers, falls, venous thromboembolism (deep vein thrombosis).

Senior nurses checked staff were completing patient records carefully. They audited ten sets of records each month. The audits focussed on whether staff were recording completion of the recommended care plans for patients with intravascular lines, pressure ulcers, and indwelling urinary catheters. An intravascular line is a tube inserted into an artery or a vein. A pressure ulcer
is an injury to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. An indwelling catheter is a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage.

Information needed to deliver safe care and treatment was available to staff in a timely and accessible way. This included test and imaging results, risk assessments, care plans and case notes.

When patients moved between teams, for example, as a referral, transfer or discharge, all the information needed for their ongoing care was shared appropriately. The critical care team ensured ward staff had a record of the patient care and treatment within critical care. The nursing staff recorded all their interventions in the electronic patient record and recorded the same information onto a paper record. The paper record went with the patient to the ward on discharge.

We checked five patient records. Records were comprehensively completed and included clear summaries of assessments, reviews, ward rounds and communications with patient’s relatives. However, the system to record treatment escalation plans was not reliable. There was no formalised protocol for recording the treatment escalation information and rationale for individual patients. The team did not use the standard treatment escalation plan used elsewhere in the hospital as they felt it did not provide enough flexibility to record the nuances of life support options offered in the unit. We checked patients’ records and found there was insufficient detail recorded about the treatment escalation plans and staff were unclear where to find this information. There was a risk staff might not be able to retrieve this information at short notice. Following our inspection, a decision was made to include a separate tab within the electronic record to locate treatment escalation plan information.

Staff stored records securely. Staff kept patients’ paper records with them at the bedside. Electronic patient records were stored on computers that were password protected.

**Medicines**

When patients were admitted to the unit, their medicines were reconciled in line with current national guidance. There were two pharmacists employed on the unit to complete clinical tasks such as medicines reconciliation and to supply stock as required.

Most medicines and intravenous fluids were stored securely. The pharmacist completed weekly storage audits. Pharmacists checked medicines were within their use by date and ensured enough stock was available for the coming week. However, we found paralysing agents, insulin and emergency medicines stored in a medicines fridge with no lock, located within 10 metres of the relatives’ waiting area. There was no door between the relatives’ area and the fridge. During our inspection a new fridge with keypad lock was ordered for the unit.

Medicines were stored at correct temperatures. The medicine room temperatures and medicine refrigerator temperatures were remotely monitored by the pharmacy department. If a fridge alarm was activated, the pharmacy department informed the unit and assessed if medicines needed to be moved or their expiry date needed to be reduced.

Controlled drugs were stored and managed securely. There was only one controlled drug key in use, and this was in line with trust policy and only authorised staff could access the key. All orders for controlled drugs were signed by a nurse. Controlled drugs for disposal were segregated and all wastage of controlled drugs was recorded in the controlled drugs register. Pharmacists completed audits of the management of controlled drugs.

Medicine prescribing systems were managed securely. There was an electronic prescribing and administration system in use and only trained staff could access this system. Medicines were
appropriately prescribed and administered in line with current best practice. We heard staff giving patients clear explanations about the medicines they were prescribed.

There were systems to monitor whether patients received the correct medicines. When staff administered medicines, they recorded this on the electronic prescribing record. We checked five of these records and all were completed correctly. Staff were encouraged to report medicine errors on the electronic incident reporting system. These were investigated, and trends were discussed at the medicine safety committee. Learning was provided to staff as a safety bulletin email.

The medical team considered antimicrobial stewardship during the ward round and when selecting appropriate antibiotic treatment. The term 'antimicrobial stewardship' is defined as an organisational or healthcare-system-wide approach used to promote and monitor judicious use of antimicrobials to preserve their future effectiveness. Antimicrobials are medicines that fight organisms and include medicines such as antibiotics. The microbiologist visited the ward once per day to provide advice and to review all patients’ medicines. The microbiologists were also readily available if the team need to make enquiries at any other time of day. All prescriptions of antibiotics included the duration and the indication for the treatment.

Incidents

Staff we spoke with had a good understanding of what constituted risk in their clinical area. Staff understood the escalation and reporting process and could access the incident reporting system using the computers at a patient’s bed space.

Staff were encouraged to report incidents and told us they felt confident to do this. There were 246 incidents reported during the 12 months preceding our inspection. The critical care team did not benchmark their incident reporting rate with any similar units. In the 2017 NHS Staff Survey, 85% of staff said the last time they saw an incident, they reported it. This was 10% lower (worse) than the score for the organisation and for comparative similar units.

Staff confirmed they were given clear feedback from incidents reported. Learning from incidents was posted onto the ‘hawk-eye’ board and communicated to staff during handover. Junior doctors gave the example of an incident where the wrong lid for a sharps box had been used. Where appropriate, the shared learning included the results of investigations of incidents at other units across the South West region. For example, a patient had received the wrong intravenous dose of a medicine at another hospital and the learning from this had been shared.

The critical care team ensured lessons were learned if necessary when patients died. Mortality and morbidity reviews were held monthly and were attended by relevant members of the consultant and senior nurse team. These reviews focused on individual deaths as well as patient harm caused by delays. The team used the trust template and global outcome data to analyse the impact of the actions of the critical care team. This included understanding the relevance of good practice as well as elements of poor practice. Critical Care leads escalated any actions for service improvement to the trust’s mortality and morbidity review oversight committee. This committee verified the plan before it was shared with the whole critical care team at monthly governance meetings.

Duty of candour was understood by staff who knew when incidents were subject to its requirements. The Duty of candour regulation (Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. All staff had a good understanding of the duty of candour and could describe when it would be used.
Never Events
The critical care team had a good safety record. From June 2017 to May 2018, the trust reported no incidents classified as never events for critical care. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS
In accordance with the NHS Serious Incident Framework 2015, the trust reported one serious incident (SI) in critical care which met the reporting criteria set by NHS England from June 2017 to May 2018. This was for a treatment delay.

This incident was not investigated in a timely way. More than three months passed between the incident and the initial review, seven weeks later a letter was sent to the patient explaining that an incident had occurred, and a further five weeks elapsed before the patient was offered an apology. The initial review of this incident was delayed because the incident was identified and reported retrospectively.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer
The Patient Safety Thermometer indicated patients received safe care. The Safety Thermometer is a tool used in hospitals to record the prevalence of patient harms, for example pressure ulcers, falls, acquired infections. Data collection takes place one day each month. The results of the safety thermometer provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Data showed the trust reported four new pressure ulcers, no falls with harm and no new catheter urinary tract infections from May 2017 to May 2018. The team displayed this data on the ward for visitors to view.

(Source: NHS Digital)

Is the service effective?
Evidence-based care and treatment
Staff took account of the current evidence base for treatment, when explaining treatment options with patients, when planning patient care, during governance meetings and when developing service proposals.

The critical care team discussed new national guidance and standards for treatment and incorporated these into their clinical practice. The Clinical Audit and Outcomes Group provided updates on national guidelines such as those published by the National Institute for Health and Care Excellence (NICE). The critical care governance lead took responsibility for sharing these with the governance meeting.

Staff considered the patients physical emotional and social care needs as part of the holistic assessment process, in accordance with NICE QS15: Patient experience in adult NHS Services. Following assessment, care was planned to meet evidence-based treatment standards. We saw the consultant team discussed individual patients in depth during the twice-daily ward rounds. Junior doctors demonstrated clear understanding of the clinical priorities for patients they presented at the ward round.
Technology and equipment was used to support patients’ independence. For example, a self-turning bed had been obtained for a patient to use when they were discharged home. The team had used charitable funding to purchase a plinth that enabled non-mobile patients to be tilted to a vertical position and achieve the benefits of a standing position. Patients were helped to breathe using specialist ventilation equipment, and their vital signs were constantly reviewed using monitoring equipment.

Staff protected the rights of Patients who were subject to the Mental Health Act 1983 and had regard to the MHA Code of Practice. Staff followed the code of practice in terms of informing patients of their rights and ensured that patients were legally detained, this was recorded in the patients nursing record. There were also robust arrangements in place for MHA administration which ensured patient rights were protected.

All patients were screened for delirium when they were admitted to the unit using a recognised confusion assessment method. This was in accordance with Guidelines for the Provision of Intensive Care Services, 2015 and NICE Quality Standard 63: Delirium in Adults (year). This assessment tool guided staff to treat the delirium, for example by minimising the environmental risks for the patient, encouraging orientation and prescribing medicines. Nurses described how they would attempt to reduce the distress caused by this condition, using orientation techniques, sensory stimulation and involving relatives. However, the treatment of delirium was not comprehensive because there was no occupational therapy and no psychology input to the critical care team. The Faculty of Intensive Care Medicine Core Standards for intensive care units state highly trained occupational therapists and psychologists should provide assessments and strategies for patients identified as suffering from delirium. Adults receiving intravenous fluid therapy were cared for by healthcare professionals competent in assessing patient’s fluid and electrolyte needs. They could prescribe and administer intravenous fluids and monitor the patient. This complied with NICE Quality Standard 66.

The critical care team followed best practice in the use of sedation in accordance with the recommendations of the Faculty of Intensive Care Medicine. There was daily assessment of each sedated patient using a recognised scoring tool. Sedation was adjusted to achieve optimal levels for each patient, thereby reducing the potential for negative side effects.

The management of critical care patients with sepsis complied with NICE QS161: ‘Sepsis’. The team ensured patients with suspected sepsis were assessed using a structured set of observations to assess risk. High-risk patients were reviewed by consultant within one hour and received antibiotics and intravenous fluids as necessary.

Patients at risk of venous thromboembolism (deep vein thrombosis) were assessed on admission and reassessed daily. Patients were offered prophylaxis (to reduce the risk of thrombosis) in accordance with NICE guideline 89: Venous thromboembolism in over 16’s: Reducing the risk of hospital acquired deep vein thrombosis or pulmonary embolism for patients in hospital (2018).

The service did not provide all aspects of care mandated in NICE QS158: Rehabilitation after Critical illness in Adults and recommended in NICE Clinical Guideline CG83: Rehabilitation After Critical Illness. When adults at risk of morbidity were transferred from critical care to the ward, physiotherapists copied their last treatment record into the handover document. This included data from an outcome measure that could be used in community settings, as recommended by Guidelines for the Provision of Intensive Care Services, 2015. However, this handover was not an individualised, structured rehabilitation programme, developed by members of a multidisciplinary team, that could be used to provide consistency in treatment and rehabilitation. There was no occupational therapy or psychology input for the patients in critical care.
During our inspection, we saw patients were treated without discrimination. We reviewed key policies, for example, the safeguarding policy and they included consideration of their impact upon equality and diversity. All staff in the critical care team had completed equalities and diversity training.

**Nutrition and hydration**

Patients basic nutrition and hydration needs were identified, monitored and met. Nurses completed a holistic assessment of patients' needs. This assessment process included a recognised standardised scoring system for nutrition. These scores identified patients who required a care plan for nutrition and/or hydration. Nurses monitored patients’ food and fluid intake as directed by the care plan.

All patients unable to take food or drink orally were given enteral or parenteral nutritional support from the day of admission, as recommended in the Guidelines for the Provision of Intensive Care Services. Nutrition can be provided either through a feeding tube (enteral nutrition) or, when the digestive tract cannot be used, through an intravenous tube called a catheter that is inserted directly into the veins (parenteral nutrition).

During our inspection, we saw medical staff assessed patients enteral and parenteral feeding needs during the ward round and prescribed appropriate feeds at appropriate rates.

There were limited resources for specialist advice regarding the more complex patients’ nutrition and hydration needs. The trust nutrition and hydration policy stated all patients who required artificial feeding should be referred to the appropriate specialist. There was a dietetic referral pathway for the trust. However, there was no lead dietitian for the unit. Input from the dietitians was limited to once per week. This meant there were sometimes delays of up to six days for a dietitian assessment for specialist intervention. Patients were sometimes admitted and discharged from the unit without gaining access to the specialist nutrition and hydration advice they required. Dietitians told us they were not involved in the assessment, implementation and management of all patients who were unable to take food or drink orally, as recommended in the Guidelines for the Provision of Intensive Care Services. Dietetic input for patients in the critical care unit had not been audited.

**Pain relief**

The consultant team carefully assessed and reviewed patients' pain. Doctors recorded their assessment of pain on the electronic patient record system using a standardised pain score.

The critical care team treated patients’ pain. All patients had an individualised analgesic plan appropriate to their clinical condition, in accordance with the Core Standards for Pain Management Services in the UK.

The critical care team could refer to the acute pain service when required. Out of hours, anaesthetists were available for specialist pain advice and treatment.

**Patient outcomes**

Information about the outcomes of patients’ treatment was routinely collected and monitored. The service submitted data to external audits to compare outcomes against other units nationwide. These included the NHS England Specialised Services Quality Dashboards for Adult Critical Care (SSQD) (reported under the ‘responsive’ section of this report) and the Intensive Care National Audit and Research Centre case mix programme (ICNARC). Internally, leaders of the service monitored the effectiveness of the service using the critical care dashboard. This displayed
monthly figures for a range of metrics including hospital mortality percentage, standardised mortality ratio and mean overall ICNARC score.

ICNARC Participation

The outcomes data showed most of the intended outcomes for patients were achieved. Outcomes compared favourably with similar services, except for the comparison in the National Emergency Laparotomy Audit. The trust’s contribution to the Intensive Care National Audit Research Centre (ICNARC) meant the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The following analysis used data from the 2017/18 Annual Report:

(Source: Intensive Care National Audit Research Centre (ICNARC) 01 April 2017 – 31 March 2018)

Hospital mortality (all patients)

The risk of patients dying was lower (better) than average. Hospitals submit data to compare the actual number of patient deaths with the expected number of patient deaths, based on risks predicted at the time of the patient’s admission. This calculates a score known as the risk adjusted acute hospital mortality ratio which for this unit was 0.81. This was two standard deviations lower (better) than the national average for all units.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (for low-risk patients)

The risk of low-risk patients dying was lower (better) than average. For Royal Cornwall Hospital’s critical care unit, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.75. This was one standard deviation lower (better) than the national average for all units.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Unplanned readmissions within 48 hours

The number of patients who were readmitted to critical care within 48 hours of being discharged was lower (better) than average. These were known as ‘unplanned readmissions within 48 hours’ and are an indicator of ineffective care. At the Royal Cornwall Hospital’s critical care unit, 1% of patients were unplanned readmissions within 48 hours. This was lower (better) than a national average of 1.1% for all units and 1.1% for similar units.

All unplanned readmissions within 48 hours were investigated by the matron. No trends were identified as investigations showed the causes of readmission could not have been avoided.

The ICNARC data showed the proportion of patients who survived was consistently above (better than) the national average for all units and for similar units.

The service performance in the National Emergency Laparotomy Audit from 1 December 2017 to 28 February 2018 was worse than average. Firstly, this showed 50% of patients were admitted to critical care following surgery when their risk of death was greater than or equal to 5% compared to a national average of 75.5%. Secondly, 60% of patients were admitted to critical care following surgery when their risk of death was greater than 10% compared to a national average of 84.2%. The trust performance on the metric ‘Risk of death documented before surgery’ was 47.1% compared to a national average of 78.3%.

The trust participated in the NHS Blood and Transplant Potential Donor Audit. Results for April 2017 to March 2018 identified the trust as ‘average’ for referrals to the organ donation team (18
out of a potential 20 organ donors were referred) and for their collaborative approach to working with the organ donation team (nine out of 11 occasions the specialist nurse was present when approaching families regarding organ donation).

Patients psychological outcomes were monitored in the critical care follow up clinic using qualitative data from a recognised health questionnaire and a trauma screening questionnaire. Within the appointment staff discussed the following topics with the patient: breathing, mobility, appetite, urology, skin, joints, work, recreation, social, sleep, psychological and quality of life.

Audit was valued as a quality improvement initiative. There was an audit lead within the team who coordinated all audits and encouraged staff to complete the audit cycle for conclusions to be verified and learning shared. The audit lead participated in a twice-yearly review of the audit programme.

The service participated in relevant quality improvement initiatives such as local audits. Staff on the unit were involved in bespoke audits that contributed to improving the quality of care for patients on the unit. These included, for example, an audit of pregnancy testing in female patients of reproductive age. Conclusions from the audit recommended revision of the electronic patient record to include a drop-down box for pregnancy status. Another audit looked at the types of clinical and non-clinical incidents that occurred during patient transfers to offsite locations. This analysed contributory themes such as grade of doctor in attendance. Audits related to mental health outcomes were planned but had not yet taken place.

Ongoing internal audits included audit of any positive microbiology results. These indicated a patient had an infection and a root cause analysis would be completed to establish the cause of the infection.

The service liaised with other services across the region to share best practice. The service was part of the South West Critical Care Operational Delivery Network.

Competent staff

Appraisal rates

Not all staff were receiving an annual performance review (appraisal). Up to August 2018, 100% of medical staff and 80.3% of nursing staff within critical care at Royal Cornwall Hospital had received an appraisal compared to a trust target of 95%. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>61</td>
<td>76</td>
<td>80.3%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>12</td>
<td>12</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Staff told us there were ample opportunities for professional development. In accordance with GPICS recommendations, over 50% of registered nurses on the unit had completed critical care qualifications. The mandatory training for critical care staff included an extra day for education especially relevant to critical care teams. This included end of life care and renal replacement therapy. Once a month the team meeting focused on professional education. In the 2017 NHS Staff Survey, 92% of staff in critical care said they had received training in the past 12 months, and 91% said this had helped them to do their job more effectively.
Leaders ensured new critical care nurses were competent to provide safe care to patients. Nurses who joined the critical care team participated in a one-week induction followed by a five-week period of supernumerary practice. All nurses were required to complete the National Competency Framework for registered nurses in adult critical care within two years of their starting date. Each competency required sign off by a senior nurse. Nurses also completed online study modules. Completion was registered on the employee staff record. In the Patient Experience Survey, 97.6% of patients said staff appeared confident and able to perform tasks when caring for them.

Nurses were supported to complete their revalidation process. However, at the time of our inspection, there were limited resources within the team to lead the ongoing professional development of the nursing staff. The Guidelines for the Provision of Intensive Care Services, 2015, recommend each unit has a dedicated clinical nurse educator responsible for coordinating the education, training and continuing professional development framework for critical care nursing staff. At the time of our inspection one band seven nurse was responsible for the professional development of 80 staff in the unit. This nurse also worked in a clinical capacity. The trust was advertising for a practice educator nurse for critical care.

Medical staff received an appraisal in line with the requirements of the General Medical Council. Performance was reviewed, and objectives were set for the coming year. The critical care team consulted other specialties to supplement their skills for complex patients. The mental health liaison team was available to advise staff regarding patients with mental health conditions or dementia. Likewise, the learning disabilities team was available to help staff understand the needs of patients with learning disability or autism.

**Multidisciplinary working**

The team wrote a treatment plan for all patients who were admitted to critical care. This plan was discussed with the consultant in intensive care medicine, as recommended in the Guidelines for the Provision of Intensive Care Services, 2015. Early in the patient’s stay, the team assessed the patients risk of developing physical and non-physical morbidity, as recommended in NICE CG83: Rehabilitation after Critical Illness.

The team made appropriate referrals to other teams such as the palliative care team where this was appropriate. For example, during our inspection, specialists from the ear nose and throat team assisted the critical care team with a tracheostomy procedure for a high-risk patient.

Staff worked across health care disciplines and with other agencies when required to care for patients. There were good working relationships with various specialist teams both employed by the trust and external to the trust. The complex care and dementia team, learning disability team, and the alcohol liaison team all employed by the trust, were well respected by staff. There were also strong links with the local substance misuse service, local mental health services and social care teams.

The team worked collaboratively with the specialist nurse for organ donation who was employed by NHS Blood and Transplant. Wherever possible, the critical care team referred patients to the organ donation team one day prior to treatment withdrawal to allow notice for the specialist nurse to prepare.

The multidisciplinary team did not include all relevant specialties as recommended in national guidelines. The critical care team referred patients to speech and language therapists and dietitians, but these therapists covered several other wards and were not part of the critical care team. There was no funded psychology service or occupational therapy service for the unit. However, the team included a physiotherapist who was suitably experienced to contribute to plans.
for weaning patients from ventilation, as recommended in the Guidelines for the Provision of Intensive Care Services, 2015.

All relevant teams and services were informed when patients were discharged from the service. All patients discharged from the unit were reviewed by the outreach service. There was an agreed referral pathway for outreach social work. Ward staff received a detailed handover from the critical care team.

**Seven-day services**

Most services continued to be delivered seven days a week as mandated in NHS Services Seven Days a Week Clinical Standards. However, there were some areas of reduced capacity.

At weekends, medical cover was close to full capacity. There was one consultant on weekends compared to two on weekdays and there were two junior doctors compared to four to six junior doctors during weekdays. However, patients continued to have timely 24-hour access to consultant directed interventions.

There were twice daily ward rounds led by a consultant in intensive care every day including weekends and bank holidays. The pharmacist attended the ward round. However, ward rounds did not have daily input from physiotherapy as recommended in the Guidelines for Provision of Intensive Care Services, 2015.

There was a reduced diagnostic service available at weekends and bank holidays. Patients could receive computerised tomography scan and interventional radiology. However, there was a reduced service for echocardiogram, magnetic resonance imaging and ultrasound diagnostic services. All time critical diagnostic requests such as endoscopy, imaging, pathology and cardiology were discussed with the on-call consultant team.

Other members of the multidisciplinary team were available with an on-call or sometimes reduced level of service. For example, physiotherapy was available for respiratory patients only. However, the team could access a 24-hour psychiatric liaison service. There was a pharmacist available at weekends trained to reconcile medicines between the electronic patient records system on the unit and the one used on the wards.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Staff sought expert advice on complex decisions where needed and involved a range of professionals to ensure the best decision was made to optimise the treatment outcomes for the patient.

Patients gave their consent whenever possible. Staff acted in the best interests of patients who were not able to make their own decisions due to a lack of mental capacity at that time. Staff recorded best interest decisions in the patients’ medical notes.

The medical team completed a mental capacity assessment for each patient every day as part of the ward round and this was recorded in the electronic patient record. Staff could also refer patients to the dedicated trust-wide team for mental capacity assessment who would then visit the ward to complete the assessment.

The trust reported from May 2017 to April 2018, Mental Capacity Act training was completed by 99.2% of staff within critical care at Royal Cornwall Hospital. Nursing staff had a completion rate of 100% and medical staff had a 95.5% completion rate.
Staff understood the requirement for Deprivation of Liberty Safeguards (DOLS) and gave examples of when DOLS applications were made.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level one training had been completed by all staff within critical care at Royal Cornwall Hospital. All medical and nursing staff had completed the training.

(Source: Updated data provided by the trust)

**Is the service caring?**

**Compassionate care**

Staff protected the privacy and dignity of patients. We saw, for example, consultants checked before entering patients bed spaces when curtains were drawn. Staff ensured curtains were drawn to protect a patient’s dignity. In the Patient Experience Survey, all patients who responded to this survey said staff introduced themselves before treatment began and 98.9% of patients said they had been treated with respect and dignity.

Staff took time to build relationships with patients. We heard team members talking to patients about their lives, sharing humorous stories. Team members tried to get to know patients in the short time they were in the unit. We looked at the entries nurses had made in patient’s diaries. These messages were caring and personal, explaining how the nurse had made the patient comfortable, saying how they had enjoyed looking after them that day.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia.

Staff gave patients information they wanted when they needed it. We heard nurses helping patients to understand what had happened to them, orientating patients to their surroundings, reassuring them they were being cared for and their loved ones were safe.

The care given by staff was consistently compassionate. In the patient experience survey, patients described the care as, for example, “second to none”. Staff were described as always kind and thoughtful. At the time of our inspection, one patient told us staff always had a smile to give, even when they had worked a twelve-hour shift. In the Patient Experience Survey, 99% of patients said staff showed them care and compassion and 98.4% of patients said they would recommend the unit to family and friends.

**Emotional support**

Patients and relatives felt supported by the team. They told us doctors and nurses had listened to their worries. We saw a consultant helped a relative to feel more at ease with a difficult decision by sensitively explaining the limited options available.

When patients or their carers were told bad news, all members of the team were aware of their need for additional support and/or privacy. Staff used a quiet room to share bad news with relatives and avoided disturbing the patient and their loved ones during this time.

Staff helped to alleviate patients’ fears and anxieties. We saw patients were given verbal reassurance prior to and during difficult procedures, such as when their breathing tube was removed. In the Patient Experience Survey, 98.9% of patients said staff made them feel at ease by being friendly and warm in conversations.

The team involved the chaplaincy services for patients who needed spiritual care. We were told the chaplain regularly visited and telephoned patients to say prayers.
Understanding and involvement of patients and those close to them

The consultant team carefully considered the needs of family members when discussing the limitations of available treatment for individual patients. For example, the team ensured care was continued to allow time for family members to travel to the hospital to say goodbye to their loved one.

The team followed best practice and involved the specialist nurse for organ donation when they approached families about organ donation when treatment was being withdrawn.

The team kept patients and relatives informed about the treatment plans. We heard doctors describing and explaining the risks of treatment to relatives using plain English. Doctors answered questions with sensitivity. Nurses helped patients to understand their condition in a kind and empathetic way. In the Patient Experience Survey, all patients said they had been involved in decisions about their care.

There were trust guidelines to encourage staff to use patient diaries. Staff we spoke with were familiar with the rationale for the use of patient diaries to help patients who might not otherwise have a record of the time when they were unconscious or semi-conscious. Nurses assessed patients’ suitability for completion of patient diary after 48 hours on the unit. During our inspection, two of the fifteen patients had diaries in use. Leaders confirmed staff needed further encouragement to ensure these were implemented consistently.

Staff listened to patients and encouraged patients to be partners in the treatment process. We heard nurses using communication aids to have conversations with patients who could not speak. The follow-up clinic gave patients an email address where they could contact the team if they had any further questions. In the Patient Experience Survey, 98.9% of patients said staff listened to what they had to say.

Is the service responsive?

Service delivery to meet the needs of local people

The facilities and equipment were appropriate for the services being delivered. The critical care team were aware of the limitations of the environment on the South side of the unit. For this reason, the team accommodated level two patients on the South side and level three patients on the North side where the environment was equipped to meet their needs.

Patients were supported to maximise their own health and well-being. All patients who had stayed on the unit for more than three days were invited to an outpatient follow-up clinic. This gave patients opportunity to discuss their ongoing care needs. Physiotherapists would attend outpatient follow-up clinics if the doctor asked them to attend for advice. However, there was no input from other therapy services.

Leaders had identified where patients needs were not being met and had incorporated this unmet need into their service development plans. For example, there was an increase in demand for level three patient care. Current funding was for six level three beds and nine level two beds. The team had submitted a bid to increase the capacity for two more level three beds.

The team had purchased equipment and provided training for staff to enhance the flexibility and continuity of care for patients. This included equipment to show the electrical signals of sensation going from the body to the brain and spinal cord. This test was used to predict how well a patient was expected to recover from their injury or illness. The availability of this equipment on the unit meant this test could be completed at any time and the team were not reliant on the cardiology service. Five of the consultants were completing training in the use of transthoracic
echocardiogram equipment. This was a type of ultrasound scan used to detect problems with the heart. An ultrasound scan is when a small probe is used to send out high-frequency sound waves that create echoes when they bounce off different parts of the body.

During periods of major disruption, the critical care team had responded to patient need with resilience. For example, during the snow of the winter of 2017/18, the ward clerk coordinated a closed social media network to organise transport. Staff who owned 4x4 vehicles used these to transport members of the team to and from work. Many members of the team stayed overnight at the hospital. Likewise, when the hospital experienced a surge in patients infected with the influenza virus, the team rented extra ventilators to meet patient need. Leaders of the critical care team were part of a South West regional group of critical care teams who met four times a year. During the influenza crisis this group shared intelligence using a social media app.

Staff signposted visitors to local bed and breakfast accommodation if they wanted to stay over to be near patients. There was a relatives’ room with sofas and facilities to make hot drinks and microwave meals.

The critical care team sought advice from other specialist units and set up home ventilation packages of support. This included trialling the most effective ventilators to suit individual patients.

**Meeting people’s individual needs**

When patients had individual needs, this was identified on the patient record and communicated to the team at handover. The electronic patient record system included ‘flags’ to identify patients with additional needs. This included, for example, risk of falls, end of life care, dementia, major trauma, infections, patients with a similar name, or sensory loss. Staff knew the relevance of these ‘flags’ and where to locate them.

Extra care was taken to meet the needs of patients with learning disabilities. The shift leader identified patients with a learning disability during handover. Staff told us they were always well informed regarding a patient’s needs, usually prior to admission to the unit. The trust’s specialist learning disability team visited the unit if a patient with learning disabilities was admitted. If the treatment for the patient was planned, where possible, patients were shown around the unit and introduced to the team prior to their admission.

The service had arrangements, known to all staff on duty, to meet patients’ urgent or emergency mental health care needs, including outside office hours. There was a service level agreement with a local mental health trust to deliver acute liaison mental health services and Mental Health Act management.

The team made sure patients with complex emotional and mental health needs received the support and care they required. Patients emotional needs were discussed in multidisciplinary meetings and plans for appropriate management and treatment plans were actioned. This included liaising with psychiatric services and securing one-off funding for psychology input. The trust’s Onward Care Team provided support to ward staff in planning the discharge of patients with complex health and social care needs.

The team cared for patients’ individual needs post-discharge. At the follow-up clinic, patients completed a standardised screening assessment for anxiety and depression and the short form health survey as a measure of health status. The follow-up team used the results of these tests to assess the psychological and physical morbidity of patients post discharge and made referrals for further treatment as required. Research nurses encouraged staff to give patients a ‘critical care discharge booklet’ when they left the unit. This booklet explained some of the anxieties patient
might experience post discharge. Patients were also signposted to useful websites where they might find support and information.

Services were delivered and coordinated to be responsive to patients with complex needs. We saw the team produced individual discharge plans for complex patients with long term, co-existing health needs. These were designed to coordinate services and ease the transition to life outside the unit for patients and their families.

The trust held an honorary contract with a shiatsu massage therapist who visited the critical unit once per week to perform head, hands and feet massage tailored to patients’ individual needs. Patients could receive this service paid for through the critical care charitable fund. Relatives could also pay privately to receive the service on the unit.

Translation services were available for patients whose first language was not English. The team also tried, where possible, to match patients with nurses who could speak their language. The ward clerk had completed a British sign language course and was skilled in lip reading, which was helpful for patients unable to speak.

At the time of our inspection, the team could order large print versions of information leaflets for patients if requested. The team had never had a request for information in alternative formats. However, contracts to provide a service for braille and other languages were in the process of being negotiated.

**Access and flow**

The surgical, theatres and anaesthetics directorate did not consistently predict the post-surgery morbidity risk of patients and plan for their critical care needs.

The competing needs of emergency and planned surgery meant that sometimes patients operations were cancelled. During 2017, there was an average of four operations cancelled each month. From January 2018 to August 2018, the mean average number of cancelled operations was 3.25 which was slightly higher (worse) than the national average of 3.02.

The critical care team liaised with the site team to endeavour to discharge a minimum of three patients from the unit each day, if safe to do so. This was to provide beds to admit two patients per day from planned elective surgery and avoid cancellations. Some groups of patients, such as bariatric patients and patients undergoing certain procedures, were routinely booked for a short stay in critical care following their surgery. Only one patient had been cancelled twice during March 2018 to August 2018.

However, not all patients were admitted to the unit in the optimal time. From January to August 2018, there was an average of seven patients per month who experienced a delay to their admission onto the critical care unit. This was slightly better than the average of eight patients per month during 2017. During the 12 months preceding our inspection, one patient had experienced harm due to a delay to their admission to the critical care unit from the emergency department.

**Bed occupancy**

From May 2017 to April 2018, Royal Cornwall Hospitals NHS Trust has seen adult bed occupancy lower than the England average for eight months of the 12-month period.

**Adult critical care Bed occupancy rates, Royal Cornwall Hospitals NHS Trust**

![Bed occupancy chart](chart.png)
Note: Data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

However, data held by the trust indicated a high occupancy rate for level three patients. The team were experiencing more demand for level three beds in the unit. During January 2018 to August 2018, the average monthly occupancy for level three patients ranged between 91% to 145%. The average level three occupancy rate during this period was 117%. This compared to an average during 2017 of 91%. The Royal College of Anaesthetists recommend an occupancy rate of less than 80% for level three patients. Exceeding this rate results in a risk of non-clinical transfers and a failure to admit patients in a timely manner. This risk was recorded on the critical care risk register.

The extra demand was met by reducing the level two occupancy which averaged at 68% in January to August 2018, compared to an average of 88% in 2017. Staffing levels were adjusted to meet patient needs and comply with national recommendations.

Delayed discharges

Sometimes patients had to wait longer than expected to be discharged from the unit. These were known as ‘delayed discharges’ and were counted in ‘bed days’. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 7.5%. This was higher (worse) than the national average of 4.9% for all units and 6.4% for similar units. These results were worse than the evidence we reported at our previous inspection.

Source: Intensive Care National Audit Research Centre (ICNARC) 01 April 2017 to 31 March 2018

During October 2017 to December 2017, data from the NHS England Specialised Services Quality Dashboard indicated the percentage of patients who were discharged within 4 hours of the decision being made was 20.1%. This was three standard deviations lower than the national average of 38.9%. A similar picture had emerged from non-validated data during January 2018 to March 2018.

The percentage of bed days occupied by patients with discharge delayed more than 24 hours was 3.8%. This was higher (worse) than the national average of 3% for all units but lower (better) than the average of 3.9% for similar units. These results were similar to the evidence we reported at our previous inspection.

Source: Intensive Care National Audit Research Centre (ICNARC) 01 April 2017 to 31 March 2018

During October 2017 to December 2017, data from the NHS England Specialised Services Quality Dashboard indicated the percentage of patients who were discharged more than 24 hours of the decision being made was 24.2%. This was within normal range. A similar picture had emerged from non-validated data during January 2018 to March 2018.
The critical care matron had evaluated the causes for delays. These were lack of availability of medical and surgical ward beds and side rooms, and a lack of availability of healthcare assistants to carry out one to one observations immediately post discharge.

The critical care team had implemented a discharge protocol to reduce the delays to discharges. Each day at 8am, the nursing team used the critical care aide memoire to prepare patients for discharge to the ward. At 9am, the consultant and nurse in charge informed the site team which patients were ready to be transferred. At 4pm each day, the consultant and nurse in charge identified patients who were clinically stable and ready for discharge within the next 24 hours. This was communicated to the site team and any additional requirement such as one to one nursing or a side room were arranged in advance. The site team agreed to support a minimum of three critical care discharges per day and prioritise critical care patients over emergency department breaches. The outreach team then reviewed all patients discharged from critical care within 12 hours of their transfer. Since February 2018, there had been a decline in the number of delayed discharges.

The multidisciplinary team planned to ensure discharges went as smoothly as possible. The team set up discharge planning arrangements to suit individual patient need. For example, these might include weekly discharge planning meetings with written updates for family members.

On a day to day basis, nursing staff planned and ensured the patients were ready for transfer. For example, patients had their arterial lines and catheters removed in advance. Consultants considered the long-term needs of patients at an early stage of their treatment. For example, consultants referred a patient for an intravenous access device for long term antibiotic use.

**Non-clinical transfers**

The unit performance was better than the national average for numbers of non-clinical transfers, and non-delayed out-of-hours discharges from the wards. Sometimes patients were transferred to another unit and the reason was not related to the treatment they needed. These transfers were known as ‘non-clinical transfers to another unit’. For Royal Cornwall Hospital, 0.1% patients had a non-clinical transfer out of the unit. This was lower (better) than the national average of 0.3% for all units and 0.2% for similar units.

(Source: Intensive Care National Audit Research Centre (ICNARC) 01 April 2017 to 31 March 2018)

**Non-delayed out of hours discharges to the ward**

Sometimes patients were discharged to the ward outside of normal working hours, between 10pm and 7am, and the reason was not due to a delay in the discharge process. These are known as non-delayed out-of-hours discharges to the ward. For Royal Cornwall Hospital’s critical care unit, 1.6% of admissions were non-delayed, out-of-hours discharges to the ward (based on 733 admissions). This was lower (better) than the national average of 2.1% for all units and the national average of 2% for similar units. These results were much better than the evidence we reported at our previous inspection.

(Source: Intensive Care National Audit Research Centre (ICNARC) 01 April 2017 to 31 March 2018)

**Learning from complaints and concerns**

**Summary of complaints**

The unit received a low number of formal complaints. From May 2017 to April 2018, there was one complaint about critical care relating to communication. Complaints were investigated by the
clinical lead and the matron. The trust took 72 working days to investigate and close this complaint. This was not in line with its complaints policy, which stated complaints should be completed within 25 days. The trust informed us this complaint had not been fully resolved in the usual timescales because the complainant did not wish to attend a local resolution meeting and therefore several responses were required to answer further questions.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The team tried to resolve complaints before they became formalised. For example, the team planned to change one of the pictures in the relatives’ room because they had received mixed feedback about its suitability.

Number of compliments made to the trust

From June 2017 to May 2018, there were 27 compliments within critical care at Royal Cornwall Hospital.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the skills, knowledge and experience to lead the service. There was a designated clinical lead consultant for intensive care. This person was the clinical and operational lead for the whole service. Lead roles were divided between the consultants within the team, for example, governance, audit, and the follow-up clinic. This arrangement provided capacity and sustainability to drive improvements as well as staff to deputise for one another if required.

There was a matron with overall responsibility for the nursing elements of the critical care and outreach service. There was a nurse in charge on duty 24 hours a day as recommended in the Guidelines for the Provision of Intensive Care Services (2015).

Leaders understood the challenges to quality in the service. Both the clinical lead consultant and the matron were located on the unit. The leadership team worked together with a cohesive focus on patient care. Both leaders were aware of areas of performance that needed to be improved. This included, for example, delayed discharges from the unit and non-compliance with NICE guideline 83: Rehabilitation after Critical Illness.

Leaders identified actions to address the challenges to quality of care in the service. There was a leadership strategy for the nursing team. This strategy outlined priorities that tallied with some of the issues raised by staff and were evident in the data during our inspection. The strategy envisaged an approach to local leadership shared by three band seven nurses, including a new vacant post. Each senior nurse would hold separate leadership responsibilities: practice education, operational management and patient experience. The expansion to the nursing leadership team would provide cover from a senior nurse at weekends to drive discharge planning across the seven-day service and lead on improvements around rehabilitation and use of patient diaries.

The critical care leadership team was held in high esteem by the divisional management team and by staff in the critical care team. Local leaders were visible and approachable. Staff told us they respected the service leaders and felt supported by them. However, we were told the trust’s executive leaders were not so often seen by staff in the critical care team.

Vision and strategy
The strategy for the unit was focused on quality and sustainability. It was presented as four themes: service delivery, service development, aspiration for excellence, and continuing professional development and education. Service delivery included adherence to the Faculty of Intensive Care Medicine Core Standards, the recommendations regarding multi-professional teams made by the British Association of Critical Care Nursing, critical care outreach, and leadership and accountability within the team. Service development included expansion of the service to seven level three and 10 level two beds, health and wellbeing of the staff, and a dedicated approach to research and development. Aspiration for excellence focussed on timely discharge, timely admissions, no night time discharges, no cancellations of elective surgery, no use of agency staff, and no delayed admissions. Continuing professional development encompassed the development of a framework for critical care staff, the development of a multi-professional educational programme and enhancement of mandatory training.

The strategy included relevant priorities for the coming year. These were: quality, people, partnership and resources. Within these themes the priorities included safety culture, strong governance, tackling delay, attracting and retaining excellent staff, offering integrated care as close to home as possible, and making the best use of resources. This included a critical care rehabilitation programme and expansion of level three bed capacity. The strategy identified challenges, for example, recruitment of nurses. However, we were not provided with evidence of a deliverable plan to execute this strategy.

The critical care patient flow improvement programme focused on the themes of delayed and overnight discharges. Leaders had introduced a new protocol for staff to follow when planning the discharge of patients from the critical care unit. The next steps, commencing September 2018, were to devise a process to categorise delayed admissions and to investigate their causes, with the purpose of reducing avoidable delays.

The trust had produced a set of values for staff. These were: care and compassion, inspiration and innovation, working together, pride and achievement, and trust and respect. These values were not well known to staff on the critical care unit. However, we observed all members of the critical care team showed behaviours that embodied these values.

Culture

The culture within the critical care team was centred on the needs and experience of patients. Patients told us staff were always focused on giving good compassionate care despite the pressures of long busy working days. In the 2017 NHS Staff Survey, 94% of critical care staff said their team had a set of shared objectives, this was 22% higher than the score for the organisation and for similar units.

Leaders of the critical care team prioritised the wellbeing of staff. Leaders recognised the potential for members of the team to feel an emotional impact from caring for very sick patients. Senior nurses and consultants held semi-formal debriefing meetings after stressful events on the unit. For further support, staff could choose to be referred to occupational health who could refer staff to clinical psychology if this was appropriate.

The trust held an honorary contract with a shiatsu massage therapist who visited the unit once per week. Staff were permitted to pay for a half hour appointment with the massage therapist during working hours. Team members covered their work to facilitate this.

There were cooperative, supportive and appreciative relationships among staff. Consultants explained how the team shared workloads and collaborated to ensure the needs of patients were always met. Junior doctors told us they were not put under pressure to work extra hours or miss
their rest periods. Nursing staff helped each other to meet the care needs of patients. For example, they helped each other when moving and handling required more than one person. Staff described the unit as a calm, cohesive and supportive unit. In the 2017 NHS Staff Survey, 94% of staff said they were satisfied with the support they had from colleagues.

Teamwork extended beyond the working day. Members of the critical care team were involved in a fund-raising challenge to convert £70 into as much money as possible in 70 days to mark the 70th anniversary of the NHS. Members of the team and past patients and relatives had been involved in several events during their free time including charity auctions and bake sales. At the time of our inspection, the team had already raised over £24,000 towards new equipment for the unit.

All members of staff told us they felt valued as part of the critical care team. This included external contractors, such as the cleaner, who demonstrated pride in their work and clearly understood their role in safe patient care.

**Governance**

There were comprehensive processes of governance at a local level. Every Thursday there was a meeting for the critical care team, with one of four different meetings on a rolling programme. These included a governance meeting, a mortality and morbidity review, a business meeting and a teaching meeting.

There were reliable pathways to provide accountability for performance at divisional level. The governance lead prepared a governance report, and this was presented to the monthly theatres and anaesthetics operation governance meeting (TOG). The monthly governance reports included results from audits, matron’s report on infection prevention and control, current vacancies, and the report from the outreach team. This meeting was chaired by the clinical director for the division. Representatives attending from the critical care team included the consultant clinical lead, the governance lead and the matron.

There were reliable pathways to escalate concerns arising from the critical care governance meeting. We saw from the minutes of these meetings that issues of concern requiring divisional management attention, such as mandatory training compliance, were appropriately raised at the TOG meeting.

There were effective governance structures to support the delivery of a good quality sustainable services. For example, the chief pharmacist reviewed incidents involving medicines (including controlled drugs), adverse events, non-medical prescribing and the prescribing of medicines on external prescription forms. The medication safety committee met every two months. It reviewed medicine incidents and adverse events and looked at learning themes and trends. This was fed back to the critical care team. The medicines management optimisation group had published a monthly newsletter which was circulated via email. Safety bulletins were also circulated following medicine incidents.

All members of the critical care team were clear about their roles and responsibilities. In the 2017 NHS Staff Survey, 97% of staff said they always knew what their work responsibilities were. Leaders knew what they were accountable for and who they reported to. The consultant clinical lead reported to the clinical director at divisional level. All levels of governance and management functioned effectively and interacted with each other appropriately.

Members of staff in trust-wide roles that impacted upon the service clearly understood their responsibilities and operated effectively within specialist accountability structures. For example, the Accountable Officer for controlled drugs ensured all incidents involving controlled drugs were investigated. The Accountable Officer reported to the NHS England controlled drugs officer every
three months and attended the Controlled Drug Local Intelligence Network (CDLIN) meetings. The Director for Medical Physics reported to the Medical Equipment Board every month regarding the routine servicing compliance of critical care equipment.

The service ensured, wherever possible, the critical care and outreach service was managed in accordance with the Guidelines for Provision of Intensive Care Services (2015). These were an essential reference point for the leadership team when evaluating the service, reviewing the audit programme, designing standard operating procedures and considering new service developments.

Within the critical care team, staff were engaged in the governance agenda. All members of the team were invited to the governance meeting, including physiotherapists. The face to face mandatory training was scheduled to coincide with the governance meeting so as many team members as possible attended the governance meeting.

Governance was prioritised and was regarded as an important aspect of care for all members of the critical care team. The governance lead ensured messages and themes from the governance meeting were available to staff who were unable to attend. The governance meeting minutes were recorded with narrative detail and any presentations were included for easy access. All members of the multidisciplinary team received a copy of these minutes by email distribution.

The governance systems were continually being improved with the aim of increasing staff engagement in the governance process. For example, leaders of the critical care team had successfully introduced a visual display board to display and disseminate essential safety communications to the team. This board was known as ‘hawk-eye’. All staff told us they checked ‘hawk-eye’ for new safety information at the start of every shift.

There was a medicines management policy/strategy and business plan. Pharmacists were involved in the development of medicine policies and procedures.

Specialty governance arrangements included meetings with stakeholders and partners to encourage appropriate interaction and promote coordinated care. For example, the Drug and Therapeutics Committee included a joint formulary committee with the clinical commissioning group. This group met every two months to discuss regional issues such as formulary concerns, prescribing trends, Patient Group Directions and safe medication practices.

Management of risk, issues and performance

There was a systematic programme of clinical and internal audit to monitor quality. The audit programme was reviewed every six months. There was an audit lead for the critical care team.

There were systems to manage performance. Leaders of the service monitored the responsiveness and effectiveness of the service using the critical care dashboard. This displayed monthly figures for a range of metrics including level two and level three occupancy, cancelled operations, number of delayed discharges and delayed admissions, average duration of delay for discharges, number of night discharges, and the standardised mortality ratio. The dashboard was discussed at the monthly critical care governance meeting and/or mortality morbidity meetings. Delayed admissions that were causes for concern were highlighted and reported through the electronic incident reporting system.

The critical care dashboard data was integrated within the performance assurance framework which was fed into the monthly trust board meetings. In addition, leaders submitted data to external organisations such as the Intensive Care National Audit and Research Centre Case Mix Programme and this was used to benchmark performance of all participating units. Reports from this data were published every three months.
There was a pharmacy dashboard which compiled performance information monthly. This included time for dispensing discharge medicines, the rate of reconciliation of patients’ medicines on admission, the number of missed doses and monitoring of the in-hospital community pharmacy service.

There were processes to identify, record and manage risks. Within the critical care team, risk management was discussed in the monthly business meetings. Leaders told us wherever possible, risks were managed effectively at a local level. Leaders of the service considered potential risks when planning how to deliver the service. For example, the number of nursing vacancies in the team impacted upon the potential for the service to expand. Risks were escalated when appropriate. Risks were added to the critical care risk register if they could not be easily managed, they had occurred more than once, or the risk had significant consequences. For example, use of an unfamiliar treatment method was included. The risk register was reviewed at the monthly TOG meeting and was aligned to the risks identified to us by the leaders of the service.

However, not all risks affecting the delivery of safe care were identified and mitigated effectively. The delayed routine maintenance of medium and high-risk equipment in the unit was not identified on the risk register. The minutes of the critical care governance meetings and the TOG meetings during the six months preceding our inspection, showed no record of discussion of this safety risk. At a trust wide level, the medical equipment board was set up in May 2018 to provide oversight of this risk. Following the inaugural meeting, there had been no further meetings to review this risk or to measure progress against the maintenance recovery plan.

Leaders took remedial action when staff performance did not match expectations. For example, when medicine errors occurred, nurses were required to repeat their medicines training and write a reflective piece about the incident. For staff members requiring extra support, the matron offered individual work programmes, including phased return and change of duties when beneficial.

Information management

Leaders used information to measure improvement. For example, the matron was monitoring the impact of the new discharge protocol for reducing delays to discharges.

Information from patient outcomes was used to provide assurance of safety and effectiveness, such as the standardised mortality ratio. Leaders completed checks to ensure the information they used was valid and reliable.

There was inadequate access to accurate and reliable data to monitor staff compliance with mandatory training and appraisal completion. Leaders at divisional level did not have a clear understanding of the data for compliance. The data submitted to the CQC prior to the inspection was inaccurate.

The ward team did not have access to accurate and reliable information regarding the status of routine maintenance of equipment used for patient care. At a trust-wide level, there was a programme of improvement to reduce this risk. However, at a ward level, leaders did not monitor the maintenance status of the equipment used by the clinical team.

Engagement

There were local initiatives to encourage staff to be engaged in monitoring and improving service delivery. There was a ‘knowing how you’re doing’ board in critical care. This displayed various indicators of performance including cleaning audit results, results of the Patient Experience Survey, staffing levels, compliments cards, results of hand hygiene audits, number of pressure
ulcers, scores from the ‘direct care time’ tool, and feedback from ‘care opinion’. The critical care matron had involved staff in the development of a critical care logo.

Patients were encouraged to share feedback to drive service improvement. At the critical care outpatient follow-up clinic, staff asked patients to give feedback regarding their experience on the unit. Several patients had agreed to be involved in the production of patient videos to share their experience on the critical care website.

Leaders of the service engaged with stakeholders such as external partners in care to make improvements to patient care. For example, the team from nearest paediatric unit visited once a year to discuss all the transfers between the services and jointly review cases.

**Learning, continuous improvement and innovation**

Staff were encouraged and motivated to improve patient care. In the 2017 NHS Staff Survey, 95% of staff said they could make suggestions to improve the work of their team. This was 20% higher than the score for the organisation and for similar units.

The outreach team planned to give patients and relatives a telephone number they could call to alert the outreach team if they noticed a deterioration in the patient soon after discharge from the unit.

The critical care team had instigated a scheme to celebrate excellence in practice. Staff were encouraged to nominate members of staff from across the hospital when they observed an aspect of practice they considered to be excellent. Nominees received a certificate and the nominations were read aloud at the governance meeting.

Leaders recognised where there were gaps in service provision. They had submitted business cases to develop the service in line with national standards and recommendations.

The service participated in relevant quality initiatives, such as research trials. Research was valued by the team as a way of improving patient care. The critical care team were the top recruiters for participants in research trials in the south west in 2017/18. The team included two-part time research nurses. The research nurses were responsible for facilitating the team participation in research trials. This included screening of patients, explaining its purpose to patients and relatives, gaining consent, training staff, data collection, processing of samples, and feeding back to staff regarding learning from the trials. Research nurses produced an informative research newsletter. This included ways staff could implement learning from research. For example, the newsletter encouraged staff to give patients a discharge booklet when they left the unit.

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**Maternity**

**Facts and data about this service**

Maternity services at the Royal Cornwall Hospitals NHS Trust provided a range of antenatal, intrapartum and postnatal care at the main hospital and within local community settings across Cornwall and the Isles of Scilly. The maternity services were part of the women, children and sexual health division of the trust. Some of the buildings and facilities within the maternity service were acknowledged to be outdated. The trust was in the process of consultation and business application for the complete redevelopment and relocation of the maternity services on the acute site.

At the Royal Cornwall Hospital there were a total of 54 maternity beds across four sites. Consultant led care was provided for women in the Princess Alexandra wing where there were...
nine birth rooms with shared en-suite facilities. There was one obstetric theatre with an adjoining second adapted theatre room and a recovery area. Close to the Princess Alexandra wing was an alongside midwifery led birthing unit with four rooms, all with birthing pools. This was available to women assessed as having low risks. There were four community midwifery teams who provided antenatal and postnatal care and supported women assessed as having low risks with home.

There were two free standing midwife led birth centres which also provided antenatal, perinatal and postnatal care. These were: Penrice based at St Austell Community Hospital, and Helston based at Helston Community Hospital. Women living on the Isles of Scilly were supported by one resident midwife and one resident GP. Women living on the Isles of Scilly assessed as having low risks had the option for a home birth or use of one birthing room at St Mary’s Community Hospital. Those women assessed with high risks or due to personal choice were transferred to one of the maternity services available on the mainland.

At the Royal Cornwall Hospital antenatal care including monitoring, and induction of labour was provided from Wheal Rose ward which had 11 beds, a bereavement suite and a licensed satellite (small) mortuary facility. A maternity outpatient day assessment unit was linked to Wheal Rose ward. This service provided appointments for monitoring, treatment and care for women with health issues related to pregnancy. Post-natal care for women and infants who required ongoing treatment or monitoring post birth was provided on Wheal Fortune ward. This had five, four bedded bays with shared bathroom facilities, six side rooms and a combined day/discharge lounge.

From January to December 2017 there had been a total of 4,147 births across all the maternity services. During this inspection we visited all areas of the maternity service at the Royal Cornwall Hospital and the freestanding midwifery led services at Helston and Penrice. We spoke 15 women and their partners. We spoke with 43 staff including: two associate departmental directors, the interim head of midwifery, two midwifery matrons, junior through to senior midwives, including those in specialist roles, paediatricians, obstetric consultants, anaesthetists, junior medical staff, theatre staff, midwifery care assistants, cleaners and ward clerks. We reviewed 14 sets of patient records.

<table>
<thead>
<tr>
<th>Site/location</th>
<th>Ward/unit</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>Wheal Fortune ward</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Wheal Rose ward</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Delivery suite</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Birthing centre</td>
<td>4</td>
</tr>
<tr>
<td>St Austell Community Hospital</td>
<td>Penrice birth unit</td>
<td>3</td>
</tr>
<tr>
<td>Helston Hospital</td>
<td>Helston birth unit</td>
<td>1</td>
</tr>
<tr>
<td>St Mary’s Hospital, Isle of Scilly</td>
<td>St Mary’s birth unit</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>54</strong></td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request – Acute sites).

**Is the service safe?**

**Mandatory training**

The trust was unable to provide a breakdown of mandatory training specifically for maternity and so the following data relates to staff working in both maternity and gynaecology. The trust set a target of 95% for completion of mandatory training. Compliance with most of the trusts mandatory training was below the trust’s target of 95%. Senior staff told us training had on occasions been cancelled when clinical duties had been prioritised. Staff with out of date training had been rebooked to attend update sessions. A breakdown of compliance for mandatory courses from May
2017 to April 2018 for medical/dental and nursing/midwifery staff in maternity and gynaecology trust wide is shown below:

Mandatory training completion by module – medical and dental staff – trust-wide

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>26</td>
<td>27</td>
<td>96.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>26</td>
<td>27</td>
<td>96.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>25</td>
<td>27</td>
<td>92.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>23</td>
<td>27</td>
<td>85.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>23</td>
<td>27</td>
<td>85.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>22</td>
<td>27</td>
<td>81.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>22</td>
<td>27</td>
<td>81.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>22</td>
<td>27</td>
<td>81.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>20</td>
<td>27</td>
<td>74.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>16</td>
<td>27</td>
<td>59.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>11</td>
<td>27</td>
<td>40.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for two of the 11 mandatory training modules shown above for medical staff at Royal Cornwall Hospital. Conflict resolution training had the lowest completion rate with 40.7% where 11 of 27 medical staff had completed this module.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in maternity and gynaecology trust wide had a completion rate of 83.5% for mandatory training. Medical staff met the target of 95% for three of the 11 applicable modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>30</td>
<td>32</td>
<td>93.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>26</td>
<td>32</td>
<td>81.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>26</td>
<td>32</td>
<td>81.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>24</td>
<td>32</td>
<td>75.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>24</td>
<td>32</td>
<td>75.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>24</td>
<td>32</td>
<td>75.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>23</td>
<td>32</td>
<td>71.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>21</td>
<td>32</td>
<td>65.6%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Mandatory training completion by module – nursing and midwifery staff – Trust wide

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>186</td>
<td>186</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Equality and diversity

<table>
<thead>
<tr>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>185</td>
<td>186</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medicine management training

<table>
<thead>
<tr>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>183</td>
<td>184</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Manual handling - object

<table>
<thead>
<tr>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>180</td>
<td>186</td>
<td>96.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Conflict resolution

<table>
<thead>
<tr>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>173</td>
<td>186</td>
<td>93.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Resuscitation

<table>
<thead>
<tr>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>157</td>
<td>180</td>
<td>87.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Information governance

<table>
<thead>
<tr>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>160</td>
<td>186</td>
<td>86.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Infection prevention (level 1)

<table>
<thead>
<tr>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>154</td>
<td>186</td>
<td>82.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Adult basic life support

<table>
<thead>
<tr>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>154</td>
<td>186</td>
<td>82.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Health and safety (slips, trips and falls)

<table>
<thead>
<tr>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>154</td>
<td>186</td>
<td>82.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Fire safety 2 years

<table>
<thead>
<tr>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>153</td>
<td>186</td>
<td>82.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Manual handling - people

<table>
<thead>
<tr>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>186</td>
<td>53.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for four of the 12 mandatory training modules shown above for nursing and midwifery staff.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing and midwifery staff in maternity and gynaecology trust wide had a completion rate of 86.1% for mandatory training. Qualified nursing and midwifery staff met the target of 95% for four of the 12 modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>183</td>
<td>183</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>182</td>
<td>183</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>181</td>
<td>182</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>176</td>
<td>183</td>
<td>96.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>173</td>
<td>183</td>
<td>94.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS[CSTF</td>
<td>Resuscitation - Level 2 - Newborn Basic Life Support - 1 Year]</td>
<td>159</td>
<td>183</td>
<td>89.8%</td>
<td>95%</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>146</td>
<td>183</td>
<td>79.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>146</td>
<td>183</td>
<td>79.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>145</td>
<td>183</td>
<td>79.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>145</td>
<td>183</td>
<td>79.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS[CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year]</td>
<td>145</td>
<td>183</td>
<td>79.2%</td>
<td>95%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>104</td>
<td>183</td>
<td>56.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for medical/dental and nursing/midwifery staff in maternity and gynaecology at Royal Cornwall Hospital is shown below:

Mandatory training completion by module – medical and dental staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>26</td>
<td>27</td>
<td>96.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The 95% target was met for two of the 11 mandatory training modules shown above for medical staff at Royal Cornwall Hospital. Conflict resolution training had the lowest completion rate with 40.7% where 11 of 27 medical staff had completed this module.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in maternity and gynaecology at Royal Cornwall Hospital had a completion rate of 83.5% for mandatory training. Medical staff met the target of 95% for three of the 11 modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>30</td>
<td>32</td>
<td>93.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>26</td>
<td>32</td>
<td>81.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>26</td>
<td>32</td>
<td>81.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>24</td>
<td>32</td>
<td>75.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>24</td>
<td>32</td>
<td>75.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>24</td>
<td>32</td>
<td>75.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>23</td>
<td>32</td>
<td>71.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>21</td>
<td>32</td>
<td>65.6%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)
The 95% target was met for four of the 12 mandatory training modules shown above for nursing and midwifery staff at Royal Cornwall Hospital.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing and midwifery staff in maternity and gynaecology at Royal Cornwall Hospital had a completion rate of 87.4% for mandatory training. Qualified nursing and midwifery staff met the target of 95% for four of the 12 modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>121</td>
<td>121</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>121</td>
<td>121</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>120</td>
<td>121</td>
<td>99.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>118</td>
<td>121</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>114</td>
<td>121</td>
<td>94.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Newborn Basic Life Support - 1 Year</td>
<td>104</td>
<td>115</td>
<td>90.4%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>101</td>
<td>121</td>
<td>83.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>99</td>
<td>121</td>
<td>81.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>99</td>
<td>121</td>
<td>81.8%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>99</td>
<td>121</td>
<td>81.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>99</td>
<td>121</td>
<td>81.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>69</td>
<td>121</td>
<td>57.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for nursing/midwifery staff in maternity and gynaecology at St Austell Hospital is shown below:

Mandatory training completion by module – nursing and midwifery staff – St Austell

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>25</td>
<td>25</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>25</td>
<td>25</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>25</td>
<td>25</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>24</td>
<td>25</td>
<td>96.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>22</td>
<td>25</td>
<td>88.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>22</td>
<td>25</td>
<td>88.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>18</td>
<td>25</td>
<td>72.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
The 95% target was met for four of the 12 mandatory training modules shown above for nursing and midwifery staff at St Austell Hospital.

*Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab*

Updated training data provided by the trust for the period April to August 2018 indicates that nursing and midwifery staff in maternity and gynaecology at St Austell Hospital had a completion rate of 79.0% for mandatory training. Qualified nursing and midwifery staff met the target of 95% for four of the 12 modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>25</td>
<td>25</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>25</td>
<td>25</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>25</td>
<td>25</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>24</td>
<td>25</td>
<td>96.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>23</td>
<td>25</td>
<td>92.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Newborn Basic Life Support - 1 Year</td>
<td>21</td>
<td>25</td>
<td>84.0%</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>16</td>
<td>25</td>
<td>64.0%</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>16</td>
<td>25</td>
<td>64.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>16</td>
<td>25</td>
<td>64.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>16</td>
<td>25</td>
<td>64.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>15</td>
<td>25</td>
<td>60.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>15</td>
<td>25</td>
<td>60.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

*Source: Updated data provided by the trust*

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for nursing/midwifery staff in maternity and gynaecology at West Cornwall Hospital is shown below:

Mandatory training completion by module – nursing and midwifery staff – West Cornwall

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>18</td>
<td>19</td>
<td>94.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>18</td>
<td>19</td>
<td>94.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>17</td>
<td>19</td>
<td>89.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>17</td>
<td>19</td>
<td>89.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>16</td>
<td>19</td>
<td>84.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>16</td>
<td>19</td>
<td>84.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
The 95% target was met for two of the 12 mandatory training modules shown above for nursing and midwifery staff at West Cornwall Hospital.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing and midwifery staff in maternity and gynaecology at West Cornwall Hospital had a completion rate of 85.6% for mandatory training. Qualified nursing and midwifery staff met the target of 95% for two of the 12 modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>17</td>
<td>18</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>17</td>
<td>18</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>16</td>
<td>18</td>
<td>88.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS CSTF Resuscitation - Level 2 - Newborn Basic Life Support - 1 Year</td>
<td>16</td>
<td>18</td>
<td>88.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>15</td>
<td>18</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>15</td>
<td>18</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS CSTF Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>15</td>
<td>18</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>15</td>
<td>18</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>15</td>
<td>18</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>8</td>
<td>18</td>
<td>44.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

**Safeguarding**

Staff had a good understanding of their roles and responsibilities in recognising and reporting safeguarding concerns. If staff had a safeguarding concern they would report this via the phone or an online referral to the midwifery safeguarding leads that sat with the trust wide safeguarding leads. Staff informed us this team was responsive and would also attend the wards if a patient was admitted with a safeguarding alert.

We were informed that staff could be alerted to safeguarding alerts in different ways. This included a safeguarding pop up alert that was placed on the woman’s electronic file. We were informed that safeguarding concerns were also discussed at team meetings and during the daily shift handover meetings. Staff could access these existing safeguarding records on the trust database.

Processes were followed to maintain confidentiality whilst ensuring appropriate personnel understood safeguarding issues and had access to information. Personal and confidential information was not written in hand held records to protect others from having access to sensitive information. We checked the trusts IT system and saw that where safeguarding concerns had
been identified these had been consistently recorded on electronic records. This ensured staff had access to safeguarding information to promote the safety of the patient.

The trust was unable to provide a breakdown of safeguarding training specifically for maternity and so the following data relates to staff working in both maternity and gynaecology. The trust set a target of 95% for completion of mandatory training. A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for medical/dental and nursing/midwifery staff in maternity and gynaecology trust wide is shown below: Safeguarding training completion by module – medical and dental staff – Trust wide

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>26</td>
<td>27</td>
<td>96.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>25</td>
<td>27</td>
<td>92.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>19</td>
<td>27</td>
<td>70.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>5</td>
<td>28</td>
<td>17.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for one of the four safeguarding training modules shown above for medical staff in the maternity and gynaecology core services.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that medical staff in maternity and gynaecology trust wide had a completion rate of 75.8% for safeguarding training. Medical staff met the 95% target for one of the four modules. Compliance improved for all four modules when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>31</td>
<td>32</td>
<td>96.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>30</td>
<td>32</td>
<td>93.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>26</td>
<td>32</td>
<td>81.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>10</td>
<td>32</td>
<td>31.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Safeguarding training completion by module – nursing and midwifery staff – Trust wide

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>186</td>
<td>186</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>186</td>
<td>186</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>170</td>
<td>186</td>
<td>91.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>166</td>
<td>186</td>
<td>89.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>155</td>
<td>186</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for two of the five safeguarding training modules shown above for nursing and midwifery staff.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that nursing and midwifery staff in maternity and gynaecology trust wide had a completion rate of 89.3% for safeguarding training. Qualified nursing and midwifery staff met the 95% target for two of the five modules. Compliance deteriorated for all five modules when compared to the initial time period.
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>183</td>
<td>183</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>182</td>
<td>183</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>155</td>
<td>183</td>
<td>84.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>151</td>
<td>183</td>
<td>82.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>146</td>
<td>183</td>
<td>79.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Royal Cornwall Hospital. A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for medical/dental and nursing/midwifery staff in maternity and gynaecology at Royal Cornwall Hospital is shown below. Safeguarding training completion by module – medical and dental staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>26</td>
<td>27</td>
<td>96.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>25</td>
<td>27</td>
<td>92.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>19</td>
<td>27</td>
<td>70.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>5</td>
<td>28</td>
<td>17.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for one of the four safeguarding training modules shown above for medical staff in the maternity and gynaecology core services.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that medical staff in maternity and gynaecology at Royal Cornwall Hospital had a completion rate of 75.8% for safeguarding training. Medical staff met the 95% target for one of the four modules. Compliance improved for all four modules when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>31</td>
<td>32</td>
<td>96.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>30</td>
<td>32</td>
<td>93.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>26</td>
<td>32</td>
<td>81.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>10</td>
<td>32</td>
<td>31.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Safeguarding training completion by module – Nursing and midwifery staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>122</td>
<td>122</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>122</td>
<td>122</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>114</td>
<td>122</td>
<td>93.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>111</td>
<td>122</td>
<td>91.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>102</td>
<td>122</td>
<td>83.6%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for two of the five safeguarding training modules shown above for nursing and midwifery staff at Royal Cornwall Hospital.
Updated data provided by the trust for the period April to August 2018 indicated that nursing and midwifery staff in maternity and gynaecology at Royal Cornwall Hospital had a completion rate of 90.2% for safeguarding training. Qualified nursing and midwifery staff met the 95% target for two of the five modules. Compliance deteriorated for three modules when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>121</td>
<td>121</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>121</td>
<td>121</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>104</td>
<td>121</td>
<td>86.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>100</td>
<td>121</td>
<td>82.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>100</td>
<td>121</td>
<td>82.6%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

St Austell Hospital. A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for nursing/midwifery staff in maternity and gynaecology at St Austell Hospital is shown below: Safeguarding training completion by module – Nursing and midwifery staff – St Austell Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>25</td>
<td>25</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>25</td>
<td>25</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>21</td>
<td>25</td>
<td>84.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>21</td>
<td>25</td>
<td>84.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>18</td>
<td>25</td>
<td>72.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for two of the five safeguarding training modules shown above for nursing and midwifery staff at St Austell Hospital. Safeguarding adults (level 2) had the lowest completion rate with 72.0%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that nursing and midwifery staff in maternity and gynaecology at St Austell Hospital had a completion rate of 82.4% for safeguarding training. Qualified nursing and midwifery staff met the 95% target for two of the five modules. Compliance deteriorated for four modules when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>25</td>
<td>25</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>24</td>
<td>25</td>
<td>96.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>19</td>
<td>25</td>
<td>76.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>19</td>
<td>25</td>
<td>76.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>16</td>
<td>25</td>
<td>64.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for nursing/midwifery staff in maternity and gynaecology at West Cornwall Hospital is shown below:
Safeguarding training completion by module – Nursing and midwifery staff – West Cornwall Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>18</td>
<td>19</td>
<td>94.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>17</td>
<td>19</td>
<td>89.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>16</td>
<td>19</td>
<td>84.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for two of the five safeguarding training modules shown above for nursing and midwifery staff at West Cornwall Hospital. Safeguarding adults (level 2) had the lowest completion rate with 84.2%. (Source: Routine Provider Information Request (RPIR) – Training tab) (Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that nursing and midwifery staff in maternity and gynaecology at West Cornwall Hospital had a completion rate of 87.8% for safeguarding training. Qualified nursing and midwifery staff met the 95% target for two of the five modules. Compliance deteriorated for three modules when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>15</td>
<td>18</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>14</td>
<td>18</td>
<td>77.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>14</td>
<td>18</td>
<td>77.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Cleanliness, infection control and hygiene

In the Royal Cornwall Hospital all areas appeared clean and this was mostly achieved by a dedicated team of cleaners employed by an external organisation who followed a cleaning schedule. Routine obstetric equipment was hygienically cleaned by maternity care assistants, midwives and cleaning staff. We observed equipment such as baby resuscitaires and weighing scales had stickers to confirm the date the equipment had been cleaned and that it was ready to use. There was a very low risk of women contracting a hospital acquired infection. From January 2017 to January 2018 no incidents of Clostridium difficile (C. diff), E. coli, methicillin-resistant Staphylococcus aureus (MRSA) or methicillin-susceptible Staphylococcus aureus (MSSA) had been reported for the maternity services.

Most areas were visibly clean and tidy; however, we found some areas cluttered. For example, on Wheal Fortune we found the linen room containing a trolley as well as open cleaning wipes on the floor. We also observed a bag of scrubs (theatre clothes) on the floor and it was not clear if these were clean or dirty.

However, at Helston community birth centre we observed the plug area in the birth pool looked dirty. The patients shower had damaged sealant and apparent rust in places. At Penrice birth centre we observed the instructions regarding the amount of cleaning product to be used for the birthing pool were unclear. These issues at both community birth centres could potentially prevent...
effective cleaning processes. We raised these issues with senior staff at the time of our inspection and were assured the issues would be further investigated and action plans put in place.

Protective personal equipment (PPE) such as disposable gloves and aprons were visible and accessible for staff and we observed these were used and changed prior to patient contact. Hand washing facilities were in appropriate places within wards and departments in the acute hospital. However, there were some issues obtaining basic infection control and hygiene equipment such as hand washing gel and hand towels in the community locations. These were locations owned by another organisation with Royal Cornwall hospital trust staff providing care from them. Neither organisation would take responsibility for the supply which resulted in staff members having to bring in and provide their own hand washing gel and towels. Staff confirmed this issue had been reported.

Staff adhered to hand hygiene procedures. This was in line with NICE Quality Statement 61 Statement 3; which states that people receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. We observed staff to be bare below the elbow, hair tied back and to wash or gel hands before contact with patients. Regular hand hygiene audits were undertaken. We reviewed the hand hygiene audits at Helston birth centre and found monthly audits had been undertaken since August 2017 and they had been 100% compliant every month.

Improvements were required regarding the equipment provided for women to use to prepare for infant feeding. Trays to carry bottles and other feeding equipment had been provided. We observed these trays were dirty in appearance (stained) and chipped in places. The trays also had instructions sellotaped in places which could have hindered adequate cleaning. No bottle brushes were available for cleaning feeding bottles and the electric sterilisers appeared dirty, with stained areas and cloudy water on the base of units.

Systems were in place to ensure the safe disposal of clinical waste. Bin liners were colour coded and written information advised staff and patients where to put clinical waste. Staff followed processes to safely seal and transfer blood products from home environments. At the Helston and Penrice community birth centres there were regular collections of clinical waste bags from secured storage areas. This ensured clinical waste did not become a hazard whilst awaiting collection.

Environment and equipment

There were areas of the maternity service in need of modernisation and updating. However, the antenatal triage area whilst in an old building, was noticed to be exceptionally tidy, clean and well organised, particularly the clinical room. We observed the trust had invested in maintaining the service. This had included repainting areas and repair of damaged flooring and equipment. Since our last inspection, new works and equipment had been installed to improve the removal of residual nitrous oxide gas to safe levels. This gas was used as pain relief by women during labour and delivery. The trust had acknowledged that updating would be limited as many structures (buildings) were outdated. The trust was progressing with plans with a major investment of a new maternity building in collaboration with women who use the service, maternity staff and the local clinical commissioning group. This was expected to better meet the needs of local women and better support the safe and effective delivery of the service.

Systems were in place to ensure women and their babies were safe when admitted to the maternity service. All areas of the maternity service at the hospital and the two community services we visited were only accessible with electronic swipe cards. These had been provided only to appropriate staff. Entrance areas were also monitored by CCTV. However, at Penrice birth centre we noticed the CCTV was not linked to the local community hospital, rather to the security
The hospital and community service had access to emergency resuscitation equipment. This included: infant resuscitaires, an emergency trolley, adult resuscitation equipment and a grab bag containing blood glucose level monitoring equipment. Emergency trolleys were secured with tamper evident fastenings. The trust policy included staff completing daily and weekly checks to ensure equipment was ready for use at any time. We reviewed records which showed gaps in documenting checks had been completed both within the trust and community maternity services. We raised this with staff during our inspection and were informed reminders would be sent to staff and the lack of checks would be raised with all staff during daily staff shift handover discussions.

We were concerned about the procedures provided to women to sterilise equipment for infant feeding. We followed the instructions to sterilise bottles which involved boiled water and clip on lids over hot steam. We noticed that the instructions did not stipulate that feeding bottles had to be stored and treated in the steriliser upside down. Failure to do this meant the bottles filled with water and were not effectively sterilised. We were concerned regarding the instructions to carry a tray with sterilising equipment from the baby care room back to the ward. If a woman felt faint or tired (blood levels can be low following birth) there was a risk these very hot items could cause accidental burns. Staff were not able to confirm if these processes had been risk assessed.

Systems were in place to keep staff safe when working in the community. There was a lone working policy and procedure which outlined the procedures to follow. Staff we spoke with were knowledgeable about this and took appropriate safety measures. Midwives working in the community completed risk assessments and where risks were identified, staff completed joint visits with colleagues. Staff had mobile telephones and reported no issues with signal when making or receiving calls. If staff felt vulnerable they could call the hospital switchboard and say a specific phrase. This would alert switchboard to the fact the staff member felt vulnerable and other actions would be immediately taken to provide additional support. Staff also reported they could ask patients to attend the clinic rather than providing home visits if there were concerns about the safety of an environment.

Medical devices and equipment was serviced by the trust wide estates team. If staff identified an issue or concern they could report either by phone or online. Staff reported that service was responsive and attended the ward areas quickly. Midwives working in the community had access to a wide range of equipment required for antenatal, perinatal and postnatal care. This included equipment necessary to safely support home and water births. We observed processes were understood and followed in the community regarding the safe storage and transportation of gases.

Assessing and responding to patient risk

Processes were in place and followed to review the health of each pregnant woman and baby at every contact. The Royal Cornwall hospital birth unit was consultant led and able to support women with high risk pregnancies and/or complex health. The alongside midwifery led birth unit at the hospital could transfer unexpected risks to consultants within minutes. Appropriate and experienced staff were always available to respond to acute, severe and unpredictable obstetric
emergencies. Anaesthetic, surgical and obstetric medical staff were available 24 hours a day, seven days per week. There was an on-call rota of senior midwives who were available out of hours for hospital or community services to escalate serious concerns and to and provide additional advice and support.

All pregnant women had comprehensive risk assessments which started at their first appointment. An extended first antenatal booking appointment was arranged with a midwife which enabled a thorough review of any potential risks. This included screening for: pre-eclampsia, gestational diabetes, venous thromboembolism, and other medical conditions. Other risk factors were assessed and discussed including: previous obstetric history, family medical history, social issues, and mental health screening. Risk assessments and action plans were reviewed with every subsequent contact with a doctor or midwife and had been updated in records.

Medical and midwifery staff attended handovers and safety briefings which took place every day on each ward in the acute trust and community locations. This was attended by all staff including anaesthetic, surgical and when possible, paediatric staff. The purpose of the safety brief was to alert staff to any patient care issues, concerns or risks and to provide update information on policies or procedures.

Nearly all maternity staff had completed additional mandatory skills and drills ‘PROMPT’ training (PRactical Obstetric Multi-Professional Training). PROMPT training was multidisciplinary and tested equipment, systems and protocols using a simulation model to recreate emergency scenarios. These had often been based on recent incidents within the service such as collapse and resuscitation of mother or baby, and management of haemorrhage, shoulder dystocia and cord prolapse. A debrief session was always held after the simulation event to analyse responses and review for service improvements. We spoke to staff who told us they found the PROMPT training valuable and non-threatening with an emphasis on learning. Staff working in the community told us they felt included as scenarios were used which replicated home or community hospital. PROMPT training was available every month. Compliance for midwives was 96% and 87% for medical staff.

There was a range of additional processes and policies routinely used to monitor, assess, identify and respond to patient risks. Observational checks had been used to monitor and identify when a mother or baby was becoming unwell and could require additional support. These included the use of Modified Early Obstetric Warning Score (MEOWS). This was important because it improved the recognition and reduced the delay in treatment of sepsis (serious infection). There was evidence that improvements had been made since our last inspection regarding how MEOWS had been used but there remained some inconsistencies. We reviewed nine sets of MEOWS records and found five of them did not have an overall score recorded, one was not scored correctly, and one was not fully completed. One of the MEOWS had resulted in a sepsis pathway being initiated. We reviewed these records and found timely observation, action and treatment was undertaken in line with the scores recorded. Some of the processes followed may have delayed the timely completion of MEOWS. Staff told us the maternity care assistants as well as midwives completed and documented observations. However maternity care assistants were not permitted to complete the overall score which had to be completed by a midwife. Senior staff were aware that improvements were required to the MEOWS recording and of written evidence of actions taken. Monthly audits of 20 MEOWS records had commenced February 2018 and remained ongoing. This had been done to establish what percentage had been completed and to evidence if appropriate and timely actions had been taken. We looked at the MEOWS audits dated February 2018 to July 2018. This documented compliance with standards of between 90% and 99%.
We reviewed other patient risk assessments and found most had been fully completed and actions taken where required. We looked at 15 risk assessments relating to pressure ulcers and 15 risk assessments for venous thromboembolism (VTE). Of these 12 had been correctly completed and actioned, one record had been incorrectly scored, one assessment had not been dated or signed and one woman had no VTE risk assessment completed.

There was no designated area for women who required high dependency care. Enhanced care on the obstetric led birth unit was restricted to level one care. This included treatment using an IV or oxygen by face mask. Women requiring any more intensive care such as organ support were transferred to the intensive care unit. Sufficient numbers of midwives had completed a 12-week accredited university course to provide enhanced level one care. This enabled one such qualified midwife to always be on duty and available to support women with level one care needs. During our inspection we saw midwives who had completed the enhanced care training were identifiable on the duty rota and available for each shift.

During our previous inspection concerns had been raised regarding the process for use of the second obstetric theatre. Staff could explain how the systems had been revised and improved. The surgical services had guaranteed to fully staff a second theatre team at any time (24/7) with staff who were present and on site. Maternity staff we spoke with confirmed this commitment had been met. A duty anaesthetist was also always available if anaesthetists assigned to maternity were short term unavailable. The surgical lists were prioritised collaboratively between the obstetricians and anaesthetists. An emergency call bell been installed in the main obstetric theatre and a cordless phone was also available. This meant laboratory test results could be swiftly accessed. Women were recovered following theatre by trained recovery nurses allocated from the surgical team. During our inspection we observed the second smaller obstetric theatre used for an emergency caesarean section. Our specialist expert advisor observed all necessary equipment and staff were promptly available and utilised. The woman (who had a positive outcome) was seen to be supported in a calm and professional manner.

Processes were followed to support safe care in obstetric theatres. The World Health Organisations (WHO) surgical safety checklist recommendations were followed when women attended an obstetric theatre. Following these procedures is known to increase the safety of patients. We observed patients attending theatre as part of our inspection and saw all elements of the checklist had been followed. Monthly audits to review the compliance with the surgical safety checklist were undertaken by the surgical services by both observing practice and retrospectively reviewing WHO documentation in patient records. We reviewed audit records dated April 2018, May 2018 and June 2018. A total of 18 observations had been completed and the records documented 100% compliance with surgical safety checklist. We spoke with the midwife lead for audit and she confirmed as part of the monthly general record keeping audit, compliance with the WHO checklist had also been checked and was recorded as 100% complaint.

Transfer rates from the woman’s home or community service at the maternity service were monitored every month and had been reviewed for learning. The data included women requiring additional support with intrapartum and postnatal care, and women who had delivered before arrival. We looked at records which showed during May 2018 there had been 10 transfers, during June 2018, seven transfers and July 10 transfers. The most common reasons were due to delay in the progression of labour, fetal concern and request for increased pain relief. Ambulance response times had been recorded and issues and actions related to ambulance delays had been documented within the maternity risk register.

Midwifery staffing
There was sufficient midwifery and other staffing roles to support the safe care of maternity patients at the Royal Cornwall Hospital and within community settings. The trust followed the Royal College of Obstetricians and Gynaecologists (RCOG, 2007) Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour. This recommended a midwife to patient ratio of 1:28 for safe capacity to achieve one-to-one care in labour. The ratio at the Royal Cornwall Hospital was slightly higher than this. Between April 2017 and June 2018, the ratio was between 1:33 and 1:26. At the time of our inspection, recruitment was ongoing to fill vacancies.

The Chief Nurse had commissioned a full staffing review utilising Birthrate Plus. This was a nationally recognised tool recommended by the National Quality Board (NHS England) used to review midwifery staffing across the whole maternity service. The review has been undertaken noting the national agenda to reduce brain injury, stillbirth and early neonatal death by 50% during the next few years and to provide greater patient choice and continuity of care. In response, the trust had committed to an investment of an additional 12.21 whole time equivalent (WTE) midwives and 3.66 WTE maternity support workers. Senior staff confirmed they had been actively recruiting and had 11 band 5 (junior) midwives starting at the end of 2018.

The trust was unable to provide a breakdown of midwifery staff data specifically for maternity and so the following data relates to staff working in both maternity and gynaecology. The trust has reported their staffing numbers below as at April 2018 for midwifery staff at Royal Cornwall Hospitals NHS Trust, with an overall staffing rate of 95%.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Planned WTE staff</th>
<th>Number in post as at April 2018</th>
<th>Staffing rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>133.8</td>
<td>128.2</td>
<td>95.8%</td>
</tr>
<tr>
<td>St Austell Hospital</td>
<td>21.8</td>
<td>18.4</td>
<td>84.2%</td>
</tr>
<tr>
<td>West Cornwall Hospital</td>
<td>14.4</td>
<td>14.9</td>
<td>Over-established by 3.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>187.9</strong></td>
<td><strong>178.1</strong></td>
<td><strong>94.8%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The trust was unable to provide a breakdown of midwifery staff data specifically for maternity and so the following data relates to staff working in both maternity and gynaecology. From May 2017 to April 2018, Royal Cornwall Hospitals NHS Trust reported a vacancy rate of 9.9%, compared to a target of 10% at March 2018 and 6% at March 2019:

- Royal Cornwall Hospital: 11.3%
- St Austell Hospital: 8.9%
- West Cornwall Hospital: 9.4%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The trust was unable to provide a breakdown of midwifery staff data specifically for maternity and so the following data relates to staff working in both maternity and gynaecology. From May 2017 to April 2018, Royal Cornwall Hospitals NHS Trust reported a turnover rate of 7.6%, compared to the trust level target range of 10-14%:

- Royal Cornwall Hospital: 4%
- St Austell Hospital: 13.8%
- West Cornwall Hospital: 19.0%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
The trust was unable to provide a breakdown of midwifery staff data specifically for maternity and so the following data relates to staff working in both maternity and gynaecology. From May 2017 to April 2018, Royal Cornwall Hospitals NHS Trust reported a sickness rate of 4.6%, compared to a target of 3.8%:

- Royal Cornwall Hospital: 3.6%
- St Austell Hospital: 10.8%
- West Cornwall Hospital: 4.8%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From May 2017 to April 2018, the trust reported 520 bank shifts and no agency shifts filled by nursing assistants in maternity at Royal Cornwall Hospital. There were no shifts unfilled. During the same period, the trust reported 1,581 bank shifts and no agency shifts filled by qualified nurses at Royal Cornwall Hospital. There were no shifts unfilled. The trust only reported nursing bank and agency data against the Royal Cornwall Hospital site. (Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)

**Medical staffing**

There 60 hours per week of consultant presence at the hospital which complied with national recommended guidance (Royal College of Obstetricians and Gynaecologists, 2007) based on the number of births per year (From January 2017 to December 2017, 3,759 births). Medical staff were available to provide clinical treatment, care and support 24 hours per day, seven days per week at the maternity services based at the Royal Cornwall hospital. Consultants were on duty 11 hours per day Monday to Friday and for three hours on Saturday and Sunday. Registrars and other junior medical staff covered all other hours. The midwives and junior medical staff we spoke with confirmed consultants were consistently supportive and responsive to the needs of patients and attended out of hours whenever required. Consultants lived within half an hour or 10-mile radius of the hospital.

In December 2017, the proportion of consultant staff and the proportion of junior (foundation year 1-2) staff reported to be working at the trust were both about the same as the England average.

Staffing skill mix for the 33.6 whole time equivalent staff working in maternity at Royal Cornwall Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Role</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>38%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>49%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
The trust was unable to provide a breakdown of medical staff data specifically for maternity and so the following data relates to staff working in both maternity and gynaecology. From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 8.0%, compared to the trust level target range of 10-14%. (Source: Routine Provider Information Request (RPIR) – Turnover tab)

The trust was unable to provide a breakdown of medical staff data specifically for maternity and so the following data relates to staff working in both maternity and gynaecology. From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 2.6%, compared to a target of 3.8%. (Source: Routine Provider Information Request (RPIR) – Sickness tab)

From May 2017 to April 2018, the trust reported no shifts filled by locum staff in maternity and there were no shifts unfilled. The trust stated in their RPIR that they do not keep information regarding bank shifts filled centrally and so do not have the information available, which has highlighted the need to collate this and will work on this for the future. (Source: Routine Provider Information Request (RPIR) – Bank Agency Locum)

**Other staffing**

Senior staff said there were sufficient staff employed in roles which supported the midwifery services. These included sonographers, ward clerks, and maternity care assistants and theatre staff. There were sufficient anaesthetic medical staff to provide surgical and clinical support to the maternity services when required. Anaesthetic and theatre staff were provided and supported by the trusts surgical department and were accessible 24 hours a day, seven days per week. Staff confirmed they had good relationships with anaesthetists and paediatricians who were prompt and responsive to any obstetric requests.

**Records**

Maternity records were maintained both in paper and electronic formats. Each pregnant woman had been provided with a set of hand held records regarding all aspects of their pregnancy covering antenatal, intrapartum and postnatal care. Records were clear and legible and organised.

We reviewed 15 sets of records and found most to be legible with a clear date and time recorded as well as a name and signature detailing who had completed the record entry. We found one record where not all entries had been signed and a name recorded, thus is was not clear who had undertaken the care provided.

The service had been focused on improving the quality of records to more fully comply with the regulations set within the Nursing and Midwifery Council (NMC). Monthly record keeping audit of midwives, doctors and anaesthetists written records had commenced during February 2018. This had involved the random selection of 20 sets of maternity hand-held records returned to the trust following birth and discharge to health visiting services. The audit tool was thorough and included how midwives, doctors and anaesthetists had recorded each patients’: personal details and risk assessments completed during antenatal, intrapartum and postnatal care. We reviewed the monthly audit records dated February 2018 through to August 2018. Compliance with standards at the start of auditing was 76%. The results and prompter action plans had been shared with all staff every month using poster messages placed on staff notice boards, verbally during staff shift handovers and through emails. In addition, all staff had been provided with name stamps to promote clearly signed record entries. The lead midwife for audit also showed us that all audit information was stored on the trusts shared drive. This meant it was accessible to any staff.
working in the maternity service. The audit actions plans were effective as standards had been evidenced as 93% complaint with record keeping standards during August 2018.

Medical records and other confidential patient information had been stored safely in lockable record trolleys.

**Medicines**

Medicines and controlled drugs were stored safely and there were always adequate supplies to meet patients' needs. In the maternity theatres and other clinical areas on the delivery suite, we observed medicines in appropriately locked cupboards, and secured within the resuscitation trolleys. Oxygen and nitrous oxide (used for pain relief) was piped into birth rooms. No controlled medicines were kept at any of the community birth centres. We observed medical gases used during labour such as Entonox and oxygen were stored securely and safely in the community birth centres.

**Incidents**

Staff of all grades and professions we spoke with demonstrated familiarity with incident reporting processes and understood the type of issues they should or could report. Staff reported incidents on an electronic reporting system. They reported it was easy to use and everyone had access. The rate of incident reporting was monitored every month. Based on previous years, the maternity service had an expected range of between 80 and 120 incidents to be reported per month. We reviewed the records dated 1 April 2017 to 31 30 June 2018. The range of monthly reported incidents during this time was between 97 and 152. The majority of these had been assessed as having no or minor patient harm.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From June 2017 to May 2018, the trust reported no incidents which were classified as a never event. (Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from June 2017 to May 2018.

Of these, the most common types of incident reported were:
Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with seven (70% of total incidents).

Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with two (20% of total incidents).

Treatment delay meeting SI criteria with one (10% of total incidents).

(Source: Strategic Executive Information System (STEIS)).

All incidents categorised as serious had required a root cause analysis (in depth) investigation completed. We reviewed four serious incidents, one which had been investigated during 2017 and three during 2018. The reports documented how the incidents had been investigated by reviewing clinical records and interviewing relevant staff. The incident investigation reports included: a chronology of events, and summaries of any contributing factors. These included: identification of any care or service delivery issues and the main factors which had caused the incident. Action plans had been put in place to reduce recurrence of similar incidents and further patient harm. The lessons learnt from investigations and recommendations had been documented as actioned and shared with the staff through directorate and patient safety meetings.

We discussed with a wide range of staff about how they had received feedback and learning from investigations and found some inconsistencies. At Royal Cornwall hospital, incidents had been discussed during weekly multidisciplinary safety meetings and during the daily safety brief meetings held on all wards every morning. We observed also in governance meeting minutes that updates from serious or significant incidents had been documented as discussed. At Helston community service we reviewed team meeting minutes and saw there was no set agenda and no discussion documented about incidents or risks. We observed patient safety newsletters were available to staff. These included learning and any changes to policy and/or clinical practice. However, it was unclear how senior staff had been assured these updates had been acknowledged by all staff. At Penrice community service, staff demonstrated their understanding of learning from incidents which had been shared during the daily safety brief talk and through emails.

Perinatal mortality and morbidity (M&M) meetings were held every month. The purpose of these was to review for learning, complex cases or those which had resulted in a serious incident. We reviewed case review summaries dated; June 2018, July 2018 and August 2018. These records were brief and included: a case summary, risk factors, good practice, learning points, reviews completed, actions required and future pregnancy management. Additional action records also reviewed monthly, documented who was responsible for achieving actions, the time frame and sharing learning. It was not possible to ascertain how actions and learning had been debated challenged and established. There were no records of discussions and no records related to which staff had attended the M&Ms.

**Duty of Candour**

There was evidence that the duty of candour regulations had been understood and complied with. Duty of candour is a regulation which was applied to NHS trusts from 27 November 2014. Trusts had already been required to be open and transparent as part of their NHS standard contract. Duty of candour requires that the trust notify the relevant person of a suspected or actual reportable patient safety incident and provide all reasonable support in relation to the incident. The provider must tell the relevant person in writing about the results of any investigation. There was evidence of an increased focus by the maternity service to comply with the duty of candour regulations. The perinatal morbidity and mortality meeting minutes dated: June 2018, July 2018.
and August 2018 recorded which women had been contacted and consulted when outcomes had not been as expected. Records documented ongoing liaison was offered following serious incidents and that women had been sent written copies of completed investigations.

**Safety thermometer**

Information about patient safety was not clearly displayed which meant patients and visitors would be unaware of how the service was performing. We reviewed all clinical areas and found there were no safety thermometer results displayed. Some information such as cleaning audit results were displayed in public areas, however these were out of date. For example, on Wheal Fortune the audit result displayed was for May 2018.

**Is the service effective?**

**Evidence-based care and treatment**

All pregnant women known to the service had their physical, mental health and social needs assessed and treatment and care was provided in line with evidence-based guidance. Each woman was provided with a set of hand held maternity records. These detailed a range of risk assessment information, guidelines and tests to promote the wellbeing of both the mother and baby and to promote the best outcomes.

We reviewed 15 records which showed women’s care had been reviewed during all contacts with the maternity service. Women identified with any additional health issues or risks had these managed in line with national guidance and specialist ante and post-natal clinics were provided by medical and midwifery staff. For example: All women identified with risk factors for gestational diabetes had been offered glucose tolerance testing as recommended by MBRRACE-UK (2015) and NICE guidelines (NG3, 2015). We observed women attending glucose tolerance testing appointments at the Penrice community service.

Ongoing monitoring of fetal movements was integral to care plans. This included risk assessments to identify if a fetus was small for gestational age and fetal growth charts to identify possible growth restriction. These followed national guidance (MBRRACE, 2015, NICE CG62 and RCOG Green-top Guideline No 57). Other evidence of compliance with best practice standards was seen in the 15 records we reviewed. These included: blood pressure routinely monitored during and after pregnancy, assessments for venous thromboembolism and assessments for ante and post-natal mental health issues (NICE QS35, QS3, and CG192). We saw appropriate assessments and actions had been documented.

There was an annual audit plan in place which midwives, obstetricians, neonatal staff and anaesthetists contributed to. This had enabled the service to benchmark the standard of maternity care provided at the trust against local and national standards. There was a midwife lead for audits and additional staff had recently been appointed to support with quality and audit information. We reviewed a sample of audit information from the 34 listed as in progress or planned for 2018. These included an audit to review the management of sepsis (serious infection) during pregnancy and postnatally. This had been completed during February 2018 and documented that staff had been 100% compliant at both identifying sepsis and complying the with nationally recommended treatment pathway within an hour (Sepsis six). Another audit completed during May 2018 had reviewed staff compliance with policy and guidance to treat women with post-partum haemorrhage. This had identified compliance of 92.5% with the recording of date and time of haemorrhage as the issue most in need of improvement. In response, actions had been documented as taken to improve this including: sharing the learning at safety huddle meetings,
emailing all staff and updating during mandatory emergency obstetric skills and drills training. Further audit had been planned to evaluate the impact of the actions.

The maternity policies we reviewed were dated and referenced national best practice. These included a range of National Institute for Heath and Care Excellence (NICE) guidelines, the Royal College of Obstetricians and Gynaecologists; Safer Childbirth (RCOG, 2007) and NHS England (Better Births, 2017). Women received care in line with NICE quality standards 22 (for routine antenatal care), 32 (for caesarean section) 37 (for postnatal care), 62 (for antenatal care for uncomplicated pregnancies) and 190 (for intra-partum care).

However, we observed in the community services the guidance for the emergency evacuation from the birth pool was not up to date with the current practical training. In addition, we observed general trust guidelines were available in the community, but these had not been adapted to the specifics of each community settings. For example; instructions for an emergency included calling an internal trust number. In the event of an emergency in the community this number would be inapplicable, and staff confirmed they dialled 999. We raised these issues with senior staff at the time of our inspection. An ongoing plan to review and update guidance to reflect national policy was being completed by the midwife lead for audit. Policy updates completed had been shared with all staff through emails, poster updates and meetings.

**Nutrition and hydration**

There was a lead midwife for infant feeding who provided specialist advice and support to patients and staff with all aspects of baby feeding. During pregnancy, women were provided with a full range of information related to nutrition and feeding. If women chose to breastfeed, midwives and midwife care assistants offered support with expressing milk, positioning and attachments. The percentage of women choosing to breast feed at birth was monitored and reported on the maternity dashboard each month.

Improvements were required to the guidance and processes to support mothers with feeding on Wheal Fortune ward. We saw guidance for the storage of milk in the fridge and freezer dated 2008. This stated milk could be stored in the fridge for no longer than 48 hours. We looked in the fridge and saw what appeared to be expressed breast milk dated 29 August, which meant it was eight days old. The same guidance stated milk could be stored in the freezer for up to three months. We looked in the freezer and saw breast milk dated between 22 and 27 April 2018, which meant it was four and a half months old. There was no guidance on how to dispose of unused or out of date milk. We also observed the parents’ guide to breastfeeding was dated 2014. The maternity services had level three accreditation with the UNICEF (United Nations Children’s Fund) UK Baby Friendly Initiative. This is a global programme based on best practice standards for feeding infants. This accreditation was due to be reviewed.

Women and relatives had access to food and drinking facilities in both the acute and community settings. On Wheal Fortune ward a kitchen was available with a fridge to store food, as well as cutlery, squash and vending machines. Women staying in the hospital had access to hot meals which catered for all dietary requirements. At the Helston and Penrice birth centres, women had access to squash and toast as well as a microwave to prepare food.

**Pain relief**

A range of medicines and other resources for the relief of pain and discomfort had been provided as required at the birth centres in the hospital and community which met NICE national standards (QS15 Patients have their physical and psychological needs regularly assessed). Pregnant women were encouraged during the antenatal period to discuss options for pain relief with a midwife in advance of birth. We observed preferences for pain management had been
documented in hand held records. Nearly all the women we spoke with told us that they regularly had their pain level assessed and that pain relief was given when required and in a timely way. If pain relief could not be given, for example due to the stage of labour they were in, this was explained to the patient.

We looked at patient care records and saw pain and comfort needs had been discussed and assessed. Birthing pools and other equipment was seen to be available across the services. This included: birth balls, couch and stools. Nitrous oxide gas and oxygen were piped into each birth room and midwives had access to mobile supplies of these for women to use to assist with home births. Birth partners were encouraged to stay and provide psychological support during labour. We were told patients could bring in and use their own equipment, such as music and TENS (transcutaneous electrical nerve stimulation) machines to support with the management of pain and discomfort. To meet additional needs, where appropriate there was evidence of referrals to the trusts nursing and consultant led pain management team.

At the Princess Anne wing in the Royal Cornwall Hospital, women were offered a wider choice of pain relief than was available at the community birth centres. Epidurals and other pain-relieving medicines were available for women in labour 24 hours a day, seven days a week. Staff confirmed anaesthetists responded promptly, usually within half an hour to requests for support with pain relief. When an epidural had been agreed the anaesthetist completed an anaesthetic risk assessment and plan which we observed was documented in records. Epidurals were not available at the community birthing centres as no medical or anaesthetic staff were routinely present at these locations.

**Patient outcomes**

A range of antenatal, intrapartum and postnatal care was provided from the hospital and within the local community. The Royal Cornwall NHS Hospital Trust provided care to approximately 4,000 women per annum (average 330 births a month). From January to December 2017 there had been a total of 4,147 births within the hospital, community birth centres or at the mother’s home.

There was evidence that most patient outcomes were within an expected or better than expected range, compared with other similar maternity services in the south west and nationally. The maternity service maintained a clinical dashboard of outcomes which was reviewed and updated every month. Information was audited, and actions taken with regards to quality and safety outcomes. Senior midwives confirmed information from the dashboard had been shared with maternity staff and with the board through various departmental and directorate governance meetings. The dashboard had been red, amber, green (RAG) rated against Royal College of Obstetrician and Gynaecologists (RCOG) recommendations or south west region targets. We reviewed the clinical dashboard dated April 2017 to July 2018 to look at several key performance indicators and observed the following:

- The rates of third degree perineal tears were below (better than) the recommended rate. At the Royal Cornwall hospitals maternity services, the average rate of perineal tears was 2%. The Royal College of Obstetricians and Gynaecologists (RCOG) guidance stated tears should occur in fewer than 5% of deliveries.

- Postpartum haemorrhage of between 500mls and 1000mls is common (RCOG, Green-top guidance no 52, 2011). Postpartum haemorrhage rate at the Royal Cornwall Hospital of between 1500mls and 2000mls, was 1%. This was at the lowest national target rate of between 1% and 5% of all births (RCOG) and lower than the south west region average rate of 3%.
• The rate of assisted vaginal birth support using forceps or ventouse (suction) in the UK accounts for approximately 12% of births in the UK. The rate of assisted births at the Royal Cornwall hospital was lower (better than) the UK average at 9%.
• In the UK the average rate of induction of labour is 29% (NHS Maternity Statistics 2016-17). At the Royal Cornwall hospital the average rate of induction was lower (better) at 26%.
• The trust had a minimum target of 75% of women to be breast feeding at birth. Between April 2017 and March 2018 this has been achieved with the average percentage at 77%. However, the numbers of women and/or babies admitted within 28 days of discharge due to feeding issues had exceeded (was worse than) the expected target. The maximum number per month for readmissions of this type had been set at 12. For seven of the 12 months the rates of readmissions for feeding ranged between 13 and 21.

In the 2017 National Neonatal Audit Royal Cornwall Hospital’s performance in the two measures relevant to maternity services was as follows:
• Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 87 eligible cases identified for inclusion, 82.9% of mothers were given a complete or incomplete course of antenatal steroids. This was as expected when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.
• Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 16 eligible cases identified for inclusion, 43.8% of mothers were given magnesium sulphate in the 24 hours prior to delivery. This was about the same as the national aggregate of 43.5% and put the hospital in the middle 50% of all units. (Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

From January 2017 to December 2017 the total number of caesarean sections was lower than expected. The standardised caesarean section rates for elective sections was as expected and rates for emergency sections was lower than expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>ROYAL CORNWALL HOSPITALS NHS TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caesarean rate</td>
<td></td>
<td>Standardised Ratio</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.7%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>23.1%</td>
<td>22.4%</td>
</tr>
</tbody>
</table>

Notes: Standardization is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.
Delivery methods are derived from the primary procedure code within a delivery episode.

Total caesarean sections were lower than the England average and normal (non-assisted) delivery rates were higher than the England average. (Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

The Royal Cornwall Hospital had participated in the MBRRACE-UK national audit programme. MBRRACE is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, New-born and Infant Clinical Outcome Review Programme. This programme reviews data and investigations of the causes of maternal deaths, stillbirths and infant deaths. Information is provided regarding individual participating NHS trusts which can be used to compare against local and national benchmarks (outcomes). The aim is to provide
information as a prompt to review and develop clinical pathways to drive down maternal and neonatal mortality rates. MBRRACE (2017) had assessed the perinatal mortality rate (per 1,000 births) for the Royal Cornwall Hospital to be 4.88. This is up to 10% lower (better than) others trusts with similar sized services. (Source: MBRRACE UK). We saw records which documented ongoing actions to comply and improve practice. This included a consultant lead audit of how effectively any small for gestational age foetus had been identified, documented and followed up.

Processes were in place to improve the care and support provided to parents experiencing loss. The service had completed an annual review of all infant loss (stillbirth, miscarriage and due to congenital abnormality). This linked to the national audit programme. MBRRACE. Since April 2018, the maternity service been participating in a national bereavement pilot care pathway (to be launched nationwide at the end of 2018). This aimed to improve bereavement care for parents following loss during pregnancy or soon after birth. The goal was to provide women with the same standard or care regardless of gestation and which service accessed. Lead midwives for bereavement had been providing information to the national data base to support learning and evaluation of treatment and care provided. In addition, staff had attended national external study days to understand how to best improve systems, processes and staff education. Information from the study had been shared widely through Royal Cornwall through emails, newsletters and meetings. For example; meetings with the trusts emergency department had enabled staff to provide treatment and care which complied with the standards promoted by the national bereavement study.

**Competent staff**

Maternity staff had the skills and competencies to work in all areas of clinical practice to support women with high and low risk pregnancies. The midwives worked in core areas such as: acute hospital or community settings, on antenatal, birth unit or postnatal ward. Midwives did not routinely rotate around the different services. However, during periods of high activity staff had been required to work in different services and locations. We spoke with midwives working at the community-based services and asked if they felt confident to work in the hospital, and those staff we spoke with confirmed they did. Staff were alerted of their training needs or requirements through an email. Training was provided both face to face and via e-learning. Midwives had been supported to update their clinical skills. Records showed a clinical update day had been facilitated during April 2018. This had included sessions on: antenatal screening, healthy lifestyles, blood transfusion, diabetes, bereavement, mentorship and record keeping.

We spoke with junior medical and midwifery staff who all told us they felt well supported and had access to senior staff for advice and were supported to have protected time for study. Junior staff told us they felt their induction to the maternity service had been comprehensive and they had been supported to feel both confident and competent with new systems and process before working independently. Both midwives and consultants had specialist skills to support women who had complex health and or complex maternity care. This included for: general high-risk pregnancy, diabetes, following complex previous pregnancy, fetal medicine, screening, and breast feeding.

Staff had been trained to use an in-depth method of fetal monitoring known as STAN. This involved a combination of fetal heart rate interpretation and analysis of the fetal electrocardiogram. This method was considered to be more reliable at detecting fetal distress than by using electrocardiogram alone (a standard clinical obstetric procedure). Nationwide, STAN is used in some, but not all maternity units. Five midwives had completed additional sonography training. We were told the training had been to a high standard she had been supported with practical elements by a senior sonographer and consultant working at the trust.
The trust was unable to provide a breakdown of appraisal rates specifically for maternity and so the following data relates to staff working in both maternity and gynaecology. Up to August 2018, 71% of staff at Royal Cornwall Hospitals NHS Trust had received an appraisal, compared to a trust target of 95%. Over this period, 67.7% of medical staff, 50% of nursing staff and 69.5% of nursing/midwifery staff had received an appraisal. A split by location and staff group can be seen in the tables below:

**Trust wide:**

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals received</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>43</td>
<td>55</td>
<td>78.2%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>107</td>
<td>154</td>
<td>69.5%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>21</td>
<td>31</td>
<td>67.7%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>2</td>
<td>4</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

**Royal Cornwall Hospital:**

At Royal Cornwall Hospital 67.7% of medical staff, 73.2% of nursing/midwifery staff had received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals received</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>35</td>
<td>42</td>
<td>83.3%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>71</td>
<td>97</td>
<td>73.2%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>21</td>
<td>31</td>
<td>67.7%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>2</td>
<td>4</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

**St Austell Hospital:**

At St Austell Hospital 56.5% of nursing/midwifery staff had received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals received</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>5</td>
<td>8</td>
<td>62.5%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>13</td>
<td>23</td>
<td>56.5%</td>
</tr>
</tbody>
</table>

**West Cornwall Hospital:**

At West Cornwall Hospital 50% of nursing midwifery staff had received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals received</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>8</td>
<td>16</td>
<td>50.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

**Multidisciplinary working**

There was evidence of effective and positive multidisciplinary working within the maternity service. Midwives, midwifery care assistants, doctors and sonographers all reported constructive multidisciplinary working. Staff said relationships were mutually respectful and supportive and
communication was open and honest. Midwives told us they felt valued and respected by medical staff who they reported to be approachable and willing to offer advice when required. There were no combined medical and midwifery handovers. Staff said this was because doctors and midwives started shifts at different times. This meant the midwifery coordinator on shift was required to attend the medical handovers and then update other staff as required.

We observed during our inspection that staff of all grades and professions in the maternity service worked seamlessly with each other to provide consistent treatment and care. We saw easy but professional conversations between staff. Staff of all grades told us they felt confident to challenge or question others and that this was perceived as supportive rather than threatening.

Staff told us they had good working relationships with staff from the neonatal services and the surgical department staff with whom they had daily contact. These views were shared by the different departmental clinical staff. Staff working on the Wheal Rose described effective working relationships with the perinatal mental health team. In care records we reviewed there was clear and detailed documentation of communication with other external services. These included; with GPs, ambulance service. Relevant information had been shared for the benefit and safety of patient care.

Seven-day services

The maternity services provided timely treatment, care and support for women at all stages of the maternity care pathway, including for unexpected emergencies. The consultant led birth centre and alongside midwifery led unit at the hospital was open with doctors and midwives 24 hours a day, seven days a week. Midwives were on call to assist with home births as all times. The two community birthing centres in Helston and Penrice were staffed by midwives and maternity care assistants during the day. During all other hours the community services were opened and staffed at any time in response to women in labour who had booked to deliver at a community service. Midwives had offices on site and ran ante and post-natal clinics from the community services, GP practices and family centres. Additional ante and postnatal clinics were provided at the hospital and at the home address of pregnant women or those who had recently delivered.

The day assessment unit was open during weekdays from approximately 8am to 6pm. During weekends and out of hours when the day assessment unit was closed women were triaged and based on the information provided, plans of action were made by maternity staff. If women required additional monitoring out of hours they had a home visit from an on-call midwife working in the community or were admitted to a birth centre or Wheal Fortune ward. Sonographers provided clinics at the hospital and community services. The three obstetric theatres were staffed by surgical staff and anaesthetists always. This enabled obstetric emergencies requiring surgery to be promptly responded to.

Health promotion

Health promotion was a routine part of all maternity care provided to women from their initial booking in appointment through to discharge. All staff worked collaboratively with women to assess all aspects of general health and to provide support and advice to promote healthy lifestyles. When women attended their first (booking) appointment they were allocated a minimum of one and half hours. This gave sufficient time for each woman’s individual health risk factors to be assessed and action plans agreed. We observed that each woman’s care records included an assessment of mental and physical health. Throughout pregnancy, scans and blood tests were used to assess for both random and inherited health conditions.

The trust participated with the four components of the ‘Saving Babies Lives’ care bundle. We spoke with staff and reviewed records which showed the maternity service had been working with
public health colleagues to facilitate direct meetings with women when they attended dating scan clinics. The purpose of these meetings was to promote healthy lifestyles and to encourage women who smoked cigarettes to stop by providing additional specialist support. Those pregnant women who smoked were closely monitored using carbon monoxide monitors to evaluate oxygen levels. Audit and evaluation of the pregnancy health improvement service had only recently commenced. We reviewed the information for the months of June 2018. This detailed that 139 pregnant women had been seen with an additional 126 partners or family members provided support and advice regarding healthy lifestyles and/or smoking cessation. Other health benefits from the meetings included identifying women taking multivitamin supplements not designed for pregnancy. Advice had then been provided regarding appropriate pregnancy vitamin supplementation to promote the health of the woman and baby.

In addition, fetal growth surveillance was provided. Fetal growth restriction is associated with stillbirth, neonatal death and perinatal morbidity and can be associated with suboptimal care (RCOG). The maternity service followed the nationally recognised best practice for fetal monitoring (GROW programme). We observed this health surveillance and health promotion information had been recorded in records.

There was a lead midwife for new-born and infant physical examination (NIPE) screening. The NHS NIPE Screening Programme purpose was to reduce morbidity and mortality by prompt identification and treatment of congenital abnormalities. This person was responsible for staff training updates related to the screening programme. This included the screening related to: eyes, heart, hips and in male infants, testes.

The maternity service promoted national advice (NHS UK, 2016) advising pregnant women should be vaccinated against seasonal flu. The lead NIPE screening midwife also facilitated regular vaccination (BCG) clinics.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood and followed the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. If concerns were identified regarding mental capacity staff liaised with medical and other staff including the perinatal mental health team and psychiatric liaison team.

The patients we spoke with about consent, confirmed that staff had asked for permission before proceeding with any care or treatment. We observed during our inspection, staff explained what they would like to do and why before proceeding with any care. Within records we observed clear documented discussions regarding consent before carrying out any intimate examination or procedure. Written consent forms were evidenced to have been completed prior to obstetric surgical procedures.

The trust was unable to provide a breakdown of Mental Capacity Act (MCA) training specifically for maternity and so the following data relates to staff working in both maternity and gynaecology. The trust reported that from May 2017 to April 2018, Mental Capacity Act (MCA) training has been completed by 100% of staff. Deprivation of Liberty training data was not included within the RPIR. (Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level 1 training had been completed by 99.6% staff within maternity and gynaecology trust wide. All medical and nursing staff had completed the training.

(Source: Updated data provided by the trust)
Is the service caring?

Compassionate care

We spoke with 15 women and their partners who were all positive about the care they had received. We reviewed thank you cards throughout clinical areas. Comments included, ‘We could not have wished for better care’, ‘thank you for being so caring, patient, understanding, supportive and knowledgeable’ and ‘So lucky to have had the level of support’.

Staff understood and respected the personal, cultural, social and religious needs of people and how these could relate to care needs. Staff reported individual needs had been assessed throughout the antenatal period and we saw this documented in records. This was done to ensure the right type of support was provided to meet individual needs. For example, there was a written directive to support staff if a woman’s religious background meant they would not want a blood transfusion.

People’s privacy and dignity needs were understood and respected. Curtains were drawn, and doors were shut when patients were receiving care and treatment. We observed staff asking before entering an area where curtains were closed or knocking on doors.

We observed how staff supported women with dignity, kindness and understanding with all aspects of care. This included when plans did not go as expected. We spoke with midwives about supporting parents with miscarriage and stillbirth. Staff explained how they had provided as much time as they were able to parents. This was to demonstrate understanding and empathy with the difficult time and emotional distress experienced by parents.

Friends and family test performance (antenatal), Royal Cornwall Hospitals NHS Trust. From May 2017 to May 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was similar to the England average. July and August 2017 saw the lowest performance levels with 86%, compared to the England average of 96%. In the latest period, May 2018, performance was 90%, compared to the England average of 95%.

Friends and family test performance (birth), Royal Cornwall Hospitals NHS Trust. From May 2017 to May 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was similar to the England average. In the latest period, performance for birth was 97%, which was the same as the England average.
Friends and family test performance (postnatal ward), Royal Cornwall Hospitals NHS Trust.
From May 2017 to May 2018 the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was worse than the England average. July 2017 saw the lowest performance levels for postnatal wards with 81%, compared to the England average of 94%. In the latest period, May 2018, performance was 90%, compared to the England average of 95%.

Friends and family test performance (postnatal community), Royal Cornwall Hospitals NHS Trust.
From May 2017 to May 2018 the trust's maternity Friends and Family Test (postnatal community) performance (% recommended) was worse than or similar to the England average. June 2017 saw the lowest performance levels for postnatal community with 86%, compared to the England average of 98%. In the latest period, May 2018, performance was 100%, compared to the England average of 98%.

(Source: NHS England Friends and Family Test)
The trust performed about the same as other trusts for 18 out of 19 questions in the CQC maternity survey 2017. For the remaining question, related to moving during labour, the trust scored better than other trusts.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.8</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.8</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.6</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone</td>
<td>8.4</td>
<td>About the same</td>
</tr>
</tbody>
</table>
by midwives or doctors at a time when it worried you?  
If you raised a concern during labour and birth, did you feel that it was taken seriously?  
Thinking about your care during labour and birth, were you spoken to in a way you could understand?  
If attention was needed during labour and birth, did a member of staff help you within a reasonable amount of time?  
Thinking about your care during labour and birth, were you involved enough in decisions about your care?  
Thinking about your care during labour and birth, were you treated with respect and dignity?  
Did you have confidence and trust in the staff caring for you during your labour and birth?  

Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?  
Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?  
Thinking about your stay in hospital, how clean was the hospital room or ward you were in?  
Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?  
Thinking about your hospital discharge, was there any delays in you being discharged?  
Was your partner, who was involved in your care, able to stay with you as much as they wanted?  
If attention was needed after the birth of your baby, did a member of staff help within a reasonable amount of time?  

( Source: CQC Survey of Women’s Experiences of Maternity Services 2017 )

**Emotional support**

Staff demonstrated they understood the emotional and social impacts that a person’s care, treatment or condition could have on their wellbeing and on those people, close to them. The women we spoke with were positive regarding the emotional support provided to them. We heard how this was extended to family members, and staff took the time to reassure them in times of emotional need. One patient told us how staff had supported them with the effect of making a horrible experience feel more manageable. Another woman told us how staff had recognised that they were exhausted and struggling to adjust tired. In response, staff arranged for the woman and her baby to be transferred to side room. This had been done to support increased rest and promote bonding between the woman her baby and other family members.

Parent-led care was delivered and tailored to individual needs. Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia. Staff recognised the emotional impact that having a baby being cared for in another area of the hospital had on women. When this happened, women were supported to attend other areas and spend time with their baby, and where possible also spend the night with them.

We spoke with staff regarding provided care to parents who had experienced miscarriage and stillbirth. Staff explained how they would show empathy, compassionate and understanding by
letting parents dictate what and how much support they required. This was in recognition that each person would experience loss differently.

**Understanding and involvement of patients and those close to them**

Women and their partners had been communicated with in a way which ensured that they understood all aspects of their care and treatment. All patients we spoke with told us they had been informed of the treatment options. This included the risks and benefits and why a treatment option may be required. Women told us this made them feel fully involved in all their care decisions.

Women’s chosen partners, family members and friends were treated as important partners in the delivery of their care. Partners and relatives, we spoke with reported that they had felt involved in the care of their relative. Staff took the time to engage with them and ensure they felt involved in decision making as much as each woman wanted them to be. One woman informed us how staff always said, “Would you like to” rather than “You need to”.

All the women we spoke with told us they their needs and wishes had been respected and that support and advice had been given to support goals. This included supporting women with their decision to either breast or bottle feed. One patient we spoke with reported how staff had taken the time to sit with them and provide practical and emotional support when their baby was having difficulty feeding. This had demonstrated how staff both understood and involved women with their care needs.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Processes were being followed to ensure the maternity services provided reflected the needs of the local population. The Princess Alexander Wing was opened in 1965 with an expected lifespan of forty to fifty years. The facilities were largely no longer fit for purpose. Whilst the trust had evidently continued to invest in updates and repair, this could only provide a temporary solution. A capital bid had therefore been submitted for a new maternity build in the centre of the Royal Cornwall Hospital site. We saw records which showed this bid had been approved by the trusts chief executive and director of finance and was progressing for NHS approval. The creation of a new building would ensure compliance with current healthcare buildings regulations and would promote both better obstetric clinical outcomes and patient experiences.

Information about the maternity services was available in a variety of sources and locations. The trust maternity website had information on the range of maternity services and facilities available. We observed a range of written and pictorial information was available throughout all the maternity services. Clinics were available across the trusts catchment area to enable women to access services close to their home. Each community birth unit facilitated ante and post-natal clinics and others were provided in children’s centers and GP surgeries. Women were also visited and provided care within their home.

From October 2016 to March 2018 the bed occupancy levels for maternity were slightly lower than the England average. In the latest quarter from January to March 2018, the trust’s occupancy levels were 56.8%, compared to the England average of 58.8%.

The chart below shows the occupancy levels compared to the England average over the period.
Meeting people’s individual needs

Systems and process were in place and followed to meet women’s’ individual needs. Staff working in the maternity service were focused on providing a responsive and needs led service. The consultants provided antenatal treatment and care for pregnant women identified with high level or complex health needs. Specialist clinics were provided for: fetal medicine, diabetes, maternal medicine and haematology. Women were encouraged and supported to make birth plans detailing in advance of delivery. Records showed where possible individual needs and wishes had been respected.

Processes were in place and practice followed which supported women with mental health needs. There was one consultant lead in post for perinatal mental health and senior staff confirmed a dedicated perinatal mental health midwifery post was due to be advertised. Records showed, risk assessments had been completed by community midwives at the initial first booking appointment and again at the 28-week antenatal appointment. Records showed that women suspected to be experiencing depression had been referred for a mental health assessment. The trust had a Service Level Agreement with a mental health trust for to provide mental health liaison and Mental Health Act management. This included to access treatment and support to meet patients’ urgent or emergency mental health care needs, this included outside of office hours and in an emergency. The maternity staff we spoke to about mental health all demonstrated they understood how to access these services.

There was a bereavement suite on Wheal Rose antenatal ward for use by women and their relatives who had experienced loss. The suite was private and had one bedroom, lounge and kitchenette area. In addition, on the ward there was a licenced satellite mortuary. This was used solely for the gynaecology and maternity women who had experienced loss. These specialist facilities enabled patients and their relatives to spend extended time together in a manner of their choosing. Staff provided personalised memory boxes, containing mementoes for bereaved parents. These had been developed in conjunction with the Stillbirth and Neonatal Death (SANDS charity). Specialist bereavement midwives worked across the maternity service providing care and support to families when required, and to other staff as required.
Records, where appropriate, contained details of patients’ who may have had additional need. We reviewed four sets of notes which showed assessments had been completed to determine if patients required additional support in understanding information. Action plans had been put in place where required. Staff had resources to support women with diverse communication needs. Staff had access to a range of communication aids from learning disabilities team. These were available and used to support women and their partners to be fully involved in all aspects of their care. Staff were familiar with, and used, a telephone translation service when required. This was reported to be prompt and effective.

Patients were aware of who was caring them and the roles of staff. Patients had reported it could be confusing to determine the roles of different staff. In response, ward and clinical areas had introduced posters informing women and visitors of the different colours of uniforms and the type of healthcare professional they related to. These had been displayed in public areas.

Facilities had been provided to support partners staying for extended periods of time. Recliner chairs were available in most areas and bedding was provided if required for partners staying with women allocated a side room. Kitchenette areas were available on Wheal Fortune post-natal ward and at the community services. These were stocked to make hot and cold drinks. However, there were no specific bathroom facilities and limited access to snacks and food for partners.

Access and flow

The maternity services responded to the needs of pregnant women living in the locality who required care, treatment and support before, during and after birth. A maternity triage and antenatal service enabled pregnant women to call or visit with concerns or queries from 8am to 8pm. If women required ongoing monitoring, treatment or care out of hours they could be reviewed by a midwife working in the community or at a community birth centre or were admitted to the hospital. Ante and postnatal clinics and parenthood classes were on offer at different times and locations to enable as many women and their partners to attend as possible. These processes supported effective flow through to the different maternity services.

There was a lack of awareness regarding the infant abduction policy. We spoke with four staff who all reported they were unaware as to whether there was an abduction policy. They told us they had not received training in what to do if an abduction concern or incident occurred. However, staff said if they had concerns they would contact the police and on-site security team.

Patients were provided with contact information if they had any concerns. This included a 24-hour midwifery contact number for patients to leave messages. Women were also advised to contact emergency services if they felt their concerns could not wait.

Postnatal care was effectively coordinated to support transfer of care from the hospital to the community. Maternity administrator staff had systems in place which kept community midwives updated. This ensured clinical information related to birth and discharge had been shared in a timely way.

Learning from complaints and concerns

We observed written information was available regarding how to make a complaint throughout the services. This included how to access the Patient and Family Experience (Complaints) Team. Information was available in different format and explained the trusts complaints process including anticipated time scales. Each pregnant woman’s hand-held records also contained prompts for women to consult their midwife with any concerns.

We looked at records which showed how formal complaints had been responded to between February 2018 to March 2018 in the women and children’s directorate. However, these summaries
did not identify how learning had changed practice or how learning had been disseminated across the maternity service. For example; one complaint related to transfer to a non-maternity ward causing limited access to the new-born baby. The summary stated the woman had been moved with her consent and that records documented access to the infant had been possible. The issue of apparent miscommunication had not been addressed. Nor was it evident how or what the learning was from this complaint was or how this had been shared widely with staff.

We looked at other complaints records. From 3 May 2017 to 13 April 2018 there were 19 formal complaints about treatment and care within the maternity service. Again, these records detailed issues related to individual complaints and identified if the complaint had been upheld or not. Of the 19, 14 had recorded the complaint had been upheld or partially upheld. There was no information related to learning or actions taken and how this had been used to make service improvements.

The trust took an average of 64.2 working days to investigate and close complaints. This was not in line with their complaints policy, which stated complaints should be completed within 25 days. The most prevalent types of complaints were those relating to communications (40%) and clinical treatment (20%). (Source: Routine Provider Information Request (RPIR) – Complaints tab)

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### Is the service well-led?

#### Leadership

There was an inconsistent response amongst the staff we spoke with regarding the effectiveness of leaders. This included the level of approachability, support and action taken in response to issues raised. However, generally all the staff we spoke with told us they understood changes in leadership, processes and practice would be required to positively develop the service. The senior leadership team had recently changed and the impact of this was being felt across the maternity service. The head of midwifery (HoM) role had been re-established to be focused solely on maternity with no other divisional commitments. This had been validated by the NHSI Maternity Improvement Advisor who had been supporting the trust. The recruitment process for a substantive HoM candidate was planned to commence before the end of 2018. Senior staff were aware of the increased anxiety amongst staff and were working cohesively to support staff. This had included increased visibility of the senior team who had attended meetings and visited clinical areas regularly.

We spoke with senior staff who demonstrated they had the knowledge, skills and experience needed for their roles. Senior staff demonstrated an understanding of the service issues that needed to be addressed because of our previous inspections. Leadership was focussed on addressing these whilst supporting staff through changes processes. Senior maternity staff told us they had access to and felt well supported by the divisional leads and director of nursing and midwifery. Senior leaders felt listened to and well supported by at board level.

#### Vision and strategy

The trust was in the process of redesigning the maternity services. From 2017 all NHS maternity services are required to develop a Local Maternity System (LMS) to bring providers and commissioners together to coordinate and plan service improvements. Patients, staff and members of the public had been consulted to share their views on the current maternity services provided by the trust. The trust was progressing plans for the provision of new build maternity service. All the staff we spoke with stated their goal was to provide high quality, person centred maternity care.

#### Culture
We spoke with 43 staff including: two associate departmental directors, the interim head of midwifery, two midwifery matrons, junior through to senior midwives, including those in specialist roles, paediatricians, obstetric consultants, anaesthetists, junior medical staff, theatre staff, midwifery care assistants, cleaners and ward clerks. Staff gave mixed feedback regarding the culture, some positive and some not so positive regarding communication and leadership styles. This reflected the impact of maternity service wide changes. This ranged from of changes in senior leadership through to organisational changes affecting practice and processes. Some of the senior leadership posts were interim and this had added to feelings of instability amongst staff.

However, overall there was a view and acceptance amongst staff that changes needed to be made to positively develop the maternity culture and working practices. The interim head of midwifery had produced her own monthly update newsletter and facilitated an open-door session one day per week where staff were able to discuss any concerns on an individual basis.

**Governance**

Governance processes needed embedding within the maternity services to ensure priority was placed on a safe and effective service delivery and actions had been evidenced as completed. New governance reporting structures had recently been put in place. These included: divisional and clinical governance meetings which linked to the trusts Quality Assurance Committee and to Board. The trust was also in the process of reviewing divisional governance meetings to ensure standardisation and clear links for 'ward-to-Board' governance.

There was a monthly combined obstetrics and gynaecology governance meeting. We reviewed the meeting minutes dated: June 2018, July 2018 and August 2018. These had been attended by; directorate leads, consultants and senior midwives. There was a standing agenda covering a range of governance data and information from approval of guidelines updated, through to complaints and audit updates. Included also was summary information related to the maternity dashboard. This contained clinical performance data which was linked to national and local standards. The information related to: public health initiatives, place and type of birth, patient feedback, infant and maternal clinical outcomes and workforce information. The dashboard was updated every month and was linked to other trusts maternity quality measures in the south west region. This enabled governance and performance information to be reviewed for trends and potential service improvements and for performance to be reviewed in comparison with other maternity services. A visual overview of the dashboard showed most outcomes dated from April 2017 to June 2018 had been evidenced to be within acceptable threshold levels.

The midwifery staffing levels had been reviewed and based on this agreement had been made at board level to increase the numbers of substantive governance and risk related midwifery posts. This included; a deputy head of midwifery role with a remit to lead risk, governance and quality improvement within the maternity service for a minimum 60% of the role.

**Management of risk, issues and performance**

Improvements had been made to how risks had been identified and acted upon since our last inspection, but this required embedding. Risks had been documented and discussed through different (daily, weekly, monthly) meetings and structures including of the divisional monthly governance processes. Identified maternity risks had been documented along with discussion points by senior staff and review of action plans. For example: a risk had been identified relating to potential delays in transfer from isolated community settings in response to an obstetric emergency. This had been recognised in response to delays in ambulance arrival times due to high demand and the wide geographic area covered. Part of the action plan was to analyse and evaluate six months of incident reports initiated from the community. This had been completed.
during March 2018. This audit found no delayed patient treatment had occurred because of ambulance delays and therefore the level of risk, whilst still applicable had been downgraded. Choice of place of birth and associated risks had been documented in the 14 patient records we reviewed.

We saw evidence that improvements to the quality and validity of obstetric root cause analysis (RCA) reports had recently been actioned. A quality assurance checklist had been developed added to the front of a recent report (dated August 2018). This additional process had reviewed and checked all elements of the investigation for thoroughness and detail. For example: that there was evidence any contributory factors had been explored, using a recognised analysis tool, that the root cause/s had been appropriately identified (with ‘human error’ and ‘failure to follow a policy’ not accepted as root causes), that effective & targeted recommendations had been developed, and appropriate people i.e. those with management/budgetary responsibility had been involved with any action plan developments. The quality assurance checklist had been completed in full and signed and dated by the head of midwifery.

There was evidence risks and performance improvements had been made since our last inspection. During June 2018 an audit had been completed to review maternity staff compliance to the trusts guideline “Severely III Obstetric woman, high dependency (HDU) care. Early Recognition and Management”. From January 2018 to May 2018 there had been 10 women requiring HDU care and all records had been reviewed for compliance to all standards set within the guideline. Analysis showed 96% compliance had been achieved. Recommendation’s and actions had been documented to improve and maintain compliance with the guidelines.

The morning safety huddle meetings had been introduced in all the key areas of the acute and community maternity service as a means of sharing, reviewing and addressing risk related information daily. For example, related to staffing shortfalls, safeguarding concerns and any potential delays in care due to unexpected emergencies. Information discussed during safety brief meetings was linked to the daily multi-disciplinary clinical team reviews.

A staff culture safety survey called SCORE had been completed during 2017 through the South West Academic Science Network. This focused on: safety, communication, operational risk, resilience and reliability, and engagement. The service was undergoing their debriefing phase which would lead to action plans. Additional plans had been made to repeat the SCORE survey during 2019 evidence whether improvements had been achieved.

**Information management**

The service was compliant with accessible information standards (NHS England). These aim to ensure that people who have a disability are provided with information that can be easily read or understood with support. This promotes effective communication with services. During our inspection we observed staff worked with familiarity with a range of resources aimed to include all women, regardless of needs attending the maternity service. This included: access and support to other professionals and services to support women with a learning disability or mental health. Practical resources were available and used to aid the explanation of procedures. We saw dolls and knitted body parts used to aid understanding.

**Engagement**

The trust had recently introduced an improve well app. The aim of this app was to provide a platform for staff to submit ideas to improve services. We were provided examples of how maternity staff had used this and how actions had been taken as a response. For example: staff raised the issues that women were not always present when staff needed to provide care resulting in some care being delayed. In response a card had been developed. Therefore, if a woman was
away from their bed space when a care or medication round took place. The card was placed on their bed informing them staff of this and requesting that they promptly find a member of staff. Staff had reported this had enabled them to complete care processes in a timelier manner.

All trust staff had been invited to participated in an annual survey which was published at the end of every year. The last staff survey dated December 2017 showed 2860 (56%) staff took part. This put Royal Cornwall trust in the top 20% of acute trusts for response rate. The results showed the trust had improved or stayed the same on almost every question.

**Learning, continuous improvement and innovation**

The maternity senior management team was focussed on addressing the issues related to inadequate ratings for safe and well led highlighted in the previous report.

### Services for children and young people

#### Facts and data about this service

Services for children and young people at the Royal Cornwall Hospitals NHS Trust are part of the Women, Children’s and Sexual Health Division with an associate director who was supported by directorate managers and the clinical team.

The team is led by an experienced clinical director. They are supported by a team of knowledgeable and skilled consultant paediatricians, neonatologists and doctors and a community team of community paediatricians and therapists. The nursing staff is led by experienced senior nurses and they are supported by staffing teams led by experienced and skilled ward managers.

Child health plans health services across acute and community services for children and young people from birth to when they transitioned to adult services. The child health directorate combines three sub-specialities: acute paediatrics, community paediatrics and children’s therapies and the neonatal unit.

The trust has 65 inpatient paediatric beds across six wards/units at Royal Cornwall Hospital:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal ward</td>
<td>20</td>
</tr>
<tr>
<td>CLIC ward / Fistral unit</td>
<td>14</td>
</tr>
<tr>
<td>Polkerris ward</td>
<td>12</td>
</tr>
<tr>
<td>Harlyn ward</td>
<td>8</td>
</tr>
<tr>
<td>Paediatrics observation area</td>
<td>8</td>
</tr>
<tr>
<td>Paediatrics high dependency unit</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>65</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Sites tab)*

Royal Cornwall Hospitals Trust (RCHT) offers a general acute paediatrics service and sees approximately 1,000 electives, 8,500 emergencies and 15,000 outpatients. It offers general paediatrics and a broader range of sub-specialist clinics in conjunction with the visiting tertiary specialists from another NHS trust.

There are shared care arrangements in several sub-specialties. Clinics are offered at the trust and in peripheral hospitals. Most admissions are unplanned and come through the Paediatric Assessment Unit with admissions increasing in the summer months with the rise in visitors to the county. The service offers age appropriate and same sex accommodation.
Paediatric surgical services are provided by the general surgical and trauma consultant led teams. There is a dedicated pre-operative assessment room, paediatric theatre and recovery area and there is close working between the paediatric and surgical teams. Children who require inpatient care will be admitted to the appropriate paediatric ward. A play room and a sensory room are available for children to use.

An outpatient department is situated on Gwithian ward on the floor below the children’s wards and is dedicated for use by children and young people.

The Neonatal Unit (NNU) is located on the first floor of the Princess Alexandra building of the hospital. It is designated a level two Local Neonatal Unit (LNU) within the south west neonatal network framework and provides care for babies above 27 weeks gestation. There are 20 cots which are used flexibly to meet demand.

The unit has a neonatal outreach service that offers specialist nursing support to babies who have been discharged from the neonatal unit with ongoing additional needs, such as home oxygen or tube feeding.

The trust provides a comprehensive community child health service covering the whole of Cornwall and the Isles of Scilly supporting a population of over 110,000 children, with close links to the acute service.

Community therapists work across the community providing physiotherapy and occupational therapy to a range of children. There is also a child in care team who monitor and assess the health needs of children in care.

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

Data from March 2017 to February 2018 showed the trust had 7,705 spells. Emergency spells accounted for 85% (6,561 spells), 11% (858 spells) were day case spells, and the remaining 4% (286 spells) were elective. Data is presented in the graph below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital (Treliske)</td>
<td>7,698</td>
</tr>
</tbody>
</table>

Total number of children’s spells by site, Royal Cornwall Hospitals NHS Trust
This trust  
7,705
England total  
1,103,628

(Source: Hospital Episode statistics)

We visited the paediatric and neonatal areas as well as facilities for adults which were also used by children and young people. During our inspection we spoke with 11 parents and five children and young people. We also spoke with 47 members of staff, including service leads, nurses, consultants, doctors, administration staff, support staff and cleaning staff. We observed how babies, children and young people were being cared for, handover meetings between staff teams, and looked at care and treatment records, and other documents provided by the trust.

Is the service safe?

Mandatory training

Not all staff were up-to-date with the trust’s mandatory training programme. This meant that some staff were not up-to-date with their skills and knowledge to enable them to care for children and young people appropriately.

Overall compliance with mandatory training remained at around 85% against a target of 95%. A downward trend was seen during the winter months. Several mandatory training sessions were cancelled during this period due to increased operational pressures.

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for medical/dental staff in services for children and young people at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>34</td>
<td>36</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>34</td>
<td>36</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>34</td>
<td>36</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>32</td>
<td>36</td>
<td>88.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>31</td>
<td>37</td>
<td>83.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>30</td>
<td>37</td>
<td>81.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>30</td>
<td>37</td>
<td>81.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>30</td>
<td>37</td>
<td>81.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>29</td>
<td>36</td>
<td>80.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>29</td>
<td>37</td>
<td>78.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>17</td>
<td>37</td>
<td>45.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>12</td>
<td>37</td>
<td>32.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was not met for any of the 12 mandatory training modules shown above for medical staff. The resuscitation training module had the lowest completion rate with 32.4%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in services for children and young people at Royal Cornwall Hospital had a completion rate of 79.6% for mandatory training. Medical staff met the target of 95% for three of the 12 modules.
A breakdown of compliance for mandatory courses from May 2017 to April 2018 for nursing staff in services for children and young people at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>48</td>
<td>50</td>
<td>96.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>48</td>
<td>50</td>
<td>96.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>48</td>
<td>50</td>
<td>96.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>46</td>
<td>50</td>
<td>92.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>42</td>
<td>50</td>
<td>84.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>41</td>
<td>50</td>
<td>82.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>40</td>
<td>50</td>
<td>80.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>40</td>
<td>50</td>
<td>80.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>39</td>
<td>50</td>
<td>78.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>38</td>
<td>50</td>
<td>76.0%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>37</td>
<td>50</td>
<td>74.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year</td>
<td>10</td>
<td>49</td>
<td>20.4%</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

The 95% target was met for four of the 12 mandatory training modules shown above for nursing staff. Resuscitation training module had the lowest completion rate with 55.6%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in services for children and young people at Royal Cornwall Hospital had a completion rate of 80.6% for mandatory training. Qualified nursing staff met the target of 95% for four of the 13 modules. None of the 43 eligible nursing staff had completed the resuscitation level 2 (newborn basic life support) module.
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>127</td>
<td>127</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>64</td>
<td>64</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>127</td>
<td>127</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>124</td>
<td>127</td>
<td>97.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>104</td>
<td>127</td>
<td>81.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year</td>
<td>65</td>
<td>84</td>
<td>77.4%</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>98</td>
<td>127</td>
<td>77.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>97</td>
<td>127</td>
<td>76.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>97</td>
<td>127</td>
<td>76.4%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>97</td>
<td>127</td>
<td>76.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>90</td>
<td>127</td>
<td>70.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>87</td>
<td>127</td>
<td>68.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Newborn Basic Life Support - 1 Year</td>
<td>0</td>
<td>43</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

There was a clear focus on improving compliance for mandatory training and achieving the 95% rate of completion. Compliance was reported monthly to the trust board as part of the integrated performance report.

Training analysis reports were available to enable attendance to be reviewed, thereby enabling staff to check their compliance with mandatory training. This supported the appraisal discussion and personal development planning. Managers saw which members of their team were in date and were able to plan when team members needed to complete refresher training. Email reminders were sent to all staff reminding them in advance of when the training was due.

Mandatory training was available using a range of methods to maximise accessibility, including face-to-face sessions and e-learning.

Most staff we spoke to said they were up-to-date with their mandatory training or had dates booked to attend training soon. Most staff told us mandatory training updates were delivered to meet their needs and they were able to access training as they needed it.

Safeguarding

There were policies, systems and processes for safeguarding children and young people. The policy was consistent with and referenced safeguarding children legislation, national policy, guidance and local multi-agency procedures.

The policy clearly described the roles and responsibilities for staff in reporting concerns about children. It covered issues including possible abuse from evidence of bruising to a child, child sexual exploitation, female genital mutilation, human trafficking, fabricated or induced illnesses, and domestic abuse.

The policy contained guidance for staff where a child did not attend clinic appointments, which were cancelled for no good reason or the patient did not arrive as booked. A safeguarding referral was generated following repeated failure to attend appointments in the outpatient department.
Staff we spoke with were knowledgeable about the trust’s safeguarding children policy and processes and were clear about their responsibilities. They described what actions they would take should they have safeguarding concerns about a child or young person.

During the period from 1 April 2017 to 31 March 2018 there had been a total of 447 safeguarding referrals. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse included: physical, emotional, financial, sexual, neglect and institutional.

Oversight of safeguarding was delivered through the trust’s safeguarding operational group (SCOG) chaired by the lead for safeguarding. Safeguarding activity was reviewed and monitored through quarterly reports to the quality and assurance committee and reported annually to the board.

A forum enabled clear links between the emergency department and paediatrics on safeguarding processes. Safeguarding screening was carried out for all children attending the emergency department to ensure any potential safeguarding concerns were detected at the earliest opportunity. Safeguarding children admission packs were used and provided the clinical teams with easily accessible information and documentation to support and evidence good quality care. An alert sticker was used for children aged 18 and under who presented to the emergency department. This sticker had been developed by the National Institute of Clinical Excellence (NICE) and was used to highlight possible safeguarding concerns.

Staff were trained to the appropriate level relevant to their role and responsibilities. These were set out in the intercollegiate document ‘Safeguarding children and young people: Roles and Competencies for Health Care Staff’.

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for medical/dental staff in children and young people’s services at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>34</td>
<td>36</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>34</td>
<td>36</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>18</td>
<td>24</td>
<td>75.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>25</td>
<td>37</td>
<td>67.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>19</td>
<td>37</td>
<td>51.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was not met for any of the five safeguarding training modules for which medical staff in children and young people’s services were eligible. Safeguarding children (level 2) had the lowest completion rate with 51.4%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that medical staff in children and young people’s services at Royal Cornwall Hospital met the 95% target for one of the four modules, with a compliance rate of 87.3% overall. Compliance improved for four modules when compared to the initial time period.
A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for nursing staff in children and young people’s services at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>48</td>
<td>50</td>
<td>96.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>47</td>
<td>50</td>
<td>94.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>32</td>
<td>37</td>
<td>86.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>41</td>
<td>50</td>
<td>82.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>39</td>
<td>50</td>
<td>78.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

The 95% target was met for two of the five safeguarding training modules for which nursing staff in children and young people’s services were eligible. Safeguarding adults (level 2) had the lowest completion rate with 74.2%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The 95% target was met for two of the five modules, with a compliance rate of 90.1% overall. Compliance improved for all modules when compared to the initial time period.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

(Safeguarding training continued to be a priority and was monitored closely. The low level of compliance remained on the risk register and was reviewed monthly as the increased training programme continued. Training levels were also included within the divisional performance assurance frameworks and monitored at monthly performance reviews.

A new on-line programme had become available and it was anticipated that this would help improve levels of compliance. Safeguarding children continued to be taught on the clinical mandatory training day. The safeguarding team had issued a new training brochure which provided comprehensive information about the level of training required and the availability of various methods for staying up to date.

The trust had named professionals for safeguarding children: the named doctor and the named nurse who worked closely together. The named nurse had taken the lead to monitor systems to
evidence good practice, monitor staff involvement in processes and offer support. They wrote to head of divisions at the end of every month with the names of staff to be reminded about completing training. The named doctor did not appear to be aware of the current safeguarding training compliance and data for the previous year and did not have a consistent understanding of child sexual abuse procedures and documents conducted by the community child health team, such as those used for video colposcopy. They were not well versed in the distinction between supervision and peer review which is recommended as good practice by the Royal College of Paediatrics and Child Health. However, other doctors confirmed they had participated in peer review.

During the safety huddle we were not assured there was sufficient information sharing about a current safeguarding case or detailed discussions about the family status. Similarly, during a ward round the family dynamics or child protection status was not flagged on the patient administration system and the appropriate fields had been left blank. This presented a risk staff would not know about the child’s status or family situation. We discussed this with the nurse in charge who raised this as an incident on the electronic reporting system and contacted the social worker and health visitor to establish the family status.

Clinical supervision was provided by the named professionals to all professionals dealing with children. Staff confirmed they were offered opportunities for debriefing and learning following difficult safeguarding events. They were encouraged to use reflection to record their learning.

Staff were knowledgeable about female genital mutilation (FGM) and aware of their responsibility to report to the police suspicions of FGM in girls up to the age of 18. The named nurse told us about an awareness day she had arranged on FGM and staff said they found it very informative and strengthened their awareness.

The child community health team provided medical support for the safeguarding of vulnerable children and young people. Community paediatricians worked closely alongside social care services and the police to provide timely medical advice, assessment and opinion to help protect the health, wellbeing and safety of children and young people.

Children and young people with a learning disability were identified when they were pre-assessed and / or admitted to the hospital. This was then recorded and filed in their medical records and alerted staff to contact the learning disability liaison team who could then provide appropriate support.

Children’s safeguarding concerns in the fracture clinic raised during the inspection in July 2017 had been resolved. An area had been designated as the children’s waiting area. Processes to book separate appointments for children were being followed.

An abduction policy was in place and staff told us they followed the guidelines set out in the policy and the hospital security team and the police were notified.

**Cleanliness, infection control and hygiene**

Systems were in place to monitor and maintain standards of cleanliness and hygiene and to prevent the spread of infection.

The units and most clinical areas were seen to be visibly clean, well-organised and tidy to make cleaning easier and optimal. However, some areas in the wards were showing signs of age, wear and tear, making them harder to keep clean.
In all areas we visited, the floors, walls, curtains, trolleys and areas in general were visibly clean. Bed and cot spaces were also visibly clean in both the easy and hard to reach areas. Bed linen was in good condition, clean and free from stains or damage to the material.

There were dedicated teams of cleaners who ensured the areas were clean and tidy. They were fully integrated with the clinical teams. There were daily schedules and weekly tasks, alongside deep cleaning as and when required. Cleaning staff were able to show us their work schedules. Cleaning equipment was colour coded, clean and well maintained, and stored in a locked area. Workloads were high in all areas. Nursing managers liaised closely with cleaning supervisors to mitigate any risks to areas when not all shifts were covered.

Equipment appeared clean and we saw green ‘I am clean’ labels placed on trolleys and equipment that had been cleaned and were ready for use.

When speaking to parents everyone commented on the frequency of the cleaning. One parent said “they’re always cleaning … I’m pleasantly surprised.”

We saw all clinical staff, including doctors, nursing staff and therapists washing their hands and using hand sanitiser gel in line with infection prevention and control guidelines. Non-clinical staff including reception and administrative staff and cleaning staff were also observed to be following the guidelines. Children and their parents were asked to wash their hands and use hand sanitiser gel when arriving on the units and this was freely available and clearly visible. All staff, as required, were bare below the elbow when working on the units.

The children’s ward was well equipped with hand wash basins with good access to liquid soap and paper towels for staff to use. There were wash hand basins at the entrance to the neonatal unit and visitors, including CQC staff, were asked to wash their hands before entering the unit.

Personal protective equipment (PPE) was available for staff to use such as plastic disposable aprons and gloves. We saw staff using PPE in all areas.

There were regular monthly environment audits undertaken for all units looking at the general environment. This included the visible cleanliness of walls, windows, ceilings and floors, hand basins being equipped with liquid soap and paper towels, and availability and replenishment of hand sanitisers. Furnishings and fittings were examined to check they were in a good state of repair. Clinical rooms, bathrooms, toilets, bed spaces, the use of personal protective equipment, waste disposal, linen management, the sluice rooms, store rooms, kitchens and equipment were also checked. Scores ranged from the lowest score of 88% to the highest score of 99% against an expected internal overall audit score of 85%, and issues and recommendations were highlighted.

There were no unit-acquired methicillin resistant *Staphylococcus aureus* (MRSA) infections or incidences of unit-acquired *Clostridium difficile* during the past year. Infection control performance indicators from 30 April 2018 which included all reportable bacteraemia, *Clostridium difficile*, hand hygiene compliance, intravascular line, urinary catheter compliance, elective and emergency screening were found to be 100%.

Data from the CQC Children and Young People’s Survey 2016 showed the trust scored 8.49 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>8.49</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Environment and equipment

The design and use of the facilities in most areas was suitable for children and young people. The neonatal unit was brightly decorated and welcoming and suitable for babies and their families.

The Polkerris ward area, which provided care for children and young people aged 0-11 years with medical and surgical conditions, trauma and orthopaedics, was tired. At the last inspection we found the high dependency unit was situated at the far end of the ward with no clear nursing observation area and this represented a risk to children who were not always visible to nursing staff despite staff best efforts to remain in the bays whenever possible. This had been identified as a risk by ward managers and the repositioning of the unit was a priority to ensure observation at all times. During this inspection we found the high dependency unit (HDU) remained at the far end of the ward. However, a nurse was always in attendance in the HDU bays to provide nursing observation. The position of the HDU was not ideal and remained on the risk register. The repositioning of the unit to the central area of the ward was preferred by the team. However, plans were constrained by the current configuration of the ward. A capital bid for a new women and children’s unit had been submitted for approval and in the meantime the team continued to work with the estates team to make the best use of the space and facilities.

Fistral ward, which provided care for children and young people aged between 11 and 16 with medical, surgical and mental health conditions, was designed because of feedback from young people and their families and funded through charitable funds and the hospital’s league of friends. There were separate bays for boys and girls.

A surgical theatre and recovery area were specifically for the use of children and young people with specialist equipment designed for children, including for resuscitation. Dedicated children’s lists were carried out on the day surgery theatre which had bays for children with paediatric equipment. Separation for children was achieved with curtains dividing bays from adults.

An outpatient department was situated on Gwithian ward on the floor below the children’s wards and was dedicated for use by children and young people. This had four day beds that could be used for children attending the hospital for procedures such as receiving medical treatment, undergoing tests and if monitoring was required before they could return home on the same day. The department was segregated from adult areas and was fully adapted for children. On the children and young people wards the doors were always closed and locked and entry was gained by using the intercom system. The CQC team were asked to provide identification on arrival at the wards. If a parent was concerned about leaving their child, a member of staff would sit with the child until the parent returned.

There were security systems to ensure the safety of babies on the neonatal unit. This included CCTV and swipe card access to areas. To gain access to the neonatal unit, parents and visitors needed to identify themselves at the entrance door using an intercom / buzzer system. This meant that access to the unit was as secure as reasonably possible. Effective use of CCTV coverage had enhanced safety arrangements. We observed parents being met and providing identification, and the CQC team were asked to provide identification on arrival to the unit.

Staff said they felt safe in their working environment.

There was age appropriate resuscitation equipment available in all areas. The trolleys carrying the equipment and medicines were checked daily for completeness and full working order and this was documented. This was to ensure they were available and ready for use in case of an emergency.
It was noted at the previous inspection in July 2017 that air/oxygen blenders and pulse oximetry in resuscitation at birth were not available on the neonatal unit as recommended in quality standards for cardiopulmonary resuscitation. The international liaison committee on resuscitation in their most recent consensus on science document suggested that for in term infants receiving resuscitation at birth with positive pressure ventilation, it was best to begin with air rather than 100% oxygen. We were told this action was under discussion and a decision was awaited about the next steps.

We saw a range of equipment was readily available and most staff said they had access to the equipment they needed for the care and treatment of babies, children and young people.

The medical physics and clinical technology directorate (MPCT) was the designated single provider of maintenance for clinical equipment. Ward managers were responsible for the safe use of medical devices within their location.

There was a system in place to ensure faulty equipment was removed from use. Faulty equipment was labelled, and the fault reported. Maintenance schedules were produced, and work was recorded within an equipment management information system. A single label marked clearly with “Do Not Use After” showed when the next service was due, regardless of its nature. We checked six items of equipment and the labels were in place with the next service date clearly written.

Filters for humidifiers were changed every three months and breast pump kits were sent for a medical fast clean as required to ensure the equipment was clean and safe to use.

Disposable items of equipment were discarded appropriately, either in clinical waste bins or sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.

During the inspection in July 2017 concerns were raised about the suitability of the facilities in the fracture clinic as children were not segregated from the visual and audible impact of adults. Action had been completed to address these concerns. An area had been designated as the children’s waiting area next to the reception and was partially partitioned off with a viewing pane through to reception. The location was chosen after reviewing the guidance of Health Building Note (HBN23) Hospital Accommodation for Children and Young People. There was clear signage to make it clear this was a child only waiting area, with accompanying adults. There were new seats made of wipeable material, a toy box, books, a small table and chairs and wall art.

The emergency department had a dedicated area for children and young people. Children were met at the main reception and would then be admitted to the paediatric department. Access was secure, and patients and relatives could only be admitted by emergency department staff. There was a secure waiting area for children and parents and the way the reception area was situated gave nursing staff a good view of the waiting area. There were two single cubicles for assessment, two trolleys for continuous monitoring in the observation area. One assessment room was set up for younger children.

The trust was in the process of consultation and business application for the complete redevelopment and relocation of the paediatric services on the acute site.

Assessing and responding to patient risk

Risk assessments relating to patients needs were completed and evaluated. There were clear processes to deal with children, young people and babies where their medical condition was deteriorating.
There was a range of processes and policies routinely used to monitor, assess, identify and respond to patient risks. The service used a nationally recognised early warning score to help detect if a patient’s condition had deteriorated. These were paediatric early warning scores (PEWS) and neonatal early warning scores (NEWS), the aim was for these to be completed within 15 minutes of arrival where the necessary clinical observations such as pulse, temperature and respirations were recorded. Staff were knowledgeable in responding to any changes in the observations which necessitated the need to escalate the child to be seen by medical staff. We reviewed six records on the paediatric wards and two on the neonatal unit and saw they had been completed according to guidance.

A digital system for recording the vital signs of children and young people had been introduced on the paediatric wards. A mobile device was used by nursing staff to collect and store observations, creating a score that assisted in making clinical judgements. This scoring could help indicate signs of deterioration and ensured clinicians had up-to-the-minute information about their patients. This enabled the nurse to remain with the patient should their observations deteriorate, as alerts could be sent automatically to the team who could then come and review the patient. It also allowed consultants to keep a track of patients when they were away from the wards. The system was used to support the handovers and safety briefings. Staff said it was “a brilliant system.” Communication had improved, and they could easily and quickly see detailed information about all patients.

There was monthly auditing of early warning scores to provide assurance about the use of the tool and results were included in the risk newsletter which was available for all staff.

A policy was in place to guide staff in the transfer and discharge of seriously unwell babies, children and young people including patients with complex continuing care needs.

The practice development team had introduced new categories to denote where observations had been refused but where there were no concerns and another where there were concerns to alert colleagues.

Data showed all checklists were completed with patient details and the completion of the sign in, time out, sign out and confirmation was entered in clinical notes.

Patient safety alerts were disseminated from the central team to divisions through the associate directors and matrons.

Records demonstrated all nursing staff within the unit had been trained in paediatric life support and consultants had also been trained in advanced paediatric life support. Staff were also trained to recognise sepsis and guidelines were available to follow. Sepsis training was available as part of the mandatory training modules and the practice educator provided regular updates.

Surgical services for children and young people were delivered through a dedicated paediatric theatre and recovered in a dedicated paediatric recovery area. Trauma and emergency surgery was performed in dedicated emergency theatres. There was a dedicated pre-operative assessment clinic which saw all elective surgical cases.

Processes were followed to support safe care in theatres. The World Health Organisations (WHO) surgical safety checklist recommendations were followed when children and young people attended theatre. Following these procedures is known to increase the safety of patients. We observed patients attending theatre as part of our inspection and saw all elements of the checklist had been followed. Monthly audits to review the compliance with the surgical safety checklist were undertaken by the surgical services by both observing practice and retrospectively reviewing WHO documentation in patient records. We reviewed audit records dated April 2018, May 2018 and
June 2018. A total of 18 observations had been completed and the records documented 100% compliance with surgical safety checklist. Of the four records we reviewed where children had undergone procedures, all had a checklist completed with patient details and the completion of the sign in, time out, sign out and confirmation was entered in clinical notes.

Recovery was overseen by a designated registered children’s nurse. Immediately after anaesthesia children and young people were cared for by registered adult nurses who had obtained additional skills in paediatric care including resuscitation and administration of medications. One nurse was allocated to each patient in this area. A member of staff with advanced paediatric life support was always available in the recovery area when children were being cared for. Second stage recovery for children was on the paediatric wards.

There was an escalation procedure for children likely to be admitted from the emergency department (ED). At times when the paediatric area had a surge of patients, or when the time to be seen was greater than three hours and the patients were likely to be admitted to the paediatric unit, patients would be discussed with the paediatric registrar on call to discuss the possibility of transferring the patient to the paediatric observation unit to be assessed. A paediatric consultant was available on a hotline between 1:30pm and 9pm Monday to Friday. In hours, service consultants were available via the trust’s switch board.

In the event of the paediatric area of the ED being overcrowded, for example, when all four trolleys were occupied due to clinical need, and / or waiting time was at capacity, there were several actions to be taken. There were outlined in the ED paediatric area crowding action card. Actions included reviewing staffing and assessing if resources could be allocated to support the paediatric area.

All seriously unwell children would be cared for in the resuscitation department by a registered children’s nurse until the Paediatric Emergency Response Team (PERT) arrived to care for the child.

All areas had access to a call bell. There were call bells and emergency call bells in each of the rooms, toilets and play area which could be heard outside of the paediatric department. There was also an intercom at the nurses’ station which could be heard throughout ED and could be used to call for assistance.

Managers advised us that activity in the paediatric area of ED between 10pm and 8am had been monitored. A pilot had been trialled for two months where the emergency department was closed, and children were admitted to the paediatric assessment unit. However, this was not effective or viable and the pilot was stopped. A sustainable long-term plan was being developed instead to maximise the use of staff and resources whilst maintaining patient safety.

There were effective handovers and shift changes to ensure that staff could manage risks to children and young people who used services. We observed the morning handover where there was enhanced attendance at senior nursing level. The handover was comprehensive and included a medical review and a review of capacity. There was also a safety briefing. The purpose of the safety brief was to alert staff to any patient care issues, concerns or risks and to provide update information on policies or procedures. Discussions included the most unwell child, those in pain, safeguarding concerns, parents’ concerns, sepsis, unchecked results, and antibiotic errors. Learning in the last 24 hours was also discussed alongside the message of the week which was repeated every morning for a week. There was also an emphasis on writing discharge summaries in a family friendly language.

A report was prepared after analysis of 2013-2018 mortality reviews by the named doctor for child death review. The review showed child mortality in Cornwall and the Isles of Scilly was
comparable with neighbouring regions. Some themes were identified across the south west region, but the trust was not identified as an outlier.

Concerns relating to the failure to recognise the severity of the child’s illness were identified as relevant and were a factor in service redesign to increase senior staff presence on the unit.

An external review had been commissioned by the trust about one child death. The report had been received at the end of August which identified several errors and recommendations. The senior team were reviewing the findings and recommendations and were fully engaged and determined to drive improvements. Changes had already been made following the internal investigations with the introduction of enhanced daily safety briefings held every morning with a senior multidisciplinary presence. Safety and quality continued to remain at the top of everyone’s agenda.

The neonatal team attended handovers and safety briefings in maternity which took place every day on each ward in the acute trust and community locations.

There was 24-hour access to mental health liaison (covering the age range of the ward/ clinic) and/or other specialist mental health support if staff were concerned about risks associated with a patient’s mental health. Staff did or arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

However, some staff did not understand the risk assessment and decision-making processes for children and young people with mental health needs. There had been a very challenging period during the past year where Child and Adolescent Mental Health Services (CAMHS) patients had stayed for lengthy periods on Fistral ward. The paediatric nursing team had asked the senior nursing team to take over the risk assessment for these patients. The senior nursing team continued to constantly risk assess the situation and worked closely with the CAMHS team. This had been all consuming for the senior nursing team. However, we were concerned there was a reliance on verbal risk assessments which were not formally documented. We discussed this with the matron who would be looking at the need for formal documentation.

In liaison with system partners it had agreed with commissioners that the acute setting was no longer to be used as a place of safety for medically fit children and young people. Patients would not be admitted to the ward instead staying in ED until a care plan had been agreed with the CAMHS team.

Data from the CQC Children and Young People’s Survey 2016 showed:

<table>
<thead>
<tr>
<th>Question number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Were the different members of staff caring for and treating your child</td>
<td>0-15 adults</td>
<td>7.66</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td></td>
<td>aware of their medical history?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Were you given enough information about how your child should use the</td>
<td>0-15 adults</td>
<td>9.53</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td></td>
<td>medicine(s) (e.g. when to take it, or whether it should be taken with</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>food)?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Nurse staffing**

Staffing levels and skill mix were at an appropriate level to ensure children and young people always received safe care and treatment.
**Planned vs actual**

At the time of the inspection levels of nursing staff and other clinical staff levels in the paediatric and neonatal units were close to the planned establishment.

The trust has reported their staffing numbers below as at April 2018 for nursing staff in children’s services at Royal Cornwall Hospital, with an overall staffing rate of 94.5%.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Planned WTE Staff</th>
<th>Number in post as at April 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>119.0</td>
<td>112.5</td>
<td>94.5%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) - Total staffing tab)*

**Vacancy rates**

From May 2017 to April 2018, Royal Cornwall Hospital reported a vacancy rate of 10.5% in children’s services, compared to a target of 10% at March 2018 and 6% at March 2019.

*(Source: Routine Provider Information Request (RPIR) - Vacancy tab)*

The ratio of children’s nurses to patients on the children’s ward met recommended levels. The children’s ward staffing levels for children over two years of age were currently one nurse to four patients in the day and one nurse to six patients at night. This was in line with Royal College of Nursing recommended staffing levels. Staffing levels were adjusted accordingly and monitored.

The neonatal unit adhered to the British Association of Perinatal Medicine standards and achieved safe staffing levels. Staffing levels were adjusted accordingly and monitored. The unit aimed to meet the staffing standards which recommended care for intensive care and high dependency babies should be provided by ‘qualified in speciality’ nurses. This recommendation was calculated based on the intensive care one to one basis, the high dependency one to two basis and special care one to four basis. The recommendation also stipulated a supernumerary team leader should be present on all shifts and this was reflected in the rota.

There was a good mix of skilled and experienced nurses and healthcare assistants in both departments. There were senior nursing staff in band eight (matron), seven (senior sisters and senior charge nurses) and six (sisters and charge nurses) supporting band five nurses and band two, three and four healthcare assistants. The band seven nurses oversaw the day-to-day running of the nursing teams in the departments, with the band six nurses in charge of their own sub-teams in the different areas.

Capacity and staffing was monitored on an ongoing basis throughout each shift considering activity as far as was known or expected. Rostering was completed six weeks in advance and in a fair and equitable fashion. Gaps were generally covered by bank and agency staff with appropriate skills and experience.

The nursing workforce was monitored with the chief nurse at the monthly matrons’ meeting. The band seven nurses also met weekly with the matron to discuss staff pressures, moves, safe care and long-term sickness and they were always aware of the wider picture across the service. They worked together to find creative solutions to staffing issues. Senior staff also looked at staffing levels before they went home to ensure the units were safe and a plan for cover was documented.

Paediatric nurses on the children’s wards were complimented by healthcare assistants and play specialists. On the neonatal unit, nurses were also supported by healthcare assistants.

**Turnover rates**
The nursing team had experienced a churn of staff due to the age demographics of the workforce. A younger workforce was developing, and proactive recruitment management had ensured the efficient and timely recruitment of nursing staff. Recruitment challenges were being addressed with the rewriting of some job descriptions to appeal to third year students.

From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 5.3% in children’s services, compared to a target range of 10-14%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Since the last inspection, a rotational post with the emergency department, had been set up and had proved successful and popular with staff. There had also been investment in advanced neonatal nurse practitioner (ANNP) training and development of the roles from the existing nursing workforce.

Plans had recently been introduced to have a supernumerary team leader present on all shifts on Polkerris ward and this was reflected in the rotas. This had already proved to be successful and there were plans to make this a permanent arrangement as it enabled staff to focus on managerial and governance elements of their role as well as being available to support the team.

During the inspection in July 2017 we found there were not always sufficient numbers of staff in the paediatric emergency department with the skills, knowledge and experience to meet patients’ needs. During our inspection in January 2018 we found there were adequate nursing staff levels to always safely meet the needs of children and young people. The area was always staffed with two appropriately trained nurses, day and night, and had continued to do so. There was a standard operating procedure (SOP) which outlined the process for managing the rota, roles and responsibilities of staff. From the rotas from the last six months we saw evidence that there were always two paediatric trained staff on duty. The rotas showed the level of training / experience of the registered nurses on the rota to ensure that all staff were clear on the staffing of that dedicated area. All band seven nurses were trained in advanced paediatric life support; all paediatric band fives and sixes were trained in paediatric life support; and a nominated selection of adult band fives were trained in paediatric life support.

**Bank and agency staff usage**

From May 2017 to April 2018, the trust reported 364 bank shifts for the children and young people’s service were filled by nursing assistants and there were three shifts not filled.

During the same period, the trust reported 1,552 bank shifts and 323 agency shifts filled by qualified nurses. There were 95 shifts not filled.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Data for June 2018 showed agency usage as 3.5 WTE on the wards. Agency usage was unprecedented as this was the first time agency staff had been used in most people’s memory. A core group of experienced staff had filled gaps and fitted in well with the teams.

There was a focus on recruitment and retention and succession planning to reduce agency use. Matrons and deputies were supporting the wards when required.

**Sickness rates**

There was a mixture of short term and long-term sickness absence which was being managed in line with trust policy.

From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 4.7% in children’s services, compared to a target of 3.8%.
Stress related absence remained the most significant cause of absence followed by injuries and other musculoskeletal problems. The divisional management team were supported by the HR team with all cases of stress related absence and were utilising the services of occupational health.

There were a variety of sickness interventions in conjunction with the HR team. These were designed to support a reduction of sickness absence and included workplace assessments and referral to occupational health and counselling services.

**Medical staffing**

There were adequate medical staffing levels to safely meet the needs of babies, children and young people with a total of 52.3 whole time equivalent (WTE).

Medical staffing levels and skill mix were compliant with the Royal College of Paediatrics and Child Health and the British Association of Perinatal Medicine standards.

**Planned vs actual**

The trust has reported their staffing numbers below as at April 2018 for medical staff in children’s services at Royal Cornwall Hospital, with an over-established staffing rate of 1.7%.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Planned WTE Staff</th>
<th>Number in post as at April 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>51.4</td>
<td>52.3</td>
<td>Over-established by 1.7%</td>
</tr>
</tbody>
</table>

**Staffing skill mix for the 49 whole time equivalent staff working in children’s services at Royal Cornwall Hospitals NHS Trust:**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>40%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>33%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>12%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

In 2017 the Royal College of Paediatrics and Child Health undertook an invited review of the community paediatric service. The report was shared across the speciality and an action plan was developed with staff to address the recommendations. Overall the review found the community was under significant pressure but was not unsafe and there was some very good practice within a popular service. The review was currently being fed into a county wide review of children’s
services commissioned by the local clinical commissioning group. Following recruitment and backfilling of maternity leave the community paediatric team had been increased to 7.18 consultants

**Vacancy rates**

From May 2017 to April 2018, Royal Cornwall Hospital reported a vacancy rate of 4.5% in children’s services, compared to a target of 10% at March 2018 and 6% at March 2019.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 17.7% in children’s services, compared to a target range of 10-14%.

A breakdown by ward/area is shown below:

- Acute paediatric: 19.8%
- Community paediatric: 8.3%

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

Workforce retirements were due in the acute paediatric medical team and job plans had been reviewed with the clinical director and networking had begun with new trainees.

**Bank and locum staff usage**

From May 2017 to April 2018, the trust reported 33 shifts filled by locum staff in children’s services and 134 shifts not filled by locum staff. The trust told us these shifts were covered by internal staff.

A breakdown by staffing group is shown in the table below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>76</td>
</tr>
<tr>
<td>Middle grades</td>
<td>0</td>
<td>54</td>
</tr>
<tr>
<td>Junior Doctors</td>
<td>33</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>134</td>
</tr>
</tbody>
</table>

In March 2018, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Sickness rates**

From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 2.4% in children’s services, compared to a target of 3.8%.

*(Source: Routine Provider Information Request (RPIR) - Sickness)*

There was good handover between clinical staff. We observed morning ward rounds in HDU. There were clear introductions and conversations with parents with an explanation of treatment and management plans. Parents were given an opportunity to ask questions. The team went through all results and treatment given and planned, and all drugs and fluids were checked to ensure correct prescribing.

**Allied Health Professional staffing**

There was safe provision of physiotherapy and occupational therapy for children and young people in both acute and community services.
Therapy staff data for the period from April 2017 to March 2018 showed several vacancies in the workforce. There were occupational therapists and physiotherapists with a planned establishment of 15.73 whole time equivalent (WTE) with an actual WTE of 13.7.

There had been good progress with recruitment to the teams, but it remained a challenge and the teams tended to grow their own workforce. Therapy students on placement and medical students completing a rotation with the community paediatricians ensured a high profile was maintained.

Other professionals supporting the care of children while they were patients on the ward included dieticians and the pharmacist team.

**Records**

Patient records demonstrated a multidisciplinary collaborative approach to care for children and young people. They were well written and managed in a way that kept people safe.

Medical notes for inpatients and outpatients were stored securely in locked cupboards to ensure confidentiality. There were occasions when records had not been correctly tracked for both inpatient and outpatient attendance. Although this was often frustrating staff said it was easily rectified with a few telephone calls and did not cause any delays in treatment.

Most patient records were well completed and reflected the needs of children and young people. We reviewed six sets of notes on the paediatric wards and two on the neonatal unit. We checked a range of information including the patient being seen by a consultant within 12 hours of admission, the diagnosis and management plan, evidence of daily ward round, observations, a review of antibiotics and input from the multidisciplinary team.

Information was complete and concise and care plans were up-to-date and there was evidence of discussions with the child or young person’s parents. Consent forms for sharing information and consent for procedures or operations were completed. All paediatric early warning scores were completed and scored.

On the neonatal unit information was clear and concise with details of what was happening now, the long-term goals, how they would be achieved, and clear review dates. Care plans were reviewed and updated regularly in conjunction with the baby’s family. All neonatal early warning scores were completed and accurately recorded to reflect the routine observations undertaken to determine where intervention might be required. Parents or guardians were encouraged to bring the Personal Child Health Record (PCHR) (referred to as red books) to admissions and appointments to facilitate sharing of child health records and hospital admissions.

There was a focus on the delivery of discharge summaries with the aim that no child would go home without a summary. If this could not be done on the day, a doctor would be allocated to complete the task in a timely way. Ward clerks would bring the planned discharges to the morning handover discussion to maintain awareness.

Community teams used paper records whereas colleagues in another community trust in the county used electronic records to which they had no access. This presented a barrier to working efficiently in the community and the trust was looking at the best electronic system available and how best to address network connectivity issues in some parts of the county.

There was also an absence of a single complete health record across the trust and the lack of an NHS Spine compliant patient administration systems represented a risk. Patient records were still provided as paper health records in addition to a range of digital clinical speciality systems.

The trust was developing a single patient record by implementing interfaces with the best clinical speciality systems. This approach would enable specialist systems to capture the detailed
information specific to the clinical area and then provide summary information through integration with the core clinical systems.

**Medicines**

There was medicines’ management to keep people safe. Staff had access to the trust medicines management policy which defined the policies and procedures to be followed for the management of medicines and included obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

We looked at the medicines storage audits, incidents and complaints, storage security, medicines records, and supply and waste-disposal processes. Medicines, including those requiring cool storage, were stored appropriately. We found all medicines we checked were stored securely and were only accessible to authorised staff. All cupboards were locked and the stocks well organised. Contents of the emergency drug cupboards were recorded. Where medicines needed to be stored in a fridge, the temperature of the fridge was checked consistently and was within acceptable temperature ranges.

Controlled drugs were stored in separate double locked cupboards. They were checked twice daily, and the check recorded by two registered children’s nurses. The record book was up-to-date and completed correctly on the wards and the neonatal unit.

Triple checks of all chemotherapy prescriptions were made by the pharmacist, the consultant or staff grade doctor.

Nursing and medical staff had access to pharmacists who were available seven days a week between 8.30am and 5pm with a late duty to support the evening and on call service. Pharmacists carried out medicine reconciliation and attended regional pharmacy meetings where changes in practice were discussed.

We saw from electronic records on the neonatal unit that prescriptions were signed and dated. Antibiotics were prescribed in line with National Institute for Health and Care Excellence (NICE) guidelines. As required, the weight of the baby was recorded. We also saw from records on the children’s wards documentation was complete and legible. It was signed and dated, with children’s age, weight and allergies recorded.

Medication incidents were reported via the trust electronic reporting system. All medication incident investigations had pharmacy input.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported one incident classified as a never event for children’s services. This was classified as a retained foreign object post procedure and occurred in July 2017.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England from June 2017 to May 2018. Two were related to abuse/alleged abuse of a child patient by third party; there were two surgical/invasive procedure incidents; and the remaining incident was a treatment delay.

(Source: Strategic Executive Information System (STEIS))
There were systems to make sure incidents were reported and investigated appropriately. Staff were open, transparent and honest about reporting incidents and said they would have no hesitation in reporting incidents and were clear about how they would report them. All staff received training on incident reporting. The incident reporting policy set out the processes for reporting and managing incidents and described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process.

All incidents were reported directly onto the incident reporting system which was available from all networked computers within the trust. Any person directly employed by the trust or who was working on a temporary, locum, or agency basis, including placement students, were able to complete an incident form. This provided a single record of each incident, subsequent investigation, agreed learning, and evidence of the learning and its effectiveness.

Staff said they were encouraged to report incidents promptly and received feedback and shared learning. Divisional boards and speciality governance meetings occurred monthly where learning from incidents was shared. There were high level shared-learning events specifically to invite debate about themes and trends either across division or the trust, and a more detailed analysis on recent applicable cases was discussed at monthly patient safety meetings. We reviewed four incidents and saw the details of the investigation, the root cause and recommendations and the action plan in place to address them. We also saw details of the learning shared following an incident relating to privacy and dignity.

Although we did not see any examples of where duty of candour had been applied, staff demonstrated an understanding of their responsibilities. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Duty of candour was also covered in the mandatory training programme and the induction for new staff. This had recently been revised and was supported by a revised Being Open & Duty of Candour Policy (April 2018) and a new trust video, and communications campaign.

Staff said information about the importance of duty of candour had been cascaded to staff through additional training sessions and by email from the medical director and the chief nurse.

A new duty of candour recording field and dashboard had recently been added to the electronic incident reporting system. The purpose was to make the duty of candour process simpler and mandatory on a ‘comply or explain’ basis.

The children’s services held paediatric mortality and morbidity meetings and minutes showed that cases were discussed and learning points and actions taken were documented. We were told these were well attended by clinical staff.

We saw details of the review of paediatric deaths over the last five years against seven themes. The report was prepared after analysis of 2013-2018 mortality reviews by the named doctor for child death review. There was no evidence of any thematic concerns found. However, concerns relating to the failure to recognise the severity of the child’s illness were identified as relevant and were a factor in service redesign to increase senior staff presence on the unit.

Patient safety alerts were issued via the central alerting system (CAS), a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the NHS.

Safety bulletins and national and local alerts were discussed at weekly leadership team meetings and disseminated to the teams.
**Safety thermometer**

There was a good safety performance on the units and the service participated in the national safety thermometer.

The Children and Young People's Services Safety Thermometer is a national tool designed to measure commonly occurring harm in people that engage with children and young people’s services. The tool focuses on deterioration, extravasation (the accidental leakage of medicines into the body from an intravenous drip in the vein), pain and skin integrity.

It is a point of care survey that is carried out on a single day each month which supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines.

Data from the safety thermometer showed the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from May 2017 to May 2018 for children’s services.

*(Source: NHS Digital)*

100% harm free care was displayed on noticeboards in all areas for August 2018.

**Is the service effective?**

**Evidence-based care and treatment**

Policies, care and treatment pathways, and clinical protocols had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them.

There was an annual audit plan in place which the clinical teams contributed to. This enabled the service to benchmark the standard of paediatric and neonatal care provided at the trust against local and national standards.

The departments undertook national audits including the National Paediatric Diabetes Audit (NPDA) for 2015-2016 and the National Neonatal Audit performance. *(Results are reported in the Patient outcomes section below).*

Local audits completed included: emergency department admission documentation audit, documentation in the emergency department to evidence correct recording and referral, safeguarding awareness in the trust and availability of information in clinical areas. On-going audits included: inter-agency referrals to the Multi-Agency Referral Unit (MARU) by trust staff, availability of safeguarding information in wards and departments, and the paediatric ward safeguarding notes audit and the leave without being seen policy.

Action plans were in place following participation in audits to address areas requiring improvement. Regular reviews were undertaken to monitor progress. The audit programme and work plan were monitored by the safeguarding children’s operational group (SCOOG) for children. Audit results were presented at the bi-monthly audit and guidelines group.

The paediatric service monitored quality and patient safety via the paediatric dashboard, neonatal dashboard and community paediatric dashboard. This was reviewed at monthly business meetings for each area and subsequently reviewed with governance oversight in the divisional meetings.

Nursing key quality performance indicators, included infection control auditing for inpatient and outpatient areas, an early warning trigger tool for inpatient and outpatient areas highlighting
workforce concerns; incidents; appraisals; number of complaints and sepsis audits highlighting areas for concern

There were clinical pathways for the most frequent reasons where children came to hospital including head injury, abdominal pain and fever. These gave clear and consistent guidance about how to treat these conditions.

The neonatal service had achieved level two accreditation of the UNICEF Baby Friendly Awards which championed evidenced based practice to promote and support breastfeeding and would be working towards level three accreditation. This had been led by the nurses and clinical support workers on the unit with support from the Burdett Trust following a successful bid. This meant that staff were supporting mothers to recognise the importance of breastfeeding, make informed choices and to support them with continuing breastfeeding for as long as they wished.

In 2017 the Royal College of Paediatrics and Child Health undertook an invited review of the community paediatric service. The report was shared across the speciality and an action plan was developed with staff to address the recommendations. The review recognised that the community team service should be valued for the quality of service and commitment of its doctors. Overall the review found the community was under significant pressure but was not unsafe and there was some very good practice within a popular service. The review was currently being fed into a county wide review of children’s services commissioned by the local clinical commissioning group.

**Nutrition and hydration**

Staff gave children and young people enough food and drink to meet their needs and improve their health.

The assessment and response to children and young people’s nutritional and hydration needs were managed effectively. Children and young people were screened to identify those who were malnourished or at risk of becoming malnourished. Snacks, sandwiches and drinks were available for children in addition to the regular breakfast, lunch and tea.

Breast feeding support was provided by the team who gave advice on milk supply, initiating lactation, pumping, transition to responsive feeding, and any other feeding issues. A room for expressing was provided on the neonatal unit together with a milk kitchen and milk fridges. Once milk had been expressed a label with the name of the baby, date and time of expression was placed over the lid and down the side of the bottle. Breast milk was stored for 24 hours in the fridges and for 48 hours in the freezers. Temperatures of the fridges and freezers were checked daily and recorded. Breast milk fridges and freezers were locked and were situated in the milk kitchen which was also locked to ensure the complete security of bottles.

A two-person check was implemented prior to the giving of expressed milk in line with the positive patient identification policy. Staff encouraged parents to label their own milk or otherwise were second checked. Where milk was decanted from a larger bottle to a syringe or smaller bottle the labels were also double checked.

Paediatric dietitians provided nutritional support, advice and education to children and parents about diet, supplements and enteral feeding.

The trust performed about the same as other trusts in the question ‘Did you like the hospital food?’ where they scored 5.91 in the CQC Children and Young People’s Survey 2016

**Pain relief**

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

A pain specialist was available for discussions about the assessment and management of pain for non-verbal children. We saw a personalised pain assessment tool which had been produced in consultation with a child’s parents. The child’s needs were such that normal assessment was not suitable to assess their pain.

Parents said staff regularly checked with their child asking them if they had any pain and gave pain relief when it was required.

For babies in the neonatal unit, pain and stress were monitored and registered simultaneously with other physiological parameters such a temperature and blood pressure. This made it possible to continuously evaluate any pain and the need for analgesics or comfort measures. Every baby was assessed on admission to the neonatal unit and before and after potentially painful interventions, and at regular intervals.

The trust performed about the same as other trusts in the questions relating to effectiveness in the latest CQC children’s survey including ‘If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?’ Data is shown below:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.76</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>67</td>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>8.89</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Patient outcomes**

Several regular audits were carried out on the units to review and demonstrate the quality and safety of services delivered against national patient outcomes. These audits were monitored and action plans to address areas of improvement were regularly reviewed.

Clinical audit activity of the service aligned with the annual clinical audit plan. Clinical audit leads were appointed at specialty level and provided leadership in their clinical area. The work was supported by the central team to ensure projects were well designed and to maximise the impact and learning.

Examples included the paediatric readmissions audit where there was an increase in the number of admissions with 28 days identified in the winter of 2017 / 2018. A sample of readmissions from one month was reviewed and identified that two thirds of the readmissions were unrelated to the initial readmission. Of the related readmissions “open access” was used in around half of the cases. Of these cases only one third of the readmissions were felt to be necessary, with two thirds of cases having no new investigation or treatment instigated. The team identified that the open access use was too broad and too lengthy leading to unnecessary admissions which could put pressure on the admissions unit, waste valuable resources as well as leading to unnecessary
travelling for patients who did not need to attend hospital. Clear reduced time limits on open access had been reduced unless deemed clinically indicated. The impact was expected to reduce the number of readmissions and would be monitored through the trust and divisional readmission monitoring processes.

**Emergency readmission rates within two days of discharge**

The tables below show the percentage of patients (by age group) who were readmitted following an elective admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that, from February 2017 to January 2018, no treatment specialty reported six or more readmissions for children under one readmitted following an elective admission. There were higher percentages of patients aged 1-17 years old readmitted following elective admission to paediatrics and ENT compared to the England averages.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Royal Cornwall Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1.9%</td>
<td>791</td>
</tr>
<tr>
<td>ENT</td>
<td>1.0%</td>
<td>586</td>
</tr>
</tbody>
</table>

No other specialties at this trust had six or more readmissions

The data shows that from February 2017 to January 2018 there were higher percentages of under ones and children in the 1-17 age group readmitted following an emergency admission to paediatrics compared to the England averages.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Royal Cornwall Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.8%</td>
<td>1,725</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

The data shows that from February 2017 to January 2018 there were higher percentages of under ones and children in the 1-17 age group readmitted following an emergency admission to paediatrics compared to the England averages.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Royal Cornwall Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.2%</td>
<td>4,593</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions
Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From March 2017 to February 2018, the trust performed similarly to the England averages for the percentages of patients aged 1-17 years old who had multiple readmissions for asthma and epilepsy.

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Royal Cornwall Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>15.2%</td>
<td>151</td>
</tr>
<tr>
<td>1-17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>1-17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>1-17</td>
<td>33.3%</td>
<td>45</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with '*'.

The service participated in several audits including the National Paediatric Diabetes Audit National Neonatal Audit Programme, paediatric allergy clinic audit, assess door to needle time in neutropenic sepsis in paediatric oncology patient, audit of the investigation of children with developmental delay, receipt of flu vaccination post chemotherapy and BTS Annual Asthma Audit

Results from the National Paediatric Diabetes Audit (NPDA) for 2015-2016, showed an improving delivery of results. In the 2015/16 paediatric diabetes audit, the proportion of patients at Royal Cornwall Hospital receiving all key care processes annually was 55.0% which was a positive outlier, compared to a national aggregate of 35.5%. The previous year's score was 51.8%.

HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. HbA1c refers to glycated haemoglobin (A1c) and is a measure of diabetes control. This level of care had been achieved by several factors including: close multidisciplinary team working; building respectful relationships with families and young people and empowering families to take ownership of the management of diabetes.

The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”

The average HbA1c value (adjusted by case-mix) at the trust was 62.9 which was a positive outlier, compared to a national aggregate of 68.3. The previous year, the hospital was also a positive outlier.

The median HbA1c value recorded amongst the 2015/16 sample was 60.5, which was a clinically significant improvement compared to the previous year's median of 65.5.

(Source: National Paediatric Diabetes Audit 2015/16)
In the 2017 National Neonatal Audit, Royal Cornwall Hospital’s performance in the four measures relevant to services for children and young people was as follows:

**Babies <32 weeks gestation who had temperature taken within an hour of admission that was between 36.5ºC and 37.5ºC**

Out of 39 eligible cases identified for inclusion, 64.3% of babies less than 32 weeks gestation had a temperature taken within an hour of admission that was between 36.5ºC and 37.5ºC. This was within the expected range when compared to the national aggregate of 61.0%.

The hospital did not meet the audit’s recommended standard of 90% for this measure.

**Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission**

Out of 388 eligible cases identified for inclusion, 98.1% of babies had a documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission. The hospital was a positive outlier when compared to the national aggregate of 90.5%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

**Babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity**

Out of the 48 eligible cases identified for inclusion, 95.5% of babies of very low birthweight or less than 32 weeks gestation received appropriate screening for retinopathy of prematurity. This was within the expected range compared to the national aggregate of 94.2%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

**Babies with gestation at birth <30 weeks who had received documented follow-up at two years gestationally corrected age**

Out of the 18 eligible cases identified for inclusion, 77.8% of babies with a gestation at birth of less than 30 weeks received a documented follow-up at two years gestationally corrected age. This placed the hospital within the middle 50% of hospitals in England for this measure. The national aggregate was 61.2%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

The service took part in specialist clinical networks; the Neonatal Critical Care Network and the south west cardiology network and welcomed national peer review benchmarking and assessment visits.

Through involvement in the safety collaborative the neonatal unit had been involved in the introduction of the beanie project as part of the (Avoiding term admission (ATAIN) work with maternity. Coloured hats were used to denote the level of observation at birth. This had led to a reduction in term admissions to the neonatal unit.

The service maintained a clinical dashboard of outcomes which was reviewed and updated every month. Information was audited, and actions taken with regards to quality and safety outcomes. Information from the dashboard was shared with staff and with the board through various departmental and directorate governance meetings.

There was a focus across the service on the delivery of discharge summaries with the aim that no child would go home without a summary. If this could not be done on the day, a doctor would be allocated to complete the task in a timely way. Ward clerks would bring the planned discharges to the morning handover discussion to maintain awareness.
Physiotherapy used a goal attainment scale as a standard to regularly audit outcomes for children and young people by capturing the extent to which individual goals for treatment were achieved.

Physiotherapists, orthopaedic surgeons and radiographers used a standardised tool with red flags aimed at reducing the need for regular orthopaedic reviews and less intrusive intervention resulting in improved outcomes.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and that there was good teamwork. Staff were encouraged to keep up-to-date with their continuing professional development and there were opportunities to attend external training and development in paediatric specific areas.

The service undertook a range of education and practice development activities aimed at enhancing the knowledge, skills and awareness and development of the staff. There were study days including simulation training on paediatrics and neonates and speciality training.

There was a trust-wide electronic staff record where all training attended was documented. Managers were informed of training completed and alerted to those staff requiring updates for mandatory training through regular discussions with the HR department.

Records showed all nursing staff within the children’s wards, the outpatient department, the child development centre, the neonatal unit and clinical staff working in the community had been trained in paediatric life support. Consultants had also been trained in advanced paediatric life support.

Surgeons and anaesthetists had appropriate training and competence to handle emergency surgical care of children, and nurses were required to maintain paediatric competency.

However, there was not a mandatory requirement for advanced paediatric life support training for surgery and anaesthesia staff.

Physiotherapist and occupational therapists were paediatric trained.

The outpatient department offered placements and training for nurses from other clinic areas to gain greater knowledge and skills in caring for paediatric outpatients. Community paediatrics offered placements for and training for any medical professionals including health visitors, nurses, GPs, therapists and any appropriate trainee.

The team had introduced the training initiative “15 at 15” where various staff members facilitated discussion and debrief, and shared learning for 15 minutes at 3pm every day. These were well attended, and staff said they were useful.

There was regular simulation training available to the multidisciplinary team covering a wide range of topics in paediatrics and neonatal. The neonatal team had presented the training nationally and internationally in New York. A simulation training session was held during our visit where staff acted out a scenario, on a synthetic model of a child. This was watched on a video link by junior doctors.

There was regular junior doctor teaching and the practice development team provided learning from incidents, complaints and serious incidents.

The nursing team continued to be involved in the apprenticeship advanced nurse practitioner role and rotational recruitment between the trust and a neighbouring trust to attract and retain staff.
However, not all staff felt the training was sufficient to provide them with the knowledge and skills required to care for patients with mental health needs, learning disabilities and autism. Staff said they learned on the job and relied on specialist teams (such as psychiatric liaison) for specialist skills and support.

**Appraisal rates**

Appraisal compliance had improved but was not compliant with trust targets.

Annual appraisal and clinical supervision structures enabled staff and managers to identify training needs, develop competence and enhance clinical practice. Most staff we spoke with said they had received an appraisal during the last year.

Up to August 2018, 83.8% of medical staff and 89.5% of nursing staff within children’s services at Royal Cornwall Hospital had received an appraisal compared to a trust target of 95%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>59</td>
<td>62</td>
<td>95.2%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>102</td>
<td>114</td>
<td>89.5%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>31</td>
<td>37</td>
<td>83.8%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>15</td>
<td>19</td>
<td>78.9%</td>
</tr>
<tr>
<td>Total</td>
<td>223</td>
<td>249</td>
<td>89.6%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – Appraisal tab)

The trust has struggled with compliance over the last 12 months. A recent audit of appraisals (April 2018) has shown three significant barriers to appraisal. They were:

- staffing pressures which reduced the time available for undertaking appraisals
- maintaining staff commitment, in the face of time constraints and operational pressures to work towards their objectives throughout the year rather than a few weeks before their next appraisal
- appraisee engagement.

A further significant impact on compliance recording was the process of inputting on to the electronic staff record (ESR) which many staff found either difficult or omitted to complete. This meant appraisals were often complete but not recorded. Several actions were being taken to address the issue including the review of the pay progression and appraisal policy and training on ESR input.

The division had developed its own appraisal compliance action plans/trajectories which were monitored through monthly performance reviews. These actions fed in to overall the trust compliance improvement trajectory which aimed to see compliance by November 2018.

The trust did not have a target for clinical supervision and data on uptake of supervision for nursing staff was not recorded centrally. The trust was considering a fresh approach to the policy for clinical supervision and had been reviewing those used by partners in the sustainability and transformation partnership (STP).
Most staff we spoke with were positive about the quality and the frequency of clinical supervision they received.

**Multidisciplinary working**

We saw evidence that staff worked professionally and cooperatively across different disciplines and organisations both in the acute hospital and in the community. This was to ensure care was coordinated to meet the needs of children and young people.

There was good teamwork across the disciplines with a focus of integrated care pathways.

Therapy was conducted on the children’s wards, the outpatient department, and the neonatal unit. Staff reported good multidisciplinary team working with meetings to discuss children and young people’s care and treatment.

There was access to an integrated community therapy service for children who had physical or sensory difficulties, developmental delay, under-nutrition or excessive weight gain. Community therapy included physiotherapy, occupational therapy and dietetics and was based at the child development centre.

Physiotherapists assessed, treated and managed children and young people with a variety of conditions affecting gross motor function, which are the bigger movements, such as rolling over and sitting, that use the large muscles in the arms, legs, torso and feet. The conditions could be neurological, developmental, orthopaedic, musculoskeletal, and respiratory or because of trauma.

Occupational therapists assessed functional and sensory needs and worked with parents and carers to enable children to become as independent as possible.

Dietetic support was available to children, their families and the professionals who worked with them. Dieticians provided individual dietetic assessment and treatment for children who met the referral criteria and offered self-referral workshops for parents/carers. They also sign-posted parents/carers to information, advice and other services and offered training for professionals.

Community therapists worked closely with community speech and language therapists who were funded by another provider.

Other professionals were called upon to care for babies, children and young people as part of a wider multidisciplinary team. They included pharmacists, audiologists, and a consultant ophthalmologist. Radiologists provided clinical imaging including x-rays, computed tomography (CT) scans, magnetic resonance imaging (MRI) scans, imaging and ultrasound.

Good teamwork was demonstrated in the anaesthetic room, theatre and recovery where the child was the whole focus of the team.

Play specialists helped children to understand their condition and medical treatment. They provided preparation and support for potentially stressful experiences such as medical or surgical procedures. The play team visited all ward areas to assess need and to set up play areas with toys and materials. They also provided support to siblings. We followed the surgery pathway where a child had visited the pre-operative assessment where the play specialist rehearsed the insertion of a cannula on a doll. The child appeared to be very relaxed in the playroom with the play specialist providing toys and activities.

The clinical teams on the children’s ward and the neonatal unit were assisted by a dedicated team of ward clerks and reception staff. They provided comprehensive support to consultants, doctors and nurses with a host of administrative tasks from welcoming children and their parents and checking their details to ensuring notes were available for clinics and answering telephone calls.
There was strong collaboration with Child and Adolescent Mental Health Services (CAMHS) in reach teams and managers to ensure appropriate action and escalation. There were also close links with learning disability teams and homecare teams to ensure care was tailored to suit individual needs and links with colleagues in tertiary centres with opportunities for learning and sharing from incidents.

A framework was available for all healthcare professionals to enable them to deliver a well-planned transitional process for young people with long-term health conditions and complex health needs as they moved from child-centred to adult-orientated services.

The transition policy set out best practice principles to ensure that all young people received a high-quality service that was coordinated, uninterrupted, patient-centred, age and developmentally appropriate. The timing of transition depended on the individual patient but was usually at some time between 16 and 18.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.71 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.  
(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Seven-day services**

There was 24-hour medical cover seven days a week on the children’s ward and the neonatal unit.

There was access to pharmacy seven days a week between 8.30am and 5pm, with a late duty to support the evening and on call services.

On call support was provided by clinical services including, radiology, central sterile services department and pathology.

**Health promotion**

Health promotion was a routine part of all care provided to children and young people. All staff worked collaboratively to assess all aspects of general health and to provide support and advice to promote healthy lifestyles.

Dieticians worked with young children (six and under) who were significantly overweight as part of the tier 3 multi-disciplinary lifestyles, eating and activity for families’ programme. They also provided support and training for professionals working with children and families around weight management.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Most staff were aware of consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Staff had attended mandatory training and knew what their responsibilities were and how to apply them within everyday practice when required. However, some nursing staff said they lacked confidence in making capacity assessments and deferred to medical staff. The completion of documentation was variable with detail missing in some notes we checked.

Staff said they obtained consent from children, young people and their parents / carers prior to commencing care or treatment. They said children and young people were given choices when they accessed their service. Staff told us about how they dealt with consent issues for young people who did not want to tell their parents. They always tried to sensitively manage the situation while ensuring that the young person received the help they needed.
Staff were aware of and knowledgeable about the Fraser guidelines and Gillick competency which helped them to balance children’s rights and wishes with their responsibility to keep children safe from harm. Fraser guidelines and Gillick competency refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. Since then, they had been more widely used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions.

Throughout the inspection we saw staff explaining the assessment and consent process to parents / carers and any need to share information with other professionals such as GPs, nursery or school before obtaining written consent. We saw consent forms signed appropriately by parents.

We heard staff discussing the treatment and care options available to children, young people and their parents.

The trust reported that from May 2017 to April 2018, Mental Capacity Act (MCA) level 1 training has been completed by 99.6% of staff within children’s services at Royal Cornwall Hospital. Nursing staff had a completion rate of 100% and medical/dental staff had a 97.2% completion rate.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level 1 training had been completed by 99.6% staff within children’s services at Royal Cornwall Hospital. All nursing staff and 98.0% of medical staff had completed the training.

(Source: Updated data provided by the trust)

Other CQC Survey Data

The trust’s performance in the CQC Children and Young People’s Survey 2016 relating to the effectiveness of the service is shown below:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>8.70</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9</td>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>7.76</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>19</td>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>8.23</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>23</td>
<td>Did the members of staff caring for your child work well together?</td>
<td>0-15 adults</td>
<td>8.71</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>33</td>
<td>During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>8.47</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>54</td>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 CYP</td>
<td>4.95</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service caring?

Compassionate care
Throughout our inspection, we saw children and young people being treated with compassion, dignity and respect.

Care from the nursing, medical staff, play specialists and support staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance.

We observed all staff taking time to talk with children in an age appropriate manner. They involved and encouraged both children and parents as partners in their own care. Parents were aware of the named nurse caring for their baby, child or young person.

During our inspection we observed excellent interactions between staff, children, young people and their families. Staff were open, friendly and approachable and interactions were very caring, respectful and compassionate. The staff were skilled in talking with and caring for children and young people. Parents, siblings and grandparents were encouraged to provide as much care for their children as they felt able to, while young people were encouraged to be as independent as possible.

The trust used several forums to gather feedback from children and their parents including a pictorial feedback form and the voice of the child.

The trust also used the NHS Friends and Family Test to find out if children, young people and their parents would recommend their services to friends and family if they needed similar treatment or care. From the dashboard for June 2018 the response rate for the friends and family test was shown as 18.1% on Polkerris, HDU and PAU with recommendation at 90.2%. On Harlyn, Fistral and CLIC the response rate was 68.7% with recommendation at 90.7%. There was no data available for the neonatal unit.

There was a children and young people’s Friends and Family questionnaire where they were asked to rate how much they agreed with the question “I would say this is a good ward/service/team for my friends and family to be looked after.” Options ranged from “I agree a lot” to “I disagree a lot”. Children were also asked to draw a picture of when they last visited, what was good about their visit and what could be better. We saw several drawings displayed on the wards where there were drawings of doctors and nurses with happy faces and comments including “thank you for looking after me” and “I'm all better.”

Children, young people and their parents we met spoke highly of the service they received. All the feedback we received from the parents was very positive about the care their children received. The comments we received from parents on the children's ward included, “I can't thank them enough”, “they're all so kind and helpful and nothing is too much trouble.”

Parents on the neonatal unit were also unanimous in their praise and many parents had written cards to express their thanks. Comments included, “the team are wonderful and the reason our baby survived”, “words will never express how grateful we are for all of your hard work and special care helping our son through his first days of life” and another said, “we will be forever grateful for your kindness and support.”

The children and young people we spoke with said how friendly the staff had been during their stay. Comments from children and young people included, “the nurses are nice and make me laugh and then I feel better”, “I like giving my doll injections like I have.”

We observed good attention from all staff to children and young people’s privacy and dignity. Curtains were drawn around bed spaces for intimate care or procedures. Voices were lowered to avoid confidential or private information being overheard. All parents said their privacy and dignity was maintained. Children under the age of 12 were always supervised by hospital staff when they did not have a parent visiting.
Play specialists supported siblings and other children to help them understand what their brother, sister or friend was experiencing.

The trust performed about the same as other trusts for all 10 questions relating to compassionate care in the CQC Children and Young People’s Survey 2016. Data is shown below:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>9.21</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>14</td>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>8.96</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>22</td>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>7.71</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>42</td>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.18</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43</td>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>9.21</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>44</td>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>8.40</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>58</td>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 CYP</td>
<td>6.40</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>64</td>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 CYP</td>
<td>8.92</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>74</td>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 CYP</td>
<td>9.41</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>75</td>
<td>Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 CYP</td>
<td>9.12</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Emotional support**

We observed staff providing emotional support to children, young people, their parents, siblings and grandparents during their visit to the unit. Children’s individual concerns were promptly identified and responded to in a positive and reassuring way. One parent told us the “staff always seem to know when I need a hug and a cup of tea ... they’re absolutely fantastic.”

Children, young people and their families were spoken with in an unhurried manner and staff checked if information was understood.

Difficult information was discussed in a sensitive manner and a parent told us how supportive the entire team had been “they’ve helped me get through things ... I don’t know where I’d be without them.”

Staff supported children and young people with mental health needs who became distressed in an open environment and helped them to maintain their privacy and dignity.

Staff talked about children and young people compassionately and with knowledge of their circumstances and those of their families.

Staff understood the impact the care, treatment or condition might have on the child or young person’s wellbeing and on those close to them both emotionally and socially. There was good support from the hospital multi-faith chaplaincy team who were always on-call for children and young people, and their family and friends.

The trust performed about the same as other trusts for the all five questions relating to emotional support in the CQC Children and Young People’s Survey 2016. Data is shown below:
### Table

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>9.01</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>29</td>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.76</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>45</td>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.24</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>65</td>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 CYP</td>
<td>8.88</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>67</td>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>8.89</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

### Understanding and involvement of patients and those close to them

Children, young people and their families were involved with their care and decisions taken. Parents said all procedures had been explained and they felt included in the treatment plan and were well informed. This included the consultant explaining the surgery events in detail to a parent and nurses talking parents through information leaflets.

We observed staff explaining things to parents, children and young people in a way they could understand.

Parents were encouraged to be involved in the care of their children as much as they felt able to. We observed that children and young people were also involved in their own care. Children, young people and parents that we spoke with all confirmed this was the case. One parent on the neonatal unit told us how staff had taken time to advise her about the importance of skin to skin care and supported her when she “felt too scared to hold my own baby.”

We observed a ward round, where the child was the focus and included in discussions and asked for their opinion about the treatment plan and if they had any questions.

Staff showed understanding and a non-judgmental attitude when caring for or talking about children and young people with mental health needs, learning disabilities or autism.

Staff had access to communication aids via the learning disabilities team to help patients become partners in their care and treatment.

Staff made sure children, young people and parents knew who the staff were and what they did. All healthcare professionals involved with the patient’s care introduced themselves and explained their roles and responsibilities.

Staff recognised when children, young people and their families needed additional support to help them understand and be involved in their care and treatment.

Staff understood and respected the personal, cultural, social and religious needs of people and how these could relate to care needs.

They were knowledgeable about the trust framework to support communication with families who were non-English speakers, or for whom English was a second language. Support was also available for families with hearing or visual impairment, or who had learning disabilities.
The trust performed about the same as other trusts for the questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. Data is shown below:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>9.22</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>12</td>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>7.62</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>13</td>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>9.28</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>15</td>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.27</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>16</td>
<td>Were you given enough information to be involved in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.54</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>17</td>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.23</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>18</td>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>8.79</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>31</td>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.78</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>32</td>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.70</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>34</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>8.58</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>39</td>
<td>When you left hospital, did you know what was going to happen next with your child’s care?</td>
<td>0-15 adults</td>
<td>8.25</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>41</td>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>8.63</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>59</td>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 CYP</td>
<td>9.25</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>60</td>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 CYP</td>
<td>7.62</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>61</td>
<td>Did you feel able to ask staff questions?</td>
<td>8-15 CYP</td>
<td>9.16</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>62</td>
<td>Did the hospital staff answer your questions?</td>
<td>8-15 CYP</td>
<td>9.54</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>63</td>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8-15 CYP</td>
<td>6.80</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>66</td>
<td>If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td>12-15 CYP</td>
<td>No score</td>
<td>No score</td>
</tr>
<tr>
<td>69</td>
<td>Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>8-15 CYP</td>
<td>9.69</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>70</td>
<td>Afterwards, did staff explain to you how the</td>
<td>8-15</td>
<td>8.67</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>operations or procedures had gone?</td>
<td>CYP</td>
<td>as other trusts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----</td>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your care?</td>
<td>8-15 CYP</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

The environment on the children’s wards, the outpatient department and the neonatal unit were designed to meet the needs of babies, children and young people and their families.

A team of specialist children’s nurses looked after patients, both in hospital and out in the community, and worked alongside other health professionals such as therapists, teachers and social workers.

Surgical services for children and young people were provided by the general surgical and trauma consultant led teams. Elective inpatient and day cases were performed on the same theatre lists. Paediatric general surgical interventions were delivered through a dedicated paediatric theatre (theatre 1 of the Tower) and recovered in a dedicated paediatric recovery area also situated within the Tower. Trauma and emergency surgery was performed in dedicated emergency theatres (in Trelawny) and on these occasions screens/curtains were used to segregate children from adults to protect their privacy and dignity. The recovery area had been personalised with child friendly transfers.

Second stage recovery for children was on the paediatric ward. There was a dedicated pre-operative assessment clinic which saw all elective surgical cases, and which worked closely with the surgical teams and the play team to ensure children were assessed and admitted appropriately.

An allergy nurse specialist role had been developed in the outpatient clinic to provide a one-stop service. The objective was to improve the patient experience and to reduce waiting times and the number of admissions.

Processes to book separate appointments for children on the fracture clinic were being followed. Procedures were in place for the management of appointments for paediatric patients (under 16 years old) attending the clinic. This ensured children were treated separately from adult patients in line with safeguarding guidance. Paediatric patients requiring new and follow-up appointments were offered appointments in the appointment slots between 8.50am and 9.40am inclusive to manage them separately from adult patients. The only exceptions to this were for patient choice or clinical reasons.

There was a dedicated playroom and sensory room. Play areas with a wide range of toys and activities were available in all areas. There was an abundance of colourful and age appropriate art work and information notice boards in all main areas.

There was a well-equipped school room on the main site and in the child development centre.

Community paediatric teams looked after children and young people who had long term, chronic and ongoing conditions, physical disabilities, learning difficulties, social communication difficulties and other long-term disabilities. This care was delivered by a team of paediatricians, including consultants, staff and associate specialists, with junior doctors providing a supporting service. Teams worked in preschools, schools and special schools.
In the child development centre there were therapy rooms and large areas for physiotherapy occupational therapy, an orthotics room, a soft play area and a garden. There was a large hydrotherapy pool with two levels and an observation trench area for parents to stand.

Community staff were committed to delivering care as close to home as possible. Children were often seen in a clinic setting or children and young people were visited in their daily lives at home or at schools and nurseries. This minimised disruption for children and their families.

Referrals to the community integrated therapy service could be made from anyone who had professional or parental responsibility for a child or young person and had concerns about their development. Referrers included GPs, teachers, educational or clinical psychologists, health visitors, school nurses, children’s centre staff, social care teams, parents / carers and young people themselves.

Assessment clinics were generally held at the child development centres across the county with any subsequent appointments taking place in the child’s school or in their home.

Therapy staff worked collaboratively with education colleagues providing training for staff in specialist schools to incorporate sensory and posture management in activities and play to develop free function and hand/eye control. Assistants and technicians supported therapists by delivering treatment programmes devised by therapist.

The community paediatric team were undertaking several service developments. These included working closely with the acute paediatric team to develop shared care pathways for the most significantly complex children, working with therapy teams to develop multidisciplinary clinics, improving the demand and capacity through clear referral, pathway and discharge guidance and developing a single neurodevelopmental pathway.

Community therapists worked across the community providing therapy to a range of children. Predominantly but not exclusively having neurodevelopmental presentations. Care was delivered as close to home as possible using specialist schools, children’s centres and health-based clinics. A change in structure had been the development of clinical lead posts for each specialty to help drive service improvement, best practice and clinical governance. The team had been restructured from four teams to two. one in the east and one in the west.

The development of integrated care involving joint clinical pathways across organisations for children and young people with long-term and life-limiting conditions within Cornwall was underway to improve outcomes. A review of service provision for children was a priority of the local clinical commissioning group.

The trust performed about the same as other trusts for most of the questions relating to the responsiveness of the service in the CQC Children and Young People’s Survey 2016. Data is shown below:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.71</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>5</td>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.89</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>25</td>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>9.11</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>26</td>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>7.44</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>
Meeting people’s individual needs

Children and young people were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs.

Care was delivered as close to home as possible using specialist schools, children’s centres and health-based clinics.

Surgical services for children and young people were delivered through a dedicated paediatric theatre and recovered in a dedicated paediatric recovery area. Trauma and emergency surgery was performed in dedicated emergency theatres. There was a dedicated pre-operative assessment clinic which saw all elective surgical cases.

There was an electronic flagging system for children and young people with a learning disability. They were assessed in the same way as any other patient for their acute health needs to ensure they received equitable care and treatment. Where necessary reasonable adjustments were made to help facilitate these assessments for example longer appointment times, quieter spaces, supported by carers or the learning disability nurses.

The acute liaison team supported children with autism and learning disabilities. Leaflets were readily available to explain about communication, appointments, understanding all the information given as well as support to the child and their family and talking about how they were feeling.
There was an educational campaign called “This is really me” which recorded what mattered to the child or young person. This constructed a portrait of the child to ensure there were no gaps between clinical assessment and over acceptance of the level of illness and behaviour.

Parents were encouraged to stay with their child on the children’s ward and there were no restrictions to visiting times. Accommodation was provided for one parent to stay overnight with their child. Each bed space had a pull-down bed next to it so that parents could stay on the ward if they preferred to do so. There were also four bedrooms available for parents to use throughout their stay at hospital. The accommodation also housed bathroom and kitchen facilities along with a sitting room so that parents could spend time away from the ward. Each ward area also had parents’ kitchens or beverage points and seating areas, so they could prepare drinks and food during their stay.

On the neonatal unit, reclining chairs were available at each cot side and there were five double rooms and shower and toilet facilities for parents to stay with their babies prior to discharge, or for parents whose baby was extremely unwell. There was a water cooler and a kitchen with facilities for storing and making food. A milk expressing room and milk kitchen were also available together with an interview room that was being used as a quiet room. Linen stores with a range of baby clothes were also available. One parent asked to speak to inspectors to praise the environment and facilities on the unit. They said it was “absolutely first class.”

During the inspection in July 2017 the neonatal unit was very hot and air conditioning units and fans were being used as a temporary measure to control the temperature. During this inspection we found the problem had been resolved and the temperatures were within appropriate parameters. Fans were available around the unit following the recent warm weather. Parents said the temperatures were comfortable in all areas.

The trust provided a framework to support communication with patients and carers who were non-English speakers, people for whom English was a second language, people with hearing or visual impairment, or who had learning disabilities. The policy set out clear standards to promote good practice and covered the use of face-to-face interpretation, telephone interpreting, and written translation services. The trust provided three main interpreting services: a 24-hour telephone interpreting and translation including braille for which each department had a unique ID access code; a face to face interpreting service and a British Sign Language service.

Outpatient appointments were made via the NHS Choose and Book system or the referral management system and children were referred for specialist clinics or seen for initial assessment in a general paediatric clinic if appropriate.

All areas we visited were accessible to disabled people and there were appropriate toilet facilities.

Several advice leaflets for parents were seen during our visit. These included conditions such as asthma, croup, eczema, nasal surgery, wheeze management, febrile convulsion. There were also leaflets with advice on going home. Developmental care leaflets were available on the neonatal unit about topics such breast feeding, sensory light, sound and touch, and skin to skin.

There were parent information boards on the children’s wards, outpatient department and the neonatal unit giving details of meal times, infection control, activities and chaplaincy services.

The hospital’s spiritual and pastoral care team provided pastoral support and spiritual care to children, young people and their families. They provided support for all faiths (and none) and maintained close contact with faith leaders in the community. There were chaplains providing a 24-hour emergency on-call service and lay volunteers.
The large play room for the wards was inviting and contained an impressive range of toys and activities. This included a book trolley, a craft table with a host of materials. Experienced play specialists assisted with child-led creative sessions. Dolls were used by the team to act out operating theatre procedures with real equipment ahead of anaesthesia. Staff were very proud that very few children required sedation for procedures.

Play specialists worked closely with the clinical psychologist and provided an outreach service to other areas in the trust. The play specialists were popular with children, parents and staff and they encouraged children to think about the creative activities they could engage with. Play specialists aimed to see every child or young person once.

There were photographs of every stage of the child’s journey of their procedure, preparation colouring books and an assessment tool with emoji faces and numbers were used to ascertain mood. There was also a range of other equipment intended to help distract and absorb children.

A well-equipped sensory room for stimulating or calming children was situated next to the play room.

Other areas with play facilities included paediatric outpatients, an area for siblings of babies on the neonatal unit and the paediatric emergency department.

Children who were well enough and were in hospital for more than five days received schooling from a local education provider. There was a school room adjacent to the outpatient department. Medical staff identified children and young people who met the criteria for educational input. A designated teacher coordinated schoolwork, liaised with the child’s school if appropriate, and attended any specific meetings. Children were taught in the schoolroom, at the bedside or on the ward. School operated during term-time.

There was a service level agreement with a mental health trust for mental health liaison and Mental Health Act management. Arrangements were in place to meet patients’ urgent or emergency mental health care needs, including outside office hours and in an emergency. The systems they followed helped to provide good care to patients in need of additional support.

The service also had appropriate discharge arrangements for children and young people with complex health and social care needs. Staff ensured that the onward care team supported them to plan the discharge of patients with complex health and social care needs.

There had been an increase in admission of medically fit patients requiring Child and Adolescent Mental Health Services (CAMHS) support to the acute wards. The issue had escalated across the Cornish system and staff from the hospital had been involved in the development of a crisis protocol with partners across organisations and agencies.

There was a lack of mental health inpatient beds locally and this had resulted in a longer length of stay in the acute inpatient ward and a higher risk of self-harm and potential harm to other patients, families and staff.

The ward environment had been risk assessed for each patient to determine specific risks. Security staff were available to attend any incidents and support ward staff. Violence and aggression teams were also available to assist with challenging behaviour. Cases had also been escalated to the CAMHS’ managers who often came to the wards to help.

All paediatric inpatients, both planned and emergency were admitted to the paediatric ward, including children admitted for planned surgery. Children’s day case activity also fell under the paediatric team. The patient flow team had hospital-wide oversight of admissions and ensured all children were directed to the unit for admission, including from the emergency department.
Children up to 16 years of age were cared for in acute paediatric areas as inpatients. Young people over 16 could choose to go to a children's area and advice was available through the local procedure for the admission of young people between the ages of 16 and 18 years old. This included standards to ensure young people received care that was integrated and coordinated. In addition, standards stated that all young people should have access to age appropriate services which were responsive to their specific needs as they grew into adulthood.

A framework was available for all healthcare professionals to enable them to deliver a well-planned transitional process for young people with long-term health conditions and complex health needs as they moved from child-centred to adult-orientated services.

The transition policy set out best practice principles to ensure that all young people received a high-quality service that was coordinated, uninterrupted, patient-centred, age and developmentally appropriate.

**Access and flow**

Children and young people of all ages had timely access to initial assessment, diagnosis, care and treatment.

From March 2017 to February 2018 the trust had 7,705 spells.

Emergency spells accounted for 85% (6,561 spells), 11% (858 spells) were day case spells, and the remaining 4% (286 spells) were elective.

From July 2017 to June 2018, neonatal bed occupancy fluctuated. However, it was lower than the England average in nine of the 12 months.

**Neonatal critical care Bed occupancy rates, Royal Cornwall Hospitals NHS Trust.**

![Graph showing neonatal critical care bed occupancy rates from July 2017 to June 2018.](image)

Note: Data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Primary diagnosis groups recorded on emergency admissions for children under one year of age included acute bronchitis, other perinatal conditions, other upper respiratory infections, viral infection, haemolytic jaundice and perinatal jaundice. For children and young people between the ages of one and 17 the diagnosis ranged from viral infection, other upper respiratory infections, abdominal pain, intestinal infection and acute bronchitis.

The paediatric assessment unit was situated in the Polkerris children's ward and provided four side rooms for admission and observation for children and young people who were acutely unwell. Children and young people were assessed and treated in the assessment unit unless otherwise directed by the need for additional infection control measures or a requirement for resuscitation in the emergency department. From the paediatric assessment unit, children might be admitted to the ward for ongoing treatment, discharged home the same day, or remained in the pediatric...
assessment unit for a longer observation period. This was to help the team determine if an admission was required.

Access to Child and Adolescent Mental Health Services (CAMHS) services were managed by the local NHS mental health trust. However, the children’s ward had strong links the CAMHS team. They contacted the ward every morning, seven days a week. They discussed the children and young people currently on the ward who either had mental health and / or social care conditions or issues. The specialist nurse for mental health ensured children and young people with mental health issues were seen by the appropriate professional in a timely way and a plan for either discharge or further assessment was made.

The service was effective for those children and young people who did not require a tier 4 inpatient bed. However, there was a risk that young people admitted with mental health issues would not receive appropriate and timely care and treatment. This was caused by a lack of level 4 tier beds locally and could result in a longer length of stay in an acute inpatient ward and a higher incidence of self-harm and potential harm to other patients, families and staff.

Increasing incidents related to violent and aggressive behaviour from CAMHS patients in paediatrics and increasing lengths of stay had resulted in a meeting between the division and the executive team to take forward this issue and decide as a trust the way forward with partners. CAMHS outreach nurses provided a monthly debrief on the wards to build resilience for staff and to look at new ways of working. Senior staff for paediatrics also attended network and planning meetings to look at service design.

The admission of CAMHS patients on an acute paediatric ward was cited as an extreme risk in the risk register and was regularly reviewed. This was an area that had seen an increase in activity and dependency in the last year and the team were working closely with system partners to improve pathways for this group of children.

A CAMHS unit was being built in Cornwall and expected to be operational in 2019. Until that time CAMHS patients were transferred to inpatient units out of county.

The division was involved in developing an eating disorders pathway to ensure that children and young people received appropriate care in a timely manner and reduced hospital admissions.

The outpatient service offered general paediatric clinics and a range of sub-specialist clinics were offered in conjunction with the visiting tertiary specialists from another NHS trust. Clinics requiring a paediatrician included allergy, urology, gastroenterology, endocrinology, respiratory, cardiac, neurology, diabetes and metabolic.

There had been 7,374 referrals during the period from March 2017 to February 2018.

During the last 12 months there had been an increase in activity through the outpatient clinics and procedures. This was due to increased clinics being held to reduce waiting times and to accommodate more specialist visiting consultants allowing care to be given closer to home.

Clinics were offered in a dedicated paediatric outpatients department and in peripheral hospitals. The children’s outpatient clinics were situated on the floor below the paediatric wards. There was a reception area which served the clinics. It was very busy during the time of our visit with general clinics running alongside visiting tertiary specialists. The receptionist checked children’s details for accuracy and updated and recorded children who did not attend.

We spoke to parents who said they were satisfied with the speed of appointments and waiting times were kept to a minimum, and they were always informed if the clinics were running late.
The team had introduced appointment text reminders for all patients who had consented which had shown an improvement in Was Not Brought (WNB) rates.

During the period July 2017 to June 2018 most referral to treatment times for non-admitted paediatric referrals reached the 92% trust target. All referrals to paediatric respiratory medicine, metabolic disease, neurodisability, cardiology, general paediatrics and community paediatrics were in target. However, areas not reaching the target were those clinics delivered by visiting consultants from another NHS trust. These included paediatric urology, gastroenterology and neurology. The frequency of clinics varied, and the trust were engaging with the other NHS trust to find a better way of delivering the clinics.

Data was also available from the same period showing the number of cancelled clinics within six weeks and over six weeks of the scheduled date. This showed a range of cancellations across the specialty clinics. For those cancelled within six weeks the highest was 23 in general paediatrics.

There had been one breach in July 2018 for a child waiting longer than 52 weeks for an appointment. This was because of the genetic testing results being sent to another hospital. No harm had been identified and the patient had been discharged. Another breach occurred in August because of the infrequency of the clinics for a visiting consultant and the patient choice.

The service continued to work with partner organisations to implement the eating disorders service.

Surgical services for children and young people were provided by the general surgical and trauma consultant led teams. Elective inpatient and day cases were performed on the same theatre lists. Paediatric general surgical interventions were delivered through a dedicated paediatric theatre (theatre 1 of the Tower) and recovered in a dedicated paediatric recovery area also situated within the Tower. Trauma and emergency surgery was performed in dedicated emergency theatres (in Trelawny) and on these occasions screens/curtains were used to segregate children from adults to protect their privacy and dignity. The recovery area had been personalised with child friendly transfers. Second stage recovery for children was on the paediatric ward. There was a dedicated pre-operative assessment clinic which saw all elective surgical cases, and which worked closely with the surgical teams and the play team to ensure children were assessed and admitted appropriately.

Data showed that surgery was rarely cancelled. The team were trying to reduce waiting lists by looking at surgical lists to make sure there was a similar number of children operated on each day.

All children arriving in the emergency department were triaged by a paediatric nurse. Children had temporary open access for 48 hours and could go straight to the ward. This was available for children who had been discharged recently and for children with long-term conditions and complex needs. We observed a couple of children who had returned to the ward under this arrangement who were seen promptly on arrival.

Data showed there were 33 discharge summaries outstanding with the oldest being from June 2018. This equated to 1.49% of total summaries not completed. The backlog of discharge summaries was monitored every day and details were incorporated into morning handover. There was an escalation policy in place where staff were pulled from other duties to clear any backlogs. The clinical director and matron reminded ward and medical staff that patients should not leave the ward without a letter and reminder notices were visible around the wards.

On the neonatal unit there was an outreach nursing service supporting discharge home for babies admitted to the unit. The community therapy team also provided support to the unit during babies’ admissions and in an outreach clinic during the winter supported by the outreach nurses.
There had been an increase in community referrals for children with sensory processing. Temporary reduced staffing levels in occupational therapy had further impacted on the ability to keep the assessment to follow up times down. A review of service and work was ongoing with partners to address the issues and looking at different models of care and inclusion criteria to meet the demand through neuro developmental pathways and training on the ground. To reduce the backlog the team planned to cease accepting referrals for six months from education and had developed training packages for special educational needs co-ordinators (SENCOs) in early years, primary and secondary education.

Current active caseloads for physiotherapy was 457, for occupational therapy was 334 (with 140 waiting follow up) and for dietetics was 172. Therapy direct child activity for 2017 to 2018 showed physiotherapy as 4,491, occupational therapy 2,560, dietetics 1,171 and support staff activity 5,347.

Data from the period from April 2017 to March 2018 showed 462 children had been placed in care in Cornwall. A further 101 children from other counties were placed in care. Health assessments were carried out for 103 children out of county.

**Learning from complaints and concerns**

There were policies and processes in place to appropriately investigate, monitor and evaluate patient’s complaints.

Parents knew how to make a complaint if they needed to and felt they could raise concerns with the clinical staff they met. Most parents told us if any issues arose they would talk to the senior nurse available.

Information about making complaints was available in all the areas we visited. ‘Raising a concern, making a complaint’ leaflets were available on all units and information could be accessed on the trust website with links about how to resolve concerns quickly and how to make a complaint entitled. Complaints could be made in person, by phone, email, or letter.

Receptionists, ward clerks and switchboard had also been issued with internal leaflets to guide them in signposting patients and families to the most appropriate department to deal with their concerns. Additionally, posters were distributed throughout hospital sites advising complainants how they could contact the patient experience team.

Staff were encouraged to try and resolve concerns as they arose. If concerns were raised verbally and resolved to the complainant’s satisfaction by the next working day, the patient experience team did not need to be involved. A new ‘type’ had been created on the electronic reporting system so that staff could record concerns resolved this way in the future; this was being rolled out with staff training.

Staff were aware of complaints and any learning that had resulted. The staff we spoke with were all aware of the complaints system within the trust and the service provided by the hospital’s patient experience team. Staff were able to explain what they would do when concerns were raised by parents. They said they would always try to resolve any concerns as soon as they were raised, but should the family remain unhappy, they would be directed to the clinical manager or the trust complaints’ process.

The patient experience group worked to deliver the patient and family experience strategy and as part of this remit reviewed the processes and handling of complaints, concerns and compliments, and their themes and trends, and received the quarterly and annual reports prior to submission to the quality assurance committee. Examples of learning from complaints were discussed at specialty and divisional level.
From May 2017 to April 2018 there were 15 complaints about children’s services. Data provided by the trust showed complaints took an average of 57.8 working days to investigate and close. This is not in line with the trust’s complaints policy, which stated complaints should be completed within 25 days. Children and young people’s services told us all their complaints were investigated within the trust’s timescales, although no evidence was provided to support this.

The most prevalent types of complaints were those relating to clinical treatment (33.3%) communications (26.7%) and value and behaviours (20%).

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From June 2017 to May 2018 there were 1,378 compliments within children’s services at Royal Cornwall Hospital. The majority of these (944, 68.5%) related to the neonatal unit.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

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**Is the service well-led?**

**Leadership**

The local leadership of the services had the skills, knowledge and integrity to lead the teams.

The clinical managers were an experienced and strong team with a commitment to the children, young people and families who used the service, and to their staff and each other. They were visible and available to staff, and we saw and heard about good support for all members of the team. Staff felt able to openly discuss issues and concerns with senior staff and their managers. They believed they would be listened to, and actions taken when necessary if anything needed to change or be addressed. The senior management team communicated with staff by email and face-to-face.

We received consistently positive feedback from staff who had a high regard and respect for their managers. One member of staff told us their manager “was always out and about… and always able to come up with an answer.” Another described their manager as “very loyal and will bend over backwards to help … they make sure we know everything as a team. … I feel very supported.”

Through the content of governance papers and talking with staff, we saw the leadership of the unit reflected the requirement to deliver safe, effective, caring and responsive and well-led services.

The leadership, both within medical and nursing staff, clearly understood the challenges to delivering good quality care. They could identify areas where the department needed to improve and to make changes when things had gone wrong. They wanted to be defined by what they had done to improve services for children and young people.

Managers encouraged learning and a culture of openness and transparency. They had an awareness that staff required different leadership styles and were flexible in their approach to the needs of their teams.

All staff we met said they felt valued and part of the team and were proud to work in an inclusive team. They said the children and young people’s service was an “enjoyable place to work.” They felt supported by the senior management team, ward managers and their colleagues. One member of staff said, “people make the place … people go beyond to step in to help colleagues.” Another said, “we all pull together, and everyone knows what they’re doing.”

**Vision and strategy**

Trust priorities for 2018 – 2020 were to provide a quality service through a safety culture, strong governance and tackling delays. This would be achieved by providing safe, effective and
compassionate care; attracting and developing excellent staff; providing integrated care as close to home as possible; and by making the best use of resources.

The values were visibly displayed across the children and young people’s service on information boards, meeting rooms, in public spaces and across the corporate documentation including presentation templates. All documentation included the brand ‘One + all | we care’ formed from the trust values.

Nursing staff carried laminated pocket-sized booklets with a summary of the vision for 2018-2020, including local priorities and values.

The business plan for the division was aligned with the trust strategic objectives of partnership, quality, people and resources. The main area was the integration of services as part of the “One Vision” transformation plan for children across Cornwall and the Isles of Scilly.

The Children and Young People Transformation Plan 2017-2020 was developed with partner organisations including commissioners and providers of education services, community and acute health services, early help and social care services, community safety and policing, work, benefits and housing.

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

Culture

The staff we spoke with during the inspection said they were proud to work on the units and were passionate about the care they provided. Managers we spoke with said they were proud of the staff they supervised. They said there was a high level of commitment to providing quality services to the children and young people. One member of staff told us, “I feel supported by my colleagues and a valued member of the team… we are like a family and do the best we can.”

Staff were positive about working for the trust, although there had been times when they felt stretched and under pressure because of the volume of their work.

Staff said the organisation was in a different place since the last inspection in July 2017 with a connection between the executive team and frontline staff. They felt their voice had been heard and changes made.

Managers encouraged learning and a culture of openness and transparency. Staff said they were encouraged to raise concerns and felt comfortable about raising any concerns with their line manager. Staff told us they were not frightened or worried to talk to their managers if something had not gone as planned

Staff were aware of the trust whistleblowing policy and the arrangements for reporting poor practice without fear of reprisal. They felt confident about using this process if required and that concerns would be taken seriously. Staff were also aware they could raise concerns about patient care and safety, or any other anxieties they had with the Freedom to Speak Up Guardian.
The staff teams told us that they were always keen to learn and develop the service. Innovation and improvement was encouraged with a positive approach to achieving best practice.

It was apparent during our inspection that all the staff had the child, young person and their families at the centre of everything they did. They were dedicated to their roles and approached their work with flexibility.

**Governance**

There were improved governance processes and oversight in the division. Staff at all levels were clear about their responsibilities, roles and accountability within the governance framework.

The trust had commissioned an external review of governance, including the systems and processes for continual evaluation and improvement of services. These were being embedded at the time of our inspection. The revised quality governance performance framework covered integrated performance reports, divisional quality performance assurance framework, ward dashboards and ward accreditation.

A framework outlined the structure, accountabilities and processes by which clinical governance was achieved at divisional level. This supported a clear understanding of the quality governance objectives and delivery mechanisms. The clinical director was accountable for the delivery of clinical governance and the reporting arrangements which facilitated this.

The new governance arrangements were still in the process of embedding, however the leadership team felt this was gathering pace and they were seeing positive change.

There was a clear performance management reporting structure with regular meetings looking at operational performance which fed into the executive performance reviews. Performance governance meetings were held each month for acute paediatrics, neonatal and community paediatrics. Minutes from these meetings showed that issues affecting the service were discussed and actions taken. These included a review of incidents reported, risks identified on the risk register and risk management, infection control, safeguarding updates and staffing.

The directorate governance lead had strengthened the link between performance and governance. They worked closely with the central governance team and other directorate leads to manage and monitor themes and processes for incidents and complaints about the service. Processes and documentation were being developed to ensure there was less chance of a single point of failure.

There were plans to further strengthen the team with additional administrative support.

There were monthly paediatric mortality review meetings where lead clinicians gave a brief anonymised presentation on each case with learning points and actions.

The children and young people’s board was now chaired by the chief executive and had a high profile across the trust. The team felt the route to the board was working well.

An extensive set of policies, was readily available on the intranet and was supported by standard operating procedures and processes. This ensured staff were able to work according to best practice guidance.

**Management of risk, issues and performance**

The units understood, recognised and reported their risks. A children and young people’s risk register was in place and we noted that this had been kept up to date. Risks were identified on the risk register with actions required and taken and a review date. Reference was made to known risks, including an extreme risk relating to the lack of appropriate Child and Adolescent Mental Health Services (CAMHS) support for young people admitted with mental health issues and an
open risk relating to the lack of workspace within the paediatric diabetes team and the risk that staff could suffer from musculoskeletal disorders.

Risk management meetings were held monthly with a full review of risks. Risks were shown by specialty and risk level and mitigating controls were recorded. A newsletter was published and circulated to staff every month and contained an update of the risk register with any learning included.

There was a trust major incident plan which outlined the decisions and actions to be taken to respond to and recover from a range of consequences caused by a significant disruptive event. The staff we spoke to were aware of the trust major incident plan and how to access this.

There were local contingency plans for the children’s ward and the neonatal unit if there were significant capacity and staffing issues, and problems with equipment. Appropriate actions were described for staff to follow depending on the status of the situation.

The governance lead also supported the schedule of audits by monitoring evidence of improvement or trends. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results. They also attended directorate meetings and risk management meetings.

**Information management**

Information to deliver effective care was available to relevant staff in a timely and accessible way. There was a range of documentation on the paediatric wards, the outpatient department and the neonatal unit and this was easily accessible. Patient paper notes were prepped for elective admissions and clinics and staff confirmed they were available in good time.

The medical teams said there was good and quick access to test results and diagnostic and screening tests.

There were still compatibility issues with IT systems across the community teams. Staff did not have access to the electronic records system used by another provider of community health care in the county. Staff said it was difficult to coordinate between the two systems and this could hamper delivery of effective care and treatment.

In the latest CQC children’s survey the trust scored 9.28 out of ten for the question ‘Did a member of staff agree a plan for your child’s care with you?’ This was about the same as other trusts in England.

There was telecommunication with patients on the Isles of Scilly although teams felt that there could be a loss of subtlety and intimacy with the child and their family without face-to-face contact.

There was lack of electronic storage for echo images. They were currently stored on a USB encrypted device and the team were working towards a more suitable solution with IT colleagues.

**Engagement**

There were systems to engage with the public to ensure regular feedback on services. This was used for and learning and development.

Parents and young people were encouraged to complete a Friends and Family Test (FFT) form. There were FFT feedback champions across the service and feedback was uploaded to the electronic system for analysis. Patient experience volunteers visited wards to collect feedback through conversations with children and young people which they fed back to the ward manager. They also supported the collection of FFT forms.

Children and young people and their parents could also comment through social media.
An example of how feedback was used in the past 12 months to improve services concerned a suggestion for paediatric x-rays staff to use a doll to show parents what position their child needed to be placed in to have their x-rays. This suggestion was taken on board by the imaging team and dolls called ‘X-ray Buddies’ with jointed limbs had been developed as a result.

From April 2018, the trust used a new survey management system to support the friends and family test and local surveys. This enabled the patient and family experience team to support local surveys and have oversight of all survey activity.

Children, young people and their parents and carers were encouraged to contribute to service development. Various specialist services within paediatrics had support groups and there were parent support groups taking place on the units with information available about other support groups in the area.

The trust participated in the CQC Children and Young People’s Survey 2016. Children and young people were asked to answer questions about different aspects of their care and treatment. Based on their responses a score out of ten for each question was allocated and showed most results about the same as other trusts. Questions were divided into issues relating to safety, effectiveness, caring, responsiveness and well led. The trust performed about the same as most other trusts in England in all categories. Details of the results have been included above in relevant sections of the report.

There was a children and young people’s friends and family questionnaire in which they were asked to rate how much they agreed with the question “I would say this is a good service for my friends and family to be looked after in if they needed similar treatment or care to me.” Options ranged from “I agree a lot” to “I disagree a lot”. Children were also asked to draw a picture of their visit, what was good about their visit, and what could be better. Previous comments were displayed on a notice board.

Notice boards across the units displayed the Patient Association CARE campaign results for August 2018. These related to C: communication with compassion; A: assist with toileting ensuring dignity; R: relieve pain effectively and E: encourage adequate nutrition. All aspects had met or exceeded the targets. Other Information about quality and safety was displayed and included information was displayed about direct care activity of staff members, hand hygiene audit and cleaning audit. All areas had been met and most exceeded.

Patient experience survey results indicated that the service had not responded to the needs of 8 – 11-year olds. The team visited a local school and invited 10 -12 young people to the trust for a “take over day”. Some were service users and others were not. They were invited to help re-design the unit and to comment about what would make it more comfortable for their age group and what was important to them. The answers included having their own duvet and pillow and wanting the doctor to talk to them and not to exclude them from any conversations as it was scarier being left out. They also designed a paediatric bespoke “wonder wall” to capture feedback.

A child had also helped to develop a leaflet about not arriving for appointments and this was in use.

A local school had made a video about the sensory experience of being in hospital and this would be available during the next school term and would be shown on a loop in the outpatient department.

There were four “wonder walls” across the trust which invited patients, relatives, visitors and staff to post comments at the main hospital site.
There were also plans to introduce the "15 Steps Challenge" where parents and children could tell what kind of care was going to be available within 15 steps of walking onto every new ward. This was a simple way of making sure the team listened to the people who used the service. The team felt it was important that children and young people had a say about how care areas could be improved.

Children and young people would be involved in the design for the proposed new build.

There were notice boards around the paediatric wards and the neonatal unit with information displayed about a variety of topics including asthma and breastfeeding and an abundance of leaflets for parents.

On the neonatal unit there were several noticeboards relating to mouthcare, nappy changing, nesting, washing, breastfeeding, sensory light sound and touch, skin to skin.

There were effective systems to engage with staff.

To support the trust improvement programme and the work on communications and engagement, the trust carried out a staff survey in March 2018 to help measure progress. The questions were based on national staff survey questions as well as the specific trust improvement programme.

The results showed an improvement on questions such as recommending the organisation as a place to work and as a place to receive treatment. There was also slight improvement on staff feeling valued and saying that communication with senior leaders was effective.

Actions were in place to address the improvements identified in the NHS staff survey. There was an "Improve Well" which focused on key aspects to generate ideas and quick actions. These included health and wellbeing at work, improving appraisal and ideas for personal development.

There were regular staff meetings and publications for patients, staff, volunteers and members. A "wonder wall" was available in the Trelawney wing where staff could thank colleagues. There were message slips and pens available beside the wall.

Regular meetings and emails provided opportunities for feedback about governance issues such as incidents, complaints and risk assessments. Performance and continuous improvement was also assessed through discussions about essential training, clinical skills and competencies.

Access to ‘talking therapy’ was available for all staff through the trust Employee Assistance Programme. This was a programme based around cognitive behavioural therapy and provided staff with an independent counselling service and advice line.

Staff said they were able to express their opinions and raise concerns through unit and trust-wide forums. Information was provided to staff through regular newsletters sent electronically to staff and displayed on notice boards in ward office areas.

Staff had access to flexible working and leave policies which included, job sharing, part time working, term time working, compressed working and annualised hours.

Leadership development was available through coaching, mentoring and learning sets to work across directorates.

Staff had a good understanding of the core values of the service and were committed to providing integrated care.

Staff annual awards were based on the values and formed the categories for nominations and awards which were celebrated and displayed throughout the trust.

Learning, continuous improvement and innovation
There was a clear focus on looking for potential innovative solutions to continue to ensure the delivery of high quality care for children, young people and their families. Staff and managers felt there was scope and a willingness amongst the team to develop services.

There were several examples of projects and programmes undertaken. The neonatal unit was awarded the prestigious Burdett funding to support work in attaining the Neonatal Baby Friendly Accreditation from UNICEF.

The nursing team continued to be involved in the apprenticeship advanced nurse practitioner role and rotational recruitment between the trust and a neighbouring trust to attract and retain staff. Innovation was supported by two Innovation leads across the trust and staff were supported to progress ideas from cultural change, processes and IT development and development of new products. Ideas were shared at the Innovation Breakfast Club and via trust communications.

The acute and community teams were working closely together to develop shared pathways for the most significantly complex children.

The community team had developed regular lunchtime drop-in sessions for learning opportunities and supervision and was developing multidisciplinary clinics with therapists.

The team were working with partner agencies to develop the single neurodevelopmental pathway, refining the autistic spectrum disorder assessment pathways, reducing the wait for diagnostic assessment, inputting into the newly formed children’s board, working on improved integrated services for children and working with regional colleagues to improve the sexual referral centre (SARC).

Observations were transferred electronically to hand held devices which were always available to all clinical staff and a system alert was generated if scores rose.

**Sexual health**

**Facts and data about this service**

The trust provided sexual health services across Cornwall. The main location was at The Hub located on the site of the Royal Cornwall Hospital Treliske. Services provided from The Hub included genitourinary medicine (GUM), contraception, HIV care and treatment, chlamydia screening, psychosexual services and genital dermatology.

Contraception and genitourinary medicine services were also provided through peripheral clinics which were held in Penzance, St Austell, Falmouth, Newquay, Bodmin, Bude, Launceston, Helston, Camborne/Redruth, Hayle and Liskeard.

From April 2017 to April 2018 the trust reported a total of 7189 patients attending for contraceptive services, with 50% attending The Hub and 50% peripheral clinics. During the same period 11,321 new patients and 4,854 follow up patients attended for genitourinary medicine services. A total of 74% (11,969 patients) sought care and treatment at The Hub and the remainder at peripheral clinics.

Patients were able to book appointments or attend drop in clinics, for which appointments were not required and patients were seen in order of arrival. The exception to this was if patients attended visibly distressed or in pain. A single booking line was in operation for both The Hub and the peripheral clinics, which was answered by reception staff working at The Hub. Services were available across the county six days a week.

During the inspection we visited The Hub and the peripheral clinic held at Newquay.
Is the service safe?

Mandatory training
Staff had access to electronic and face to face mandatory training. Staff we spoke with were positive about the content and delivery of the training.

Reminders were sent to the staff by emails, which were generated through the trust’s electronic system which managed personal HR records. It was the responsibility of individual staff members to book themselves onto mandatory training to ensure they kept up to date.

Mandatory training completion rates
The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for medical/dental and nursing/midwifery staff in sexual health at Royal Cornwall Hospital is shown below:

Mandatory training completion by module – medical and dental staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling - object</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>10</td>
<td>13</td>
<td>76.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for four of the 12 mandatory training modules shown above for medical staff at Royal Cornwall Hospital.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in sexual health at Royal Cornwall Hospital had a completion rate of 85.0% for mandatory training. Medical staff met the target of 95% for four of the 12 modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>13</td>
<td>15</td>
<td>86.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>13</td>
<td>15</td>
<td>86.7%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>13</td>
<td>15</td>
<td>86.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>13</td>
<td>15</td>
<td>86.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Health and Safety (Slips, Trips and Falls) 12 15 80.0% 95% No
Fire Safety 2 years 12 15 80.0% 95% No
Conflict Resolution 11 15 73.3% 95% No
NHS|CSTF|Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year] 0 8 0.0% 95% No

(Source: Updated data provided by the trust)

Mandatory training completion by module – nursing and midwifery staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire safety 2 years</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>7</td>
<td>13</td>
<td>53.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for six of the 11 mandatory training modules shown above for nursing and midwifery staff in sexual health at Royal Cornwall Hospital. Manual handling (people) training had the lowest completion rate with 53.8%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in sexual health at Royal Cornwall Hospital had a completion rate of 94.7% for mandatory training. Qualified nursing staff met the target of 95% for five of the 11 modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>11</td>
<td>12</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>11</td>
<td>12</td>
<td>91.7%</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>11</td>
<td>12</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Safeguarding

The service had robust procedures in place to safeguard adults and children against abuse.

Safeguarding policies and procedures were in place and accessible to staff on the intranet regarding the protection of children and adults. The safeguarding lead for children within the service was part of a working group who were writing the safeguarding children policies and procedures for the south west region. There was a separate policy and procedure outlining the action to take should any child be considered at risk from child sex exploitation (CSE). This was currently being reviewed and developed. The electronic records system used within the service prompted staff to ask relevant questions to identify those at risk of abuse and CSE. The system was being developed to include an alert to inform staff of any child previously considered to be at risk from CSE.

Information was in place to inform staff of the risks to women and children from female genital mutilation (FGM) and the action they must take should they identify or suspect this. The electronic patient record system provided staff with prompts to gain appropriate information from the patient. The policy and procedure was in line with current legislation regarding the reporting of FGM. Staff we spoke with said they had not had to report any cases of FGM within the service.

Staff were aware of their responsibilities and demonstrated a good understanding and knowledge of safeguarding adults and children. The electronic assessment templates completed when patients attended the clinics prompted staff to ask relevant questions, which would alert them to potential risks. Any information relating to a sexual assault resulted in a safeguarding alert being made. Staff we spoke with discussed the action they would take should they have any concerns. This mainly included speaking with a senior member of staff such as the safeguarding children and adults leads within the department. The reception staff provided examples of when they had witnessed incidents in the waiting area, or when taking a telephone call, which caused them concern. These had been reported immediately to senior clinicians within the department.

Any children attending the service who were age 13 or under were automatically considered to be a safeguarding risk and an alert was made. Staff aimed to speak with children who attended the department with a parent or representative alone, as well as with the representative. However, if the child refused, this was accepted. At times a conversation could be held outside of the clinical room when the child was alone with the clinician to ensure they were happy to speak in front of the other person. During our inspection we saw one child had attended the clinic with a representative but refused to have any tests or speak with the clinician alone. This potentially reduced the ability to have a free conversation regarding any sexual activity or concerns. Staff took appropriate action to ensure that safeguarding of the child was taken.

There was a monthly multidisciplinary meeting held within the service which was attended by the relevant staff such as the services’ safeguarding lead, medical and nursing staff and the trusts’ safeguarding lead for children and for adults. External professionals attended from the local mental health trust, the looked after children team and from Social Services. At this meeting the records of children who had attended the service were reviewed and any concerns highlighted and

| Health and Safety (Slips, Trips and Falls) | 11 | 12 | 91.7% | 95% | No |
| Infection Prevention (Level 1)            | 11 | 12 | 91.7% | 95% | No |
| Manual Handling - People                  | 10 | 12 | 83.3% | 95% | No |

(Source: Updated data provided by the trust)
discussed in full. Adults who had attended the service and had been identified as vulnerable, and those where their circumstances had highlighted a potential risk to their children, were also discussed. We attended the monthly meeting in September and observed an integrated team approach to the needs of the patient. Information was shared and discussed between the health care professionals present. This ensured professionals working with the patient and their families were provided with detailed up to date information about their circumstances and the support, care and treatment required.

The online chlamydia testing service was not accessible to children. Face to face contact was arranged with the child to ensure their safety. Staff were aware that on occasions children had tried to log in again using a different date of birth to access the system, but this showed as an alert to staff. Should this happen the screening team discussed their concerns with the safeguarding leads in the department.

There was no system for formal safeguarding supervision for staff involved in safeguarding incidents. However, all staff we spoke with said safeguarding concerns or incidents were discussed and they were supported by the senior nursing staff and consultants. A multi-disciplinary safeguarding meeting was held each month which reviewed all safeguarding concerns. We attended this meeting and saw that staff support featured within the meeting.

**Safeguarding training completion rates**

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for medical/dental and nursing/midwifery staff in sexual health at Royal Cornwall Hospital is shown below:

### Mandatory training completion by module – medical and dental staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>11</td>
<td>12</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for two of the five safeguarding training modules shown above for medical staff in sexual health at Royal Cornwall Hospital. However, all five modules had completion rates over 90%. Safeguarding children (level 3) had the lowest completion rate with 91.7%. It is important to highlight the low numbers of staff in this team impacting the percentage scores. In the three cases where the trust’s target was not met, this related to just one member of staff.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that medical staff in sexual health at Royal Cornwall Hospital met the 95% target for two of the five modules, with a compliance rate of 91.7% overall. Compliance deteriorated for two modules when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Cleanliness, infection control and hygiene

Patients were protected from acquiring a healthcare associated infection through the systems and processes in place in the sexual health service. However, the systems in place did not fully protect the staff when cleaning in the department.

Staff were aware of the policies and procedures available on the intranet relating to the control of infection. Single use equipment was used where possible. For example, speculums for cervical examinations and procedures.
Cleaning records were in place which showed the environment and equipment was regularly cleaned. Staff cleaned equipment following use and attached a sticker which alerted their colleagues that the equipment was ready for use.

Systems were in place for the management and disposal of clinical waste at both The Hub and the peripheral clinics.

Safety measures were in place relating to the control of substances hazardous to health (COSHH) and the service had an identified COSHH lead. The COSHH risk assessments and guidance for use of cleaning materials were being reviewed and developed at the time of our inspection. These were available to staff on the intranet. While staff stated they were aware where to find the assessments and guidance, this could potentially cause a delay if needed urgently.

Staff had access to spillage kits to safely clean and remove bodily fluids. However, not all staff were aware these were available or the importance of using them. We observed one member of staff cleaning a spillage of urine with disinfectant wipes. The staff member told us that should a large spillage occur they would request the service of the hospital deep cleaning team.

The ‘dirty’ utility room was used for carrying out tests on patient urine. There were hatches which opened directly into the utility room from the patient toilet. This meant that urine did not have to be carried throughout the department. There was no sink for disposing of the urine in the dirty utility room and the practice was for the urine to be returned through the hatch and dispose of in the toilet. However, one member of staff told us this would be emptied into the hand washing sink in the utility room. Other staff did not agree with this practice.

Staff had access to protective personal equipment such as disposable gloves and aprons which we saw in use during our inspection. There were handwashing facilities located throughout the clinics and in non-patient areas together with alcohol hand gel. We observed staff worked bare below the elbows and regularly washed their hands.

**Environment and equipment**

The environment, maintenance and use of facilities and premises kept patients who visited the service safe.

The Hub provided patients with a light airy environment with sufficient waiting and clinical treatment areas. Staff had access to rest rooms and office space. We visited the periphery clinic held at Newquay hospital and while small, the clinic area provided sufficient waiting and clinical areas for the number of patients attending. Rooms were available to staff and patients to have confidential conversations. The nursing station was separate to the waiting area with doors that could be closed for privacy. For example, when making telephone calls, carrying out the daily safety brief or discussing individual patients.

Single use equipment was ordered weekly and stored at the Hub. The system in place required staff to order required stock once a week. There was no facility for accessing further stock during the week. Staff told us that if equipment was required urgently they had to borrow from other wards or departments in the hospital, who had a more regular equipment delivery and the facility to have ad hoc requests met. This did not impact on patient care but meant staff had to spend additional time sourcing equipment from other areas.

Single use equipment had a use by date and the health care assistants regularly checked these dates to ensure the equipment was safe to use. When new stock arrived, stock rotation was carried out to ensure the equipment with the shortest use by date was used first.
Equipment was available within clinic rooms for staff to monitor and assess patients. For example, blood pressure recording machines and weighing scales. These were serviced and/or calibrated regularly. An incident report had been generated when equipment was not made available to staff within a peripheral clinic. This had been addressed and no further issues raised.

Consulting rooms were lockable from the inside and curtains were in place around the examination couch to ensure patients privacy during intimate examinations.

An emergency resuscitation trolley was located in the nurse’s station and accessible to all staff. This contained equipment and medicines to respond promptly should a patient collapse while in the department. Daily and weekly checks were carried out to ensure the trolley was ready to use.

**Assessing and responding to patient risk**

Risks to patients were assessed and their safety monitored and managed so that patients and staff were safe.

Risk assessments were carried out using proformas on the electronic patient records system when patients attended clinics. This ensured staff asked appropriate questions to identify risks to patients and their care and treatment. Standard proformas were followed to ensure safety when prescribing contraception. For example, when dispensing contraception medicines appropriate physical observations such as weight, body mass index and blood pressure was reviewed. This was in line with the Faculty of Reproductive Health (FRH) guidelines. Staff were prompted to check that patients who attended the HIV clinic had an annual cytology screening carried out.

Patient records alerted staff to known allergies and other risk factors for patients who had attended the clinic previously. For patients who were attending for the first time, relevant information was gathered and highlighted on their electronic records.

Patients who attended the clinic for HIV care and treatment were encouraged to attend their GP service for a flu vaccine or smear test if required. However, if patients were reluctant or unable to do this the staff would arrange for this to be carried out at the clinic. This was to keep patients safe from the risk of not having this test or treatment.

Test results, such as blood and urine, were checked and a notes monitoring audit carried out to ensure positive results were relayed to the patient so that treatment could be commenced. To reduce the risk of incorrect labelling two members of staff checked the patient details and samples prior to sending the specimen to the laboratory.

Staff discussed partner notification with patients. When required the service contacted previous known partners of patients with a sexually transmitted illness. The service was in the process of reviewing and developing the relevant policy and procedure with reference to the British Association for Sexual Health and HIV (BASHH) guidelines. Partner notification is an essential intervention for the control of sexually transmitted infections and helps to ensure that affected people get appropriate treatment and reduce the spread of infection. Contact tracing to locate potentially affected partners was carried out confidentially to protect the patient’s details. Staff told us of recent liaison with clinicians in another area to trace a contact of one of their patients, who had been diagnosed with a sexually transmitted disease.

Staff were alerted through the electronic patient record system of known patients who had previously been violent or aggressive. This enabled arrangements to be made with the trust security staff prior to a booked appointment. Staff told us that the security staff were very responsive should an incident occur in the walk in or booked appointment clinics.
Panic alarms were in place in the reception area and consulting rooms at The Hub and staff had attended a drill to ensure the response procedure would take place in an emergency. Staff spoke with were aware of the action they would take in the event of the alarm sounding. The alarms at The Hub were tested monthly. However, there had been a gap as no testing had taken place in August 2018.

There were panic alarms in the peripheral clinic in Newquay within clinic rooms. If pulled the reception staff had a visual warning and would follow the recognised process to respond. There was no alarm in the reception area, but the staff were separated from patients by a window which could be shut in an emergency. Staff reported that should an incident occur with a violent or aggressive patient the local police would be called. In previous experience this had worked well, and the police responded promptly.

### Nursing and midwifery staffing

The staffing levels and skill mix of staff was planned and reviewed so that patients received safe care and treatment in the clinics. The service planned to recruit staff who were able to provide patients with an integrated service meaning they were trained and competent to provide genitourinary and contraceptive care and treatment.

A daily briefing took place at the Hub each morning. At the briefing staffing levels for the day were reviewed to ensure there were sufficient staff to run the planned clinics and those in peripheral locations. The briefing also highlighted to staff incidents and updates.

### Planned vs actual

No planned versus actual staffing data was provided by the trust for nursing staff in sexual health.  
*(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

Staffing levels and vacancies were discussed at a monthly meeting with the finance department. We were told that when vacancies arose they were initially back filled with part time staff increasing their hours. This also occurred when there was long term sickness in the department.

### Vacancy rates

From May 2017 to April 2018, Royal Cornwall Hospital reported a vacancy rate of 15.9% for nursing staff in sexual health, compared to the trust target of 10% at March 2018 and 6% at March 2019. Since this data was collected several vacancies had been filled.  
*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

At the time of our inspection there were several nursing staff vacancies. There were two band six vacancies, one of which was within the chlamydia screening service. A part time band five nurse and administration vacancy were being advertised. Part time hours were available for two further posts at band two and three.

### Turnover rates

From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 10.6% among nursing staff in sexual health, compared to the trust level target range of 10-14%.  
*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

### Sickness rates

From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 2.3% for nursing staff in sexual health, compared to the trust target of 3.8%.  
*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*
Bank and agency staff usage

From May 2017 to April 2018, the trust did not report any nursing shifts within sexual health that were covered by bank or agency staff or left unfilled.

(Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)

Medical staffing

Planned vs actual

No planned versus actual staffing data was provided by the trust for medical staff in sexual health.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

At the time of the inspection we were told there were no medical vacancies.

From May 2017 to April 2018, Royal Cornwall Hospital reported a vacancy rate of 3.0% for medical staff in sexual health, compared to the trust target of 10% at March 2018 and 6% at March 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 8.8% among medical staff in sexual health, compared to the trust target range of 10-14%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 0.7% for medical staff in sexual health, compared to the trust target of 3.8%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From May 2017 to April 2018, the trust did not report any medical staff shifts that were covered by locum staff or left unfilled.

The trust stated in their RPIR that they do not keep information regarding bank shifts filled centrally and so did not have the information available. Because of this information request, the need to collate this was highlighted.

(Source: Routine Provider Information Request (RPIR) – Bank Agency Locum)

Quality of records

Information maintained in patient records was not always an accurate reflection of the conversations, advice and treatment provided.

We reviewed ten electronic patient records. We found the recorded information was not always clear. For example, one set of notes referred to advice given about discussions the patient would have with future employers. This gave the impression that the patient would have to advise employers of their HIV status. However, staff were clear in their understanding of patients not having to legally inform employers, and the discussion had been in the context of this not being necessary.

The records were brief and consisted of completed proformas. This did not evidence that staff recorded all the conversation held with the patient. We saw one set of records where the patient
had received advice and support regarding their diagnosis, but this was not evidenced. Where a child had attended the clinic, the record did not include their refusal to speak with the clinician alone or the medical history provided by the referring clinician.

Two records we reviewed evidenced that the service had consulted specialists in other parts of the country for specialist advice and discussion. Another patient record clearly provided detail on the reason the patient was visited in another part of the hospital, as opposed to attending the clinic. This provided a clear record for staff who could be asked to visit the patient in the future.

Paper records were securely stored in locked cupboards or filing cabinets. Electronic records were protected from unauthorised access using a system that was accessible to sexual health staff only. The computer systems were password protected and all staff had individual log in passwords. We observed staff signed off when leaving computers to ensure patient confidentiality was not breached.

**Medicines**

Medicines were stored, administered and dispensed safely.

Staff had access to medicine policies and procedures to ensure correct procedures were followed when providing care and treatment to patients.

The HIV service had the support of a pharmacist who attended each clinic to provide advice and ensure patient understanding of their often complex medicine regimes. Pharmacy staff attended The Hub to check stock levels and arrange for replenishment of the medicines held in the department. Additional medicines could be ordered when needed, using a requisition pad that was submitted to the pharmacy department. Staff stated these requests were addressed promptly. We saw clear records which provided an audit trail of medicines that came into and left the department. Pharmacy staff returned medicines to the pharmacy for disposal, for example when the expiry date had passed. Medicines arriving from and being returned to pharmacy were transported in sealed tamper evident bags. The health care assistants checked off the stock list to provide an audit of medicines that had been received.

Staff dispatched medicines to the peripheral clinics to ensure an adequate stock was held for the running of clinics. An audit trail showed which staff had prepared these medicines. Records were held which identified the stock check at the peripheral clinic, the medicines used and those received from The Hub. The medicines were transported in a sealed tamper evidence medicines bag. Medicines which required cold storage, such as vaccines, were transported in a cold storage box which kept medicines at the correct temperature for nine hours. This ensured the medicine was safe to use and was returned to the fridge in The Hub if not needed at the end of the peripheral clinic.

Medicines were stored securely in locked cupboards within locked rooms. This ensured that only authorised staff could access them. Pharmacy staff carried out spot checks to ensure medicines were always stored securely. Medicines which required cool storage were stored in fridges which were for this purpose only. The fridge temperatures were recorded and overseen remotely within the pharmacy department. The medicine storage room temperature at The Hub was monitored as there had been concerns that the temperature of the room could adversely affect the medicines.

An incident had been reported regarding a short expiry date on contraceptive medicines. This had impacted on the patient as they were unable to be given a 12-month supply of their contraceptive but had to return after three months for a further appointment. Following this, action had been taken by pharmacy to ensure short expiry date medicines were not supplied to the service. There had been another incident reported when the wrong medicine had been dispensed to a patient.
This was identified prior to the patient leaving the department so was classed as a near miss incident. Staff were advised of action to take to reduce the risk of this reoccurring.

Medicines were prescribed for patients by the medical staff and administered or dispensed by nursing staff following Patient Group Directions (PGD). PGDs allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. The PGDs were written by the consultants for use within the clinics.

Medical gases were secured appropriately within the department. For example, oxygen cylinders were chained to the wall and the liquid nitrogen used for cryotherapy was secured in an external building. Cryotherapy is a form of treatment that uses extreme cold for therapeutic effect. There were procedures in place for the safe use of the liquid nitrogen which included the restocking of the cylinders and transportation. We saw staff complied with the safety measures detailed in the policy and procedure.

Information sheets were available for staff in clinic rooms to prompt them regarding treatment for certain conditions. For example, there was information relating to the risks when using certain products and treatment algorithms for treatments such as genital warts in men and women.

**Incident reporting, learning and improvement**

The service ensured action was taken and learning taken when things went wrong.

The service used the trust electronic reporting system to report and monitor incidents. Staff were provided with information on what constituted an incident and when to report these. Staff we spoke with said they were encouraged to report incidents and were confident on how to do this.

Reported incidents were investigated and action taken to reduce the risk of the incident reoccurring. For example, a confidentiality breach had been reported by a patient. The service had reported this as an incident which was subsequently investigated. Appropriate action had been taken to address the issue. An immediate email was sent to all staff reminding them of the importance of confidentiality. The information governance lead for the trust had been informed of the incident. Although the investigation had not been able to identify how the breach had occurred, the investigation had resulted in information and reminders for staff of the importance of patient confidentiality.

There had been several needle stick injuries within the department and as a result, the make of syringes had been changed. This had seen a reduction in the injuries.

Feedback from reported incidents was discussed in the daily briefing and at staff meetings. Any associated learning was cascaded to staff at these times and in emails to all staff.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported one serious incident that was classified as a never event for sexual health. This was classified as wrong implant/prosthesis.

*Source: Strategic Executive Information System (STEIS)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in sexual health which met the reporting criteria set by NHS England from June 2017 to May 2018, which was a never event.
The serious incident was categorised as a surgical/invasive procedure incident meeting SI criteria.  
(Source: Strategic Executive Information System (STEIS))

Action had been taken to address the risk of the serious incident reoccurring. The service had implemented a check list that was completed prior to the fitting of intrauterine devices and systems and a further check was now made following the fitting.

**Duty of Candour**

Staff we spoke with were aware of the Duty of Candour legislation which was introduced in November 2014. The legislation requires that as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person that the incident has occurred and provide reasonable support in relation to the incident and offer an apology. We saw that the service provided an explanation and support to patients when incidents had taken place together with feedback on the action taken.

**Is the service effective?**

**Evidence-based care and treatment**

The service carried out internal and external audits to ensure the care and treatment was in line with recognised legislation and best practice.

Staff were knowledgeable and followed nationally recognised guidelines and best practice recommendations provided by the British HIV Association (BHIVA), the British Association of Sexual Health and HIV (BASHH), the Faculty of Sexual and Reproductive healthcare (FSRH), National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG). During the inspection we observed staff complied with these guidelines. For example, BHIVA guidelines were followed when reviewing stable patients with HIV every four to six months and the provision of annual screening for all HIV patients.

Policies and procedures referenced national guidelines. Staff were updated regarding changes in practice and guidelines by email from a staff member who had responsibility for cascading information from external websites regarding changes. There had been a recent change in antibiotic treatment for patients with gonorrhoea. Staff had been advised of the changes at meetings and through email correspondence.

**Nutrition and hydration**

Patients had access to water within waiting areas.

**Pain relief (only include if specific evidence)**

Guidance was given to patients attending the clinic for an intrauterine device or system to be fitted. They were recommended to take pain relief prior to attending the clinic and ensure they had sufficient pain relief for following the procedure. The service did not provide this to patients.

**Patient outcomes**

The service collected data for Public Health England for a project which was reviewing patients who had recently acquired HIV and was participating in national audits regarding patients who had contracted gonorrhoea and chlamydia.

An internal audit had taken place regarding the treatment of patients with gonorrhoea. An action plan had been put into place and following the re-audit it had been found outcomes had improved for patients regarding their care and treatment and partner notification numbers were higher.
Staff ensured that appropriate care and treatment was provided to all patients. Patients with complex care and treatment needs were discussed at monthly meetings attended by clinicians. This provided the opportunity for the patient’s treatment plans to be discussed and agreed. When necessary specialist support and the views of other clinicians sought to ensure best practice was delivered to the patient. For example, discussions at the regional HIV group.

Patients attending the HIV clinic were provided with information regarding their medicine regime and adherence checks were carried out. This ensured the patient was taking their medicine as prescribed, and if they were not to provide support to ensure the treatment had an effective outcome.

There was no unmet demand for sexual health services. If patients attended a drop-in clinic that was full an alternative date and time was provided for the patient to attend.

Data included in the sexual and reproductive health profiles produced by Public Health England, showed the service provided double the national average of long-acting reversible contraceptives (LARC). These are methods of birth control that provide effective contraception for an extended period without requiring user action. They include injections, intrauterine devices (IUDs) and subdermal contraceptive implants.

**Competent staff**

Staff were trained and supported to carry out their roles.

All staff were provided with a period of induction training when starting work in the service. This included the support from an experienced member of staff whilst completing competencies relevant to their role. The programme of induction was recorded in a handbook for reference which also provided evidence of when competencies were complete. Training was provided within the service and from the trust. One member of staff we spoke with confirmed that existing staff cascaded information and knowledge to support their learning and they also completed online training and attended training at the Knowledge Spa, for example, venepuncture.

New staff were supernumerary for an initial period until competent and confident to be part of the staff rota. Staff we spoke with said they had been well supported during their induction period.

All staff were provided with job descriptions and a staff handbook which outlined their role and responsibilities and provided information relating to local and organisational policies and procedures and other relevant information.

Staff participated in the STI Foundation education programme which is a sexual health training and assessment programme for nursing and non-specialist medical staff, from basic to advanced practice. The course was developed by the British Association for Sexual health and HIV (BASHH)

The nursing staff were not trained to insert intrauterine devices or systems which meant that patients were required to attend consultant led clinics for these procedures. Not all nurses were trained and competent to provide both a contraceptive and genitourinary service which meant patients who required both services had to either see two clinicians within the same clinic or attend two clinics which could be on different days.

A monthly education meeting took place which was accessible to all staff in the department. This provided information on updates and changes to practice as well as having guest speakers. The planned agenda for the September meeting included new information on the upcoming HPV vaccination programme and an external speaker regarding the online safety and protection of young people and children.

**Appraisal rates**
Up to August 2018, 92% of staff in sexual health at Royal Cornwall Hospital had received an appraisal, compared to a trust target of 95%. This included 80% of medical staff, and 100% of nursing staff. Appraisals give the member of staff and their line manager an opportunity to discuss past performance and the future and set goals for employee performance, development and support.

A split by staff group can be seen in the tables below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals received</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>22</td>
<td>23</td>
<td>95.7%</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>12</td>
<td>15</td>
<td>80.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>46</strong></td>
<td><strong>50</strong></td>
<td><strong>92.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

**Multidisciplinary working and coordinated care pathways**

Staff worked well within and across the trust and with external organisations to deliver effective care and treatment.

A single booking telephone line was available to patients who were guided regarding which clinic or service they required by the reception staff.

The chlamydia screening service for Cornwall was operated from The Hub and worked with other services within the trust. For example, the microbiology and haematology departments.

The HIV service team worked closely with external health providers, both regionally and nationally and within the voluntary sector. For example, the care and treatment of one patient was discussed at a national radiology multidisciplinary team meeting. This provided the service with a wider group of clinicians to offer opinions and practice.

A multidisciplinary team meeting regarding the HIV patients took place during our inspection. The meeting was attended by two consultants, two registered nurses, two junior doctors and the pharmacist for the service. Clinical cases were discussed using power point presentations led by the consultant. The discussions considered social and emotional aspects affecting patients as well as the medical care and treatment. We observed there was limited involvement from the team and the main discussions were led by the consultants. However, the meeting evidenced that the service knew the patients and their circumstances well and considered holistic aspects of care and treatment.

Further support, discussion and learning took place at the South West regional HIV meetings which were held twice a year. All new patients who had received a late diagnosis were discussed and antiretroviral therapy (ART) regimens reviewed. All deaths of patients with HIV across the region were also reviewed.

The monthly safeguarding meeting evidenced excellent proactive and reactive multidisciplinary working between health professionals within, and external to, the trust. A clear process was in place to refer patients to other appropriate professionals and clinicians to provide a seamless care pathway.

A charitable organisation was based in the HIV clinic and was available to all HIV positive patients and the staff to provide support. The organisation reported positive working relationships with staff which benefitted the care of the patients.
Care pathways were in place for women attending the clinics who were pregnant. Should a woman wish to terminate the pregnancy, staff were able to refer them to the termination of pregnancy (TOP) clinic which was held in the department for initial assessment. The TOP service also referred patients to the clinic for ongoing contraception requirements when necessary.

**Health promotion**

Patients were supported to live healthier lives and provided with relevant and up to date information.

Patients attending services were provided with information on a variety of contraception methods and advised regarding safe sexual practices. This included the contraception, genitourinary and HIV clinics.

Children and young people who reported using drugs and alcohol were provided with advice and signposted to relevant support and partner organisations. Adults who spoke of drug or alcohol use, either for themselves or partners, were provided with information and support on addressing these issues.

At the contraception clinics, weight management and stopping smoking advice was provided and information on organisations who would also be able to support the patient.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The service ensured consent to care and treatment was always sought in line with legislation and guidance.

Verbal consent was obtained from patients prior to care and treatment when attending a clinic and in consultation with health professionals.

Patients requesting the fitting of an intrauterine device or system attended were pre-assessed and provided with verbal and written information regarding the procedure. Written consent was obtained from the patient prior to the fitting of the device or system.

The written consent form also prompted the use of an interpreter where necessary. The interpreter was required to sign the consent form to state the patient whose first language was not English, had access to appropriate information to make an informed choice regarding the procedure.

Staff we spoke with were aware of Gillick competence. This is used in medical law to establish whether a child (16 years or younger) can consent to his or her medical treatment without the need for parental permission or knowledge. We saw written evidence within patient records where children had been assessed as having Gillick competency and where they had not. This demonstrated each child was assessed on an individual and appropriate basis.

However, it was not evident there was a clear process for staff to speak with children under the age of 16 alone if they attended with their parent(s) or another person. All staff we spoke with said they would ask the child if they were happy to speak in front of the other person and if the answer was yes, they would be able to remain in the room. The staff added they would take the opportunity to speak to the young person alone when showing them to another area for tests. However, this opportunity was not available when children refused any screening tests.

Fraser guidelines refer to the provision of contraceptive advice and treatment for children and young people without their parents’ consent. Staff were knowledgeable about the guidelines and proceeded care and support to children and young people appropriately.

**Mental Capacity Act and Deprivation of Liberty training completion**
The trust reported that from May 2017 to April 2018, Mental Capacity Act (MCA) level 1 training was completed by all staff groups within sexual health at Royal Cornwall Hospital. The service did not report any deprivation of liberty safeguards.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level 1 training had been completed by all staff within sexual health at Royal Cornwall Hospital.

(Source: Updated data provided by the trust)

Is the service caring?

Compassionate care

Patients received a caring, compassionate and empathetic service. Staff treated patients with respect and promoted their dignity when attending the service. The reception staff welcomed patients in a warm and professional manner. Systems were in place to protect patient confidentiality when they reported to the reception desk. The patient was asked to complete a booking in form on which was recorded their full name and relevant details. A list of clinics and reasons for attending those clinics was shown to the patient so that they could point to the clinic they required. This process meant they did not have to vocalise personal information that others could potentially hear.

The waiting room was located outside of the clinical areas. Seating was separated into smaller groups to avoid patients sitting around the outside the room and there was a radio playing to distract from the discussions which took place at the reception desk. The HIV service had a separate waiting room and access should patients wish to use this. Other services used the clinical facilities in the basement (when the HIV service was not in operation) and meeting rooms on the second floor. There was a separate back access which was used at these times to ensure the privacy and confidentiality of patients using the waiting area for the sexual health services. These measures promoted the privacy and confidentiality of patients attending for these services.

Clinicians called their next patient into the treatment area by asking for them by their first name only. The full details of the patient were checked once in the consulting room to ensure they were the right person.

Patients we spoke with provided consistently highly positive comments. We were told: “I was very nervous at my first visit, but the staff reassured me fully”, “a very friendly, welcoming and professional service”, “the staff were kind and put me at ease”, “this is the best NHS service used and I’ve been to many. The staff are effective and responsive”, “I never feel judged for my choices” and “I was treated with respect”.

A patient attending the HIV clinic said, “the staff have lots of empathy, they don’t make me feel judged and I can tell them anything”.

Another patient said they had accompanied young people as part of their work many times over the years and added “the treatment given to them has always been respectful, understanding and consistently friendly”

Emotional support

Patients were provided with or signposted to appropriate emotional support.

Health advisors were on duty in each clinic. The health advisor role was carried out by a registered nurse who was able to provide additional support to patients following their appointment with
another clinician. This support included discussing any anxieties or concerns with their care and treatment programme.

Negative results were provided to the patient by text if they had agreed to this method of communication. Patients whose results were positive were asked to contact the advice line or attend a clinic. This ensured they were provided with support at the time of receiving the results. Patients were able to ring the clinic and speak with a clinician should they need to do so.

Referrals were made to external organisation for patients who required additional emotional support. There were pathways in place to arrange counselling or access to mental health services.

**Understanding and involvement of patients and those close to them**

Patients were able to make informed choices regarding their care and treatment. We saw patients attended the clinic alone or with a representative of their choice. Staff spoke with patients and their representatives if the patient consented to this.

Patients were able to email a specific HIV service email address for non-urgent queries. Staff then either emailed the patient or telephoned them to provide support and information regarding their care and treatment.

Following attendance at the genitourinary clinics, an information sheet was provided to the patient on how to obtain their results. The information was discussed by the staff with the patient at the appointment to ensure their understanding of the process. Additional information was on the sheet regarding specific sexually transmitted infections they may have been tested for, which were also discussed at the appointment. Patients confirmed this had been useful to them and given them the opportunity to ask questions regarding their care and treatment. One patient stated, “I was encouraged and able to ask questions, the nurse was very attentive and listened to me”.

Patients reported they had sufficient time during their appointment to ask questions and discuss any concerns. We saw one patient spent one hour with a consultant and then further time with the pharmacist to discuss their complex medicine regime.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

Services were planned and delivered to meet the needs of patients in various locations and at differing times.

The Hub was open from 9am to 5pm five days a week. Twice a week there were also evening appointments and a clinic was held on alternate Saturday mornings. Clinics in peripheral locations were held on varying days of the week and covered morning, afternoon and evening appointments. Patients were able to choose the clinic they wished to attend and could either ring the booking line or access on line services to book their appointment. The drop-in clinics were advertised as such, so that patients knew at what time they needed to arrive to be seen.

Drop in clinics were often busy but auditing showed very few patients left without being seen. Patients who required emergency contraception, or were in pain or distressed, were always seen. The receptionists liaised with clinicians if patients attended after the end of the advertised clinic time.

There was no formal system to refer patients to another clinic once a certain number had booked in. Patients were informed of the waiting time, and at times were recommended to book another appointment or attend a different drop in clinic if the wait was going to be extensive. One patient we spoke with said they had attended their first drop in clinic 10 minutes prior to the end of the
clinic. They were advised there would be a wait to be seen by reception staff. They chose to remain at the clinic and had waited for one hour but were satisfied with this and the information they were provided with.

The service aimed to be an integrated service so that patients could access contraception and sexual health services in one visit. However, out of the twelve nurses only five were trained in both contraception and sexual health. This meant that at times patients would need to return to another clinic to have the care and treatment they required. The clinic in Bude had services provided by a dual trained doctor to ensure patients did not have to return. The Newquay clinics were often busy and provided services from an associate specialist, nurse and health advisor to mitigate patients needing to return later.

The trust’s termination of pregnancy (TOP) service was provided by another speciality within the directorate. Staff worked closely together to ensure patients attending who required contraceptive services could attend a clinic while at their appointment.

Patients were encouraged to attend their GP practice for smear tests and vaccinations. However, regular patients who attended The Hub for HIV services, and who could not or did not want to see their GP, were provided with these services.

The public funding for sexual health services has been reduced nationally by 18-20%. However, the funding for Cornwall services, of which the trust is the main provider, may be reduced by 35%. Staff were concerned that while they currently provided clinics within 13 locations in rural areas, the service specification for 6, developed to meet the reduced budget, meant considerable impact on patients being able to attend.

At the time of our inspection the trust was in the process of reviewing the service in line with a tendering process which had been announced. A reconfiguration of services would be required to provide the service at the reduced funding.

Meeting the needs of people in vulnerable circumstances

The service provided a personalised care service that took in to account the needs and choices of different people.

Work had been ongoing to encourage other directorates to offer sexually transmitted infection (STI) testing. For example, the gynaecology, urology and paediatric wards. During our inspection we observed discussion and liaison with the paediatric ward regarding a patient who had been admitted to the ward. This resulted in the consultant meeting with the patient and providing advice.

The staff had access to translation and interpretation services. However, we heard that there had been difficulties accessing a Thai speaking translation service. Staff considered using a family member to assist with obtaining a medical history from the patient. Following discussion at a multidisciplinary meeting it was decided this would not be appropriate and further attempts would be made to access appropriate services. This was because using family members did not ensure the patients privacy and dignity, and their consent could not be assured if their first language was not English.

The service supported patients to notify previous known partners when they had tested positive with a sexually transmitted illness. Partner notification was carried out confidentially by clinic staff if the patient was unable to do this themselves.

Young people and children who did not attend for an appointment were always contacted and followed up to ensure their safety. If necessary safeguarding referrals were made to ensure the patient had access to support services. Adults who did not attend for appointments were sent a
text to remind them of the missed appointment and to encourage them to book a further appointment when clinically indicated.

Any patient who attended the service following a sexual assault was referred to the local sexual assault centre. A Sexual Assault Referral Centre (SARC) provides services to victims/survivors of rape or sexual assault regardless of whether the survivor/victim chooses to report the offence to the police or not. The staff maintained good working relationships with the centre. When receiving a referral for a patient form the centre, staff ensured they were given a prompt appointment with sufficient time to discuss their situation.

Patients who were identified as being at risk or experiencing domestic violence were provided with support to access appropriate services. The staff signposted patients to external services if they required assistance with drug and alcohol issues. If the patient refused to access these services, this did not negate the support provided at The Hub or peripheral clinics.

Patients who were homeless were provided access to genitourinary and contraceptive services at a weekly clinic located in an external organisations homeless and social exclusion centre.

A social worker worked within the service as a volunteer and was able to support patients with housing and social issues.

Staff had access to the learning disability support service within the trust. On occasions when a patient living with a learning disability had booked an appointment at a clinic, the specialist team were able to provide support to the patient. This helped the patient to share information and feel comfortable as they often had met the team previously.

The environment and facilities were suitable to ensure access for people with a disability. The main entrance to The Hub was on the ground level with automatic opening doors and a lift to the first and lower ground floors. Toilets were accessible with a pull cord to summons assistance if required.

Access to the right care at the right time

Patients were able to access care and treatment in a timely way.

Referrals were made by patients themselves as well as those from external clinicians such as a GP, the emergency department or gynaecology services.

A single booking line system was in operation. Patients and external clinicians were given advice and information regarding the next available appointment, or walk in clinic, in a location of their choice. Patients also had the choice to book their appointment on line. We spoke with patients who commented that this had worked well for them.

Text messages were sent to patients to remind them of their booked appointment. Staff reported that this had reduced the number of patients who did not attend for their appointment.

The guidelines published by the British HIV Association (BHIVA) were followed and newly diagnosed patients were seen by a consultant within one week of their diagnosis or GP appointment. Patients with care and treatment plans which were stable, which made up 85% of the services’ cohort of HIV patients, were seen every four to six months.

The free on-line chlamydia screening service was managed through The Hub. Patients were able to request chlamydia tests and telephone the service to obtain their results and receive treatment if required.
The HIV clinic enabled patients to attend the clinic for one appointment where their care and treatment needs were met. This meant they had relevant blood tests carried out and saw the consultant and pharmacist on one day, without the need for multiple appointments.

One of the consultants specialised in genital dermatology. Patients who had attended clinics for other reasons were provided with an appointment for this service when necessary. This negated waiting for a referral to other departments within the trust.

Patient feedback was positive regarding their access to the service. For example, we were told; “not a long wait to my appointment”, “the booking line was answered quickly, and helpful staff provided detail on appointments and where was best for me to attend” and “I was provided with a follow up appointment before I left the clinic.”

**Learning from complaints and concerns**

Patients complaints and concerns were listened and responded to. However, patients were not provided with full information on how to make a complaint.

Patients had access to information about the service offered and how to access clinics. At the genitourinary clinics, an information leaflet about accessing test results was given to patients. The leaflet also advised patients that if they were not happy with the care provided to speak to reception staff. Patients we spoke with said they would not necessarily do this at the time, as reception was in the waiting room. Two patients said if they had a complaint they would probably ring the service later. There were no formal complaints leaflets for patient’s which explained the action they could take and timescales in which they would receive a response.

Staff told us that while there had been no formal complaints made to or about the service, concerns raised by patients had been regarding waiting times in walk in clinics. To mitigate against this, patients were consistently kept informed of approximate waiting times on arrival and during their wait. Reception staff also offered to make appointments for patients at booked clinics if the waiting time was lengthy.

**Summary of complaints**

From May 2017 to April 2018 there were no formal complaints about sexual health at Royal Cornwall Hospital.

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

**Number of compliments made to the trust**

From June 2017 to May 2018 there were no compliments within sexual health at Royal Cornwall Hospital.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

**Is the service well-led?**

**Leadership**

The leadership and management of the service ensured high quality care and treatment was delivered. The senior nurse manager was provided with dedicated management hours.

Staff were positive about the local leadership of the sexual health service. They all knew who their line managers were and the management structure within the department. Staff said they were able to approach the managers with any queries or concerns. The clinical matron for the service visited the department regularly and staff were all aware of her role.
Senior staff were aware of the management arrangements within the division and were familiar with the organisational structure within the division of women, children and sexual health services. The associate director had been in post for approximately one year and, together with the associate director of nursing and the divisional governance lead, offered support to the sexual health management team. However, not all staff were aware of who these senior managers were within the division in which they worked.

Several staff knew who the recently appointed chief executive was but had not met them or other trust board members.

Training was available to management staff within the trust. For example, we saw notices advertising coaching and mentoring study days and culture and leadership focus groups. A manager’s passport was also in place for band six and band seven staff, which provided information and training including finance, sickness and other management issues.

A series of meetings took place to provide support and leadership/management discussions regarding the service. The nurse manager attended a meeting with the human resources department each month to review vacancies and staffing issues in the department. A weekly operational meeting was attended by the speciality leads including directorate management.

**Vision and strategy**

The strategy and forward planning for the development of the sexual health service was under review at the time of our inspection. A process of tendering was ongoing by the commissioners. Staff had been fully briefed on the process and a series of meetings were taking place to look at the opportunities when making an application for tender.

The service had developed a set of values which staff were aware of. The values were; care and compassion, inspiration and innovation, working together, pride and achievement and trust and respect. The values were displayed in patient and staff areas for all to see.

**Culture**

Staff felt supported, respected and valued.

It was evident the wellbeing of staff was important within the trust and service. There were notices relating to the wellbeing of staff such as those advertising activities such as lunch walks, yoga classes and running groups.

Staff new to the team reported a warm welcome and a feeling of inclusion.

All staff said they worked well as a team and supported and received support from their colleagues. We observed different roles of staff communicating well at all levels. Staff were able to challenge each other to improve practice and were encouraged and felt able to report incidents.

Not all the nursing staff were dual trained which meant both contraceptive and genitourinary services could not be provided to the patient by one person. There was training available within the trust, but some staff were unwilling to take on the additional roles. This had an impact on the service becoming truly integrated.

**Governance**

There were clear responsibilities, roles and systems of accountability which supported good governance and management.

The service had a named governance lead who ensured appropriate information and data was collated to inform the senior managers and trust board. A monthly governance meeting took place.
which was attended by key managers and followed a set agenda. Topics for discussion included, staffing, incident reporting, overview of incidents and any action taken to mitigate the risk of reoccurrence and complaints and compliments.

Information from the governance meeting was reported to the divisional governance leads and to the monthly directorate governance meeting. A divisional board meeting took place each month which was always attended by the speciality lead or the consultant governance lead from the sexual health service. A report from information gathered and discussed at this meeting informed the trust board of any issues within the sexual health service. Information from the board meetings and trust executives was cascaded to staff through these meetings.

**Management of risk, issues and performance**

The service had systems in place for effectively managing risks and issues.

There was a local risk register that showed identified risks, the action taken to address the risk and a red amber or green rating. Any identified risks were reviewed at the operational meeting to measure against the trust criteria prior to being placed on the risk register. The risk register was reviewed at the divisional management team meeting for actions to be approved or for escalation to the organisational risk register. This ensured that the trust had an awareness of issues and risk within the sexual health service and the action being taken to reduce the identified risk.

At the time of the inspection the local risk register had three identified risks listed. Action was being taken to mitigate against each of these risks.

Not all staff we spoke with were aware of the risk register and therefore were also not aware of the process to record identified risks on it. However, all staff would share identified risks with senior staff and therefore the process would be followed to alert divisional and trust wide managers to the risk.

In the event of a major incident the doctor's office in The Hub became the communication centre for the trust. This was located upstairs with a separate access so that the running of the service was not affected.

In the event of an electricity power cut, there was an emergency generator which provided a backup service. This was tested by the trust each week.

**Information management**

Information regarding the service was available, processed and shared with the trust.

Operational and divisional meetings reviewed performance data to ensure the service performed to a national standard.

The retendering of sexual health services in Cornwall was a concern to the service and planning and development meetings were taking place to prepare for the tendering process. Staff were involved in these meetings and kept up to date about the process.

Patients had access to online information on the service website and were able to contact clinicians through email and by telephone.

**Engagement**

Patients, staff and external partners were engaged and involved to improve the quality of the service provided.

The friends and family test was offered to each patient attending an appointment. Results were overwhelmingly positive. Where suggestions had been provided by patients of how the service
could be improved action was taken and feedback provided on a ‘you said, we did’ board which was displayed in the waiting room.

The service had participated in an accredited patient survey in 2017. The patient survey for 2018 had been carried out by the service and the outcomes were being audited and reviewed at the time of the inspection.

The service had attempted to form a patient ambassador group but had not been able to recruit any patients to start this project.

Children and young people from a local college had participated in a scenario training of the patient journey and had provided feedback on any areas they thought could be improved.

The service and wider trust engaged with the staff through a series of information sharing methods. Staff were provided with information relating to the service and trust through a staff newsletter, hot topic of the month, emails drops and monthly staff meetings. The chief executive held a monthly briefing called ‘team talk’ to which all staff were invited.

**Learning, continuous improvement and innovation**

The service was proud of the safeguarding processes that had been implemented. This had been developed following a safeguarding alert to improve safety and safeguard adults and children against abuse. The monthly multidisciplinary meeting ensured that partners within the trust and externally all shared information to make sure all were fully informed of identified safeguarding risks for individuals.

A new electronic booking system was being developed for the service which would enable any administrator or peripheral clinic to respond to calls on the booking line to support patients wanting to book an appointment. This would mitigate against patients having to wait in a queue for the telephone to be answered.

The service had developed and implemented a dedicated quality assurance programme for microscopy for the clinical staff. This has now been recommended by BASHH to other services to follow.

The service received recognition in July 2018 for achieving first place nationally in an audit of the delivery of emergency contraception. Data included in the sexual and reproductive health profiles produced by Public Health England, showed the service provided double the national average of long-acting reversible contraceptives (LARC). These are methods of birth control that provide effective contraception for an extended period without requiring user action. They include injections, intrauterine devices (IUDs) and subdermal contraceptive implants.

### End of life care

**Facts and data about this service**

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

End of life patient care is provided by staff working on any ward or clinical setting, such as within outpatient clinics and the emergency department. Additional expertise is available from the trusts integrated specialist palliative care and end of life (SPEOL) nurse led service. The team provides
trust wide expert clinical advice, support and staff training, particularly for patients with complex care needs.

There is a cancer support centre accessible to any person affected by cancer. This is staffed by McMillan professionals and are not employed by the trust. A range of training is also available to all staff through the centre.

From April 2017 to March 2018, the trust had 1,661 deaths.

(Source: Hospital Episode Statistics)

The trust has an integrated specialist palliative care and end of life (SPEOL) nurse led service. Most of the referrals into the SPEOL team are from within Royal Cornwall Hospital. The trust states that the total number of referrals made to the team during 2017/18 was 1,173, 93.4% of which were accepted.

Medical cover for the SPEOL service is provided through collaborative working with Cornwall Hospice Care. An in-reach service is provided by the local hospice for the provision of a palliative care consultant daily. This complements the employment of one whole time equivalent specialist palliative care consultant by the trust. Collectively, the consultants from the hospice and the trust provide 10 sessions of consultant time per week at Royal Cornwall hospital. This is a new process which was introduced in April 2018 and was reviewed in September 2018.

The End of Life Group with representation from clinical staff, patient experience, bereavement services and Healthwatch meet bi-monthly and currently reports to the Quality Assurance Committee.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

During this inspection we visited wards and specialist departments. These included: the onward care team, the cancer centre, the mortuary, chaplaincy service and bereavement office. We spoke with 12 patients and those close to them. We reviewed 18 sets of patient care records and looked at 17 combined patient treatment escalation plans and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms.

We spoke with 39 staff about end of life care. These included; specialist palliative care consultants, specialist nurses, registered nurses, health care assistants, chaplains, the bereavement team, the patient experience team, the end of life trust lead (who was the director of nursing), administrators, the mortuary manager, and junior doctors.

Is the service safe?

Mandatory training

The specialist palliative end of life (SPEOL) team had staff with the right training to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Medical staff required updates to mandatory training.

All staff were required to complete mandatory training and had access to face to face mandatory training and e-learning modules, they were alerted when mandatory training was coming up or due for renewal.

End of life training was added to mandatory training for all staff in October 2017. When staff were questioned about end of life mandatory training all reported that they had received it and they found it of use.

Mandatory training completion rates
The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for medical/dental and nursing staff in end of life care at Royal Cornwall Hospital is shown below:

**Mandatory training completion by module – medical and dental staff – Royal Cornwall Hospital**

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>0</td>
<td>2</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>0</td>
<td>2</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for four of the 11 mandatory training modules shown above for medical staff. The conflict resolution and manual handling (people) training modules had the lowest completion rate with 0% each, however this is based on only two members of staff being eligible for the modules.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in end of life care at Royal Cornwall Hospital had a completion rate of 80.0% for mandatory training. Medical staff met the target of 95% for five of the 11 modules.

**Mandatory training completion by module – nursing staff – Royal Cornwall Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

*(Source: Updated data provided by the trust)*
<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult basic life support</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for 10 of the 11 mandatory training modules shown above for nursing staff. The manual handling (people) training module did not meet the target and had a completion rate of 80%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in end of life care at Royal Cornwall Hospital had a completion rate of 82.5% for mandatory training. Qualified nursing staff met the target of 95% for four of the 10 modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>3</td>
<td>8</td>
<td>37.5%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Safeguarding

The trust had processes in place to safeguard vulnerable adults and children from abuse. All the staff we asked were clear about their responsibilities and what actions to take if they needed to make a safeguarding referral. Staff were also able to demonstrate an understanding of the types of concerns that may alert them to a possible safeguarding concern. Staff were able to name the trust’s safeguarding lead and knew the information was available on the intranet.

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.
A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for medical/dental and nursing staff in end of life care is shown below:

Safeguarding training completion by module – medical and dental staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
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<tr>
<td>Safeguarding children (level 2)</td>
<td>0</td>
<td>2</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for two of the four safeguarding training modules for which medical staff in end of life care were eligible. Of the two eligible staff for safeguarding children (level 2) training, neither had completed the course as at April 2018.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that medical staff in end of life care at Royal Cornwall Hospital met the 95% target for three of the four modules, with a compliance rate of 80.0% overall. Compliance improved for one module when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
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<td>3</td>
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<td>Yes</td>
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<tr>
<td>Safeguarding adults (level 2)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Safeguarding training completion by module – nursing staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 95% target was met for all four safeguarding training modules for which nursing staff in end of life care were eligible, with 100% completion rate in each course.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in end of life care at Royal Cornwall Hospital met the 95% target for all modules, with a compliance rate of 100%. This was the same when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
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<td>Safeguarding children (level 2)</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Safeguarding children (level 1) 8 8 100.0% 95% Yes
Safeguarding adults (level 1) 8 8 100.0% 95% Yes
Safeguarding adults (level 2) 8 8 100.0% 95% Yes

(Source: Updated data provided by the trust)

Cleanliness, infection control and hygiene

Systems were in place to prevent and protect people from healthcare associated infections in most of the areas we visited.

On wards and in clinical areas there were plentiful supplies of hand hygiene gels and sinks with soap for hand washing. Posters reminded staff and visitors to ensure their hands were clean whilst in these areas. We saw staff washing their hands and using the hygiene gel regularly, as well as using the personal protective equipment that was available to them. All staff we observed were bare below the elbows as per policy requirements at the trust.

The mortuary area had plentiful supplies of personal and protective equipment including gloves, cleaning gel, aprons, shoe coverings and wellington boots.

However, the mortuary post mortem room posed an infection control risk to staff. The mortuary service conducted approximately 1,300 to 1,400 post mortems a year. We observed the post mortem tables were made of porcelain which was chipped and that there were faults with the drainage from these tables. We were told this resulted in contaminated water and bodily fluids regularly spilling onto the floor instead of being directed safely into a drain. There was exposed wood which was porous in the post mortem room which also posed an infection control risk as it could not be cleaned effectively. Electrical lights had black tape stuck on them which also provided an infection risk due to the inability to clean effectively. A lack of storage for equipment, meant that it was stored in clinical waste bins. This meant there was a risk they could be mistaken for clinical waste bins with soiled rubbish being put in with the equipment stored within them.

Environment and equipment

The mortuary service did not have suitable premises and equipment, and these were not maintained sufficiently to keep staff safe.

The post mortem room had unsafe equipment and had suffered from a lack of investment for a sustained period. The post mortem tables were not height adjustable, and we heard that for some staff this created difficulties in them carrying out their role. Of the four tables in the post mortem room, three had water leaking from their pipes, causing a constant stream of running water over the floor. The bariatric table was often not used for bariatric patients as it had a lipped edge which made it more difficult to safely manage larger bodies. This meant that these post mortems were carried out on tables that had not been designed for the purpose. It was clear that there had not been any capital investment into the post mortem area for some years. Despite these issues being raised by NHSI in July 2018, we saw no evidence of a plan to address these issues at the time of our inspection. We brought this to the attention of the trust, and following our inspection, it was confirmed that a programme of works was scheduled to refurbish the post mortem facilities. Additionally, the leaks had been mended.

The trust had a backup generator in the event of a power failure and this ensured power was not lost to refrigeration systems in the mortuary. Additionally, the main fridges were connected to a central system that sounded an alarm if the temperature deviated from within set limits. This ensured that any risks from a rise in temperature could be managed in a timely way. However, the 24 extra capacity mortuary spaces were not connected to this system and were on a different floor.
to the main mortuary. This meant that if their refrigeration systems malfunctioned in any way out of hours, there was no system that automatically raised the alarm. This carried the risk, for example, that if the system malfunctioned on a Friday evening, it would not be detected until the mortuary was staffed again on the Monday, meaning bodies could start to decompose during the intervening time. Compounding this risk was the fact that these fridges were most often in use during bank holiday hours, due to demand, which was also when the mortuary was not staffed.

The mortuary and bereavement service had a viewing room for relatives to spend time with the deceased. There was only one viewing room which meant there was a high chance that visitors may have to wait to be able to view deceased patients. However, this was mitigated by a booking system used by the bereavement team. The viewing room was sparsely decorated, with harsh lighting and few comforting features. Additionally, it was not accessible for people who used wheelchairs as the corridor leading to it was too narrow. This meant, that whilst some bereaved were able to visit the deceased, this was not accessible to all.

There was a lack of side rooms for end of life patients meaning they were often cared for in shared areas. This impacted the privacy of these patients and those close to them when they were at the end of their lives. Where possible, patients at end of life were accommodated in side rooms if that was what they wished. We saw a specialist palliative end of life nurse request a side room for an end of life patient who was on the ward. The side rooms were being used for infection control purposes and so was not available for this patient. On Phoenix ward, staff had raised money to decorate a side room dedicated for end of life patients.

The trust had an “equipment library” which was used to store all equipment that may be required. If end of life patients required syringe drivers, these could be ordered, collected by porters and brought to the ward, normally within 30 minutes. Staff reported that there were no issues with obtaining equipment. All equipment checked was serviced within the last 12 months. The trust provided training to staff on use of equipment. For example, we saw there were enough trained staff on wards that could set up a syringe driver.

Access to the mortuary was safe and secure. Entrance to the mortuary was secure via alarmed doors which were monitored by CCTV and required a swipe card to gain entry. Only defined staff were given an entry swipe card which meant that the manager of the mortuary could be assured of its security. Footage from the CCTV was regularly monitored to ensure that the entry system was being used effectively, as well as to enable the manager to be confident the mortuary was being appropriately and safely accessed out of hours.

Staff followed the trust’s policy and procedures to transfer patients safely in and out of the mortuary. Porters had to undertake training run by the mortuary staff before they were able to transfer patients in and out of the mortuary.

Mortuary equipment in use outside of the post mortem room was serviced and maintained by trained staff through a combination of external and internal contracts with companies specialising in the field. We were told that these companies were responsive and attended to maintain equipment when requested.

Assessing and responding to patient risk

Staff identified and responded appropriately to changing risks of patients. The specialist palliative care team met every morning to discuss and review new referrals as well as ongoing cases needing attention. The aim of this daily briefing was to prioritise cases and review changing patient needs. In addition, they met weekly for a full multidisciplinary discussion about all patients in the trust who were referred to the team. They were joined at this meeting by the end of life consultant,
the hospital chaplain, an occupational therapist, a member of the onward care team and an administrator. We attended this meeting and saw that comprehensive and detailed discussions were had about all patients, including their pain relief, completion of treatment escalation plans and their preferred place of care.

Patients receiving end of life care on wards benefitted from daily clinical meetings which allowed for a regular review of their care. Doctors and nurses discussed patient’s conditions and amended treatment plans accordingly. The specialist palliative end of life nurses attended some of these clinical meetings and inputted into the discussion. We spoke with junior doctors and nurses who stated they felt able to raise for discussion whether a patient near the end of life should continue to be aggressively treated. It was at these clinical meetings that a patient was referred onto or out of the end of life pathway.

Risk assessments were carried out for patients receiving end of life care and management plans developed that were in line with the ambitions for care national guidance. We also saw that for patients in the last phases of life, such interventions were stopped to minimise the amount of discomfort and disruption to patients.

The specialist palliative end of life nurses had a pager so that ward staff could alert them if they were required to assess the changing risk of a patient. One of the team would hold the pager and delegate as necessary according to the need of the patient.

**Nurse staffing**

The specialist palliative end of life (SPEOL) nursing team comprised four whole time equivalent band six nurses, two band seven nurses, and a vacant band eight position which the band seven clinical nurses shared as a development opportunity. This was an improvement from the previous inspection where there were only three registered nurses and meant the team offered a full service which included addressing end of life training needs on the wards. Staff on the wards commented that the SPEOL team were accessible and responsive.

The SPEOL team was a nurse led service. We saw that they worked as a cohesive team providing support to the staff of the clinical areas and addressing patients psychological and physical needs. The team shared information about end of life patients every week day morning at a handover meeting. The team helped to spread information, improving awareness of policies and procedures and promoting best practice in specialist palliative and end of life care. At the time of inspection, the SPEOL team was a five-day service, Monday to Friday 8am – 4pm, however there were plans to extend this to a seven-day service in October 2018.

There were end of life link nurses on each ward who liaised with the specialist palliative end of life nurses and would be first in line to receive additional end of life training.

There were no cover arrangements in place for the specialist palliative end of life nurses in the event of any absence. This is confirmed by data received that indicates between May 2017 to April 2018 no bank or agency staff were used. The potential risks created by this were mitigated by the increased size of the nursing team.

The planned versus actual staffing number figures below report as at April 2018. We are aware that two SPEOL nurses joined the team in May 2018 and asides from the vacant band eight position, the SPEOL team is at establishment.

**Planned vs actual**

The trust has reported their staffing numbers below as at April 2018 for nursing staff in end of life care at Royal Cornwall Hospital, with an overall staffing rate of 90.7%.
### Ward/Site

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Planned WTE Staff</th>
<th>Number in post as at April 2018</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>5.0</td>
<td>4.6</td>
<td>90.7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

### Turnover rates

From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 19.2% for nursing staff in end of life care, compared to a target range of 10-14%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

### Sickness rates

From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 0.3% for nursing staff in end of life care, compared to a target of 3.8%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

### Bank and agency staff usage

From May 2017 to April 2018, the trust reported no bank or agency shifts were filled by qualified nurses or nursing assistants at Royal Cornwall Hospital and there were no shifts unfilled.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

### Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust only had the equivalent of one full time end of life consultant for its service, however there had been an improvement in the resilience of medical cover within the end of life and palliative care service since the last inspection in October 2017. Whilst the level of medical cover had not increased, a trial of in reach working from the local hospice meant that cover was provided by 3.4 whole time equivalent consultants and was shared across the trust, hospice and community setting. There was a dedicated plan of cover should a consultant be off sick which helped to improve the resilience of the trust service. Guidance from NHS England (Specialist Level Palliative Care: Information for Commissioners, 2016) stated there should be sufficient medical and nursing cover to allow assessment, advice and patient management seven days a week. Furthermore, the guidance stated there should be provision for 24-hour telephone advice. At the time of our inspection, consultant provision was available between Monday and Friday from 8.30am until 5pm. Outside of these hours staff had access to a 24-hour advice and support ran by the local hospice. This line had access to both doctor and consultant advice when required. At the time of the inspection the chief nurse stated the trust would look at increasing the consultant provision for end of life.

### Turnover rates

From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 0.0% for medical staff in end of life care, compared to a target range of 10-14%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

### Sickness rates

From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 0.0% for medical staff in end of life care, compared to a target of 3.8%.

(Source: Routine Provider Information Request (RPIR) - Sickness tab)
**Bank and locum staff usage**

From May 2017 to April 2018, the trust reported no shifts filled by locum staff in end of life care and there were no shifts unfilled.

**Records**

People’s individual care records, were not always written and managed in a way that kept people safe. Completion of end of life records was variable. Records available for use, did not support staff to identify patients who may be in the last 12 months of life. The risk of not identifying patients who were in the last 12 months of life was that patients could receive inappropriate treatment or information that did not reflect the point they had arrived in their disease process. There were effective identification and use of records for the care and treatment of patients who were in the last days and hours of life. The records were easily identified by a butterfly logo.

Patients in the last days of life were moved onto the ‘priorities for care’ documentation system. This documentation was designed to support the provision of dignity, comfort, sensitive communication and compassionate care in the last days or hours of life and was based on national guidance around the ‘Five Priorities of Care’. Audit work around the trust’s end of life documentation showed that there was still some improvement required to the actual documentation but that the use of the documentation had been embedded across the trust. We saw minutes from the end of life group meetings that discussed the improvements required and staff told us that there was a plan to introduce a new version of this documentation.

An audit of 50 sets of notes was undertaken between February and May 2018. This showed 80% of records had a decision to stop non-essential medicines recorded. 86% of records had a daily entry detailing a review of the patient. However, only 54% of patients with this documentation had had their preferred place of care documented. This meant for those patients where this hadn’t been documented, the trust could not be assured that this information was considered by those providing care to patients. Additionally, only 56% of patients had their family’s wishes detailed in their documentation, and 76% of records did not document whether anyone held a lasting power of attorney. Whilst the audit detailed recommendations, we did not see any evidence of an action plan to address the poorly performing areas.

The trust could not be assured that ceilings of treatment were being consistently identified and documented for patients at end of life. Treatment Escalation Plans (‘TEP’) were not fully completed for each patient. This had been identified as a concern in the previous CQC inspection. For example, an audit of TEPs in April 2018 indicated only 40.5% were fully completed with appropriate information contained in all the relevant fields. However, the inspection team looked at 17 TEPs and all were fully completed. Staff also reported that TEP forms were a priority for consultants who worked hard to put them in place for each patient. At the time of the inspection we were informed that the Trust had appointed a new TEP lead with a view to further improve the practice around use and completion of treatment escalation plans.

We saw that records were organised and stored safely in locked cabinets to ensure the privacy and confidentiality of patient’s information.

**Medicines**

Arrangements for managing the medicines required by patients at the end of their lives kept people safe. The specialist palliative end of life (SPEOL) care nurses worked closely with other clinical staff to ensure that the necessary anticipatory medicines were prescribed for patients at the end of their life. Anticipatory medicine describes a collection of medicines that are used to treat symptoms that affect patients in the last phases of life. We saw guidance for prescribing
anticipatory medicines for pain and symptom relief that aimed to assist doctors who were not specialists in end of life care.

Medicines were appropriately prescribed, administered and supplied to people in line with the relevant legislation and current national guidance. Three of the SPEOL nurse team were non-medical prescribers, with a fourth member undertaking the qualification. These band six nurses were able to prescribe anticipatory medicines and pain relief alongside doctors. These nurses offered specialist advice regarding end of life medicines. We observed junior doctors approaching the SPEOL team for advice regarding end of life medicines.

Systems within the trust ensured there were sufficient supplies of medicines needed by patients at end of life. Support from pharmacists was readily available and staff spoke confidently about accessing any type of medicines they may need.

The trust had a policy and procedure for management of subcutaneous infusions in adults which was in date and due to be reviewed in 2019. The trust had undertaken an audit to ensure compliance in line with this policy. We observed the SPEOL team spot checking syringe drivers and informing staff of any deviation in policy and procedure. For example, a SPEOL nurse saw the battery life of a syringe driver had fallen below 33% which was against trust policy. We observed the SPEOL nurse inform a member of the ward staff who then changed the battery. We were told spot checks were carried out by the SPEOL team on an ad hoc basis.

There were enough trained staff to set up a syringe driver when it was required. Training records were provided detailing staff on shift who were trained to set up a syringe driver. Staff reported they could approach the SPEOL team, the medical device trainer or another ward for syringe driver advice.

We were informed by all staff there was no delays to treatment due to a lack of medicines being available.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

From June 2017 to May 2018, the trust reported no incidents classified as never events within end of life care. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from June 2017 to May 2018.

There had been an improvement in the oversight and scrutiny of incidents that related to end of life care at the trust compared to the previous inspection. End of life incidents were reported via an electronic system and identified by a tick box which enabled the service to analyse end of life incidents. The SPEOL team were informed of all incidents via the electronic system and were able to identify areas for improvement and implement learning events to spread best practice. For example, the SPEOL team provided ‘tea and cake’ sessions which bought education from incidents to the wards. Several staff members spoke highly of the training sessions run by the SPEOL team.
Incidents were discussed quarterly at the end of life care group meetings. We received minutes from these meetings that showed incidents were being reported and themes from these incidents identified. For example, the minutes documented that the trust reported 63 incidents referring to End of Life Care between 1 August 2017 to 28 February 2018 and that the prominent themes consisted of pressure damage, medication, recognising dying, communication and incidents where staff perceived unsafe transfer of dying patients and unsafe discharge.

All staff we spoke with understood what constituted an end of life incident. The trust had put an end of life incident prompt list on the intranet. It highlighted that not being in the preferred place of care, not being with loved ones and being in discomfort represent significant risk and harm to the end of life patient and should be raised as an incident in these cases.

Staff gave examples of learning that happened from incidents. There was a standing item for learning from incidents in the end of life bi-monthly newsletter. For example, there was a briefing alert regarding the treatment of secretions, following an incident where a patient was prescribed the wrong dosage of medicines. The correct dosages were reiterated in the newsletter.

The SPEOL team were aware of the duty of candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. One nurse from the SPEOL team gave an example of when this had been implemented.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and was beginning to introduce processes that evidenced its effectiveness.

End of life care at the trust was underpinned by the national “Ambitions for Palliative and End of Life Care” a national framework for local action. This framework described six key priorities to be followed when caring for patients at end of life, as designed by The National Palliative and End of Life Care Partnership. At the time of our inspection, the trust's draft end of life strategy (2019-2022) was out for consultation. The strategy stated that it was underpinned by the Ambitions for Palliative and End of Life Care framework.

End of life specific documentation was based on but did not meet all aspects of the Leadership Alliance for the Care of Dying People’s “Five Priorities of Care”. These priorities aimed to ensure the dying person was the focus of care in the last few days and hours of life and exemplify the high-level outcomes that must be delivered for every dying person. The leadership alliance was made up of several organisations, including the National Institute for Health and Care Excellence (NICE). The Priorities for Care were aligned with the existing NICE Quality Standard for end of life care. We saw that some care delivered to patients in the last days of life was in accordance with NICE guidelines. This included the effective recognition of patients at this stage, at which point the end of life specific documentation was used. However, this documentation was not detailed enough for all aspects of NICE guidelines to be followed. For example, there was not clear information about discussion of individualised care available for staff to record, or a place for details of who should be involved in decisions about care in the last days of life. Whilst some reference was made in the document to acknowledging spiritual and social needs, there was nowhere that prompted staff to document any discussions about individualised care. The end of life care document lacked the detail required to ensure that the five priorities of care were addressed for patients at this phase of their care.
Not all patients at the end of life were identified. We found a strong focus on patients in the last days of life, but this emphasis was not seen for patients whose death was less imminent. When we spoke to ward staff about patients who may be at end of life, only a very small number of patients were identified. However, when we asked about patients who may be in the last year of life, staff identified larger numbers of patients who they felt fit the criteria. We were not therefore assured that patients at end of life were always being identified correctly. We saw an example of a patient who had not realised their condition was life limiting, and this had not been communicated to them. They told us, that had they known this sooner, they may have made different decisions about their care and treatment.

We found that the trust was completing audits around various aspects of end of life care, but we did not see any action plans for how the issues identified would be addressed.

The trust carried out separate audits of some aspects of its performance with regards to end of life care. Specifically, it audited the completion of the end of life documentation, the use of treatment escalation plans (TEPs), the use of syringe drivers and the prescribing of anticipatory medicines. The aim of these audits was to enable the service to be assured of the effectiveness of its delivery.

The trust performance in the audit of treatment escalation plans, continued to be a poor. The trust’s interim audit report, completed in August 2018 stated, “Spot audits have continued to demonstrate a similarly disappointing picture with partially complete forms a regular finding within the case notes.” An audit in April 2018, showed that of a sample of 37 TEPs, only 40.5% were fully completed with appropriate information contained in all the relevant fields. Treatment escalation plans detail the limits of treatment for patients, as well as their capacity to consent to decisions and as such determine the course of treatment for patients at end of life. The trust’s audit did not therefore provide assurance that patients receiving care at end of life do so in a manner which was reflective of their needs. Leaders within the specialist palliative care and end of life team recognised this issue and we learned that a “TEP Lead” had been appointed with a view to addressing the continuing shortfalls. However, the poor performance relating to the completion of TEP forms had been documented in the previous two inspection reports for end of life care.

The audit of the use of syringe drivers, carried out in 2017, showed a generally positive picture at the trust. However, when broken down by ward, there was some significant variation in performance, with Lowen ward performing consistently positively, and Tintagel ward performing consistently poorly against the same measures. When collated, the results of the audit showed a generally positive performance of over 90% in areas such as using the correct syringe, correct battery life, and prescription on the electronic system. The poorest performing area was the audit of four hourly checks, which were made in only 37% of cases.

An audit of 17 patients looked at how well the trust was meeting prescribing standards for end of life care. The result of this audit indicated that 70.2% of patients had anticipatory prescribing in place for each symptom. It identified that more work was required around prescribing opioids for pain and breathlessness. This information was publicised in the end of life and specialist palliative care newsletter where the message regarding the outcome of the audit and learning was disseminated.

**Nutrition and hydration**

People's nutrition and hydration needs were identified and met at end of life. We saw that the section of the end of life documentation that encouraged staff to consider the continuation of food and fluid was regularly completed. Additionally, this document contained advice for staff to consider when deciding on the continuation or cessation of nutrition and hydration in the last phase of life. The SPEOL team had access to dieticians and nutritionists if required.
Pain relief

Pain was assessed and managed well for patients at end of life. We saw that for patients at end of life, staff were alert and aware of the need to effectively manage their pain. The end of life care plan contained a section for staff to complete to ensure that anticipatory pain relief could be prescribed should it become necessary. Staff on wards could call on the SPEOL team to review patients’ pain medicines.

Pain assessment and relief needs of patients who required additional support were recognised. We saw a “Plan and do” sheet which detailed an assessment to be carried out for patients unable to communicate verbally. This provided a clear framework to support staff to assess the pain of patients, and act accordingly.

Wards were well stocked with pain relieving medicines, and staff said that these were readily available for patients when needed.

Syringe drivers were easily obtainable for patients and were sourced via a central store. Not all staff were competent in their use, but on the wards we visited staff were confident there would always be staff available to set these up. We also saw a poster which directed staff to support should it be required to set up drivers.

On the wards we visited we saw that patients at end of life had anticipatory pain relief prescribed, and staff were confident in initiating their use, should the need arise. We saw that patients with syringe drivers were being managed safely, and in accordance with best practice.

Patient outcomes

Information about the outcomes of people’s care and treatment was collected and monitored. However, it had not been analysed at the time of our inspection. The trust was taking part in the National Audit of Care at the End of Life (NACEL) audit. This audit focused on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales. This was due to conclude in the months following our inspections, with outcomes provided to the trust expected shortly after. The trust hadn’t participated in the National Care of the Dying audit in 2016, and so the NACEL audit provided the trust with an opportunity to measure its performance with regards to end of life care against a national framework.

Competent staff

Staff working within the specialist palliative care and end of life team had the skills and knowledge required for their role. This meant that patients receiving care from this team could be assured they had the competency to do so.

The specialist palliative end of life team provided training sessions on end of life informally on a ward by ward basis. Ward staff reported receiving training from the specialist palliative end of life team and were complimentary about this. Additionally, individual wards could request input from the specialist palliative end of life team, who were responsive in doing so.

Staff told us they felt well equipped to care for patients at end of life and were supported to do so. We observed staff delivering care to end of life patients in an effective manner. We were assured that end of life care was being delivered by staff who were confident and competent to do so.

There was a lack of confidence in advance care planning in nearly all the areas we visited. Whilst staff felt confident in identifying patients in the last days of life, they felt less confident in discussing patients who may be in the last year of their lives. We were told that advance care planning training was not available to staff. This meant that there was a risk of patients at end of life not
being given appropriate opportunities to discuss their care and treatment options at an early enough opportunity.

**Appraisal rates**

Up to August 2018, 100% of medical staff and 25% of nursing staff within end of life care at Royal Cornwall Hospital had received an appraisal compared to a trust target of 95%, although these were based on low staff numbers.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>9</td>
<td>11</td>
<td>81.8%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>1</td>
<td>4</td>
<td>25.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>23</strong></td>
<td><strong>78.3%</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Appraisal tab)*

At the time of our inspection, two of the nurses within the SPEOL team had joined the trust in the past four months. Therefore, an appraisal had not been carried out for these staff due to their recent employment at the trust.

**Multidisciplinary working**

We saw that all necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment to patients at the end of their lives. Multidisciplinary (MDT) meetings were held weekly and discussed all patients at the trust receiving end of life care. These were well attended, and the SPEOL monitored who was present. During the year to our inspection, multidisciplinary meetings had been attended by consultants on 71% of occasions. The MDT coordinator attended 85% of these meetings. However, occupational therapists only attended 15% of meetings.

We saw on the wards we visited that care was delivered in a coordinated way. Ward based staff liaised and communicated clearly and regularly with the SPEOL team and spoke positively of their approach.

An end of life care group met bi-monthly and was attended by staff from different areas of the trust – both clinical and non-clinical, and by external stakeholders. This group addressed a standing agenda of issues related specifically to end of life care and aimed to provide a rounded approach to this.

The specialist palliative care and end of life care team, provided support and input into other teams providing care at the trust by attending ward multi-disciplinary meetings and providing ad hoc training events. This included to groups, such as consultants and student nurses.

We saw that staff worked collaboratively with community-based colleagues to coordinate care for patients leaving hospital. There were good links with the local hospice, who worked closely with the SPEOL team.

In terms of transfer to community hospitals across Cornwall, the transfer documentation was provided by the ward on transfer, including communication between nursing and medical teams.
There was no specific communication from the hospital palliative care team, although informal telephone calls were often used to back up specific information and the SPEOL team inputted into the patients care record.

**Seven-day services**

Specialist palliative care and end of life provision was not available seven days a week. Specialist palliative care and end of life provision was available from 8.30am until 4.30pm between Monday and Friday at the time of our inspection. Outside of these hours, staff had access to an advice line, provided by the local hospice for support and queries. We heard that the hours that the SPEOL team were available were invaluable as they provided much needed support to nurses and doctors to ensure an optimum provision of end of life care. However, staff told us that the lack of specialist provision at weekends caused additional pressure at this time.

There was a plan for SPEOL service to be extended in October 2018 to cover weekends. There was a genuine desire from the SPEOL team for this to get underway. As well as extending the provision to a more comprehensive level of cover, it was felt that it would also reduce the pressure felt by SPEOL staff at the end of the week.

The mortuary operated between the hours of 9am and 4pm Monday to Friday. However, an on-call service ensured that if those close to patients wished to view them outside of these hours, this could be facilitated.

The chaplaincy service was structured so that it could provide a seven day a week service to patients. Additionally, volunteers were divided into those providing regular visits, and those available on holy days.

**Health promotion**

We were not assured that staff identified patients at end of life who may not be in the last phases of life. This meant, that it was possible the extra support needed by these patients was not offered. We heard of a patient who was not aware that their illness was a life limiting condition until their disease had progressed significantly. They told us that had they known, they would have made different decisions about their care and treatment.

We witnessed meaningful discussions between staff and patients, or those close to them about the implications of treatment, or the decision to leave hospital in the last phase of life. Whilst the end of life care documentation did not provide guidance for a detailed discussion of options, we did see that these patients and those close to them were involved in meaningful conversations about care and treatment.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

We saw that staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When we looked at the treatment escalation plans for patients at end of life, was saw that where decisions had been made about the resuscitation status of patients, their capacity to consent had been considered and documented. However, the document did not detail the steps taken to determine the level of capacity of patients.

Staff confidently described to us the steps they would take if they felt that patients lacked the capacity to consent to either resuscitation decision or a treatment escalation plan. We observed in records where conversations had been held with patients next of kin, and the outcomes recorded.

**Mental Capacity Act and Deprivation of Liberty training completion**
The trust reported that from May 2017 to April 2018, Mental Capacity Act (MCA) level 1 training had been completed by 100% of staff within end of life care at Royal Cornwall Hospital. (Source: Routine Provider Information Request (RPIR) – Training tab)

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level 1 training had been completed by all staff within end of life care at Royal Cornwall Hospital. (Source: Updated data provided by the trust)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We spoke with four end of life patients and eight relatives. They told us both ward staff and the specialist palliative end of life team were always welcoming and helpful. One message received from a relative of an end of life patient stated, “I only met ‘x’ a couple of times as my husband passed away quickly, but she was marvellous, and got me and my family to the hospital in time on his last day to spend precious hours with him. That was the most important thing she could have done. She was wonderful.”

The bereavement service provided supportive and compassionate care. The bereavement staff contacted families the day following death and each successive day until the necessary arrangements had been made. The bereavement team accompanied families to view the body of the deceased and liaised with funeral directors and registrars on the family’s’ behalf. They provided a bereavement booklet with information to support decision making.

Patients and relatives had access to an on-site service that was provided by a cancer charity. This provided counselling and psychological support. Services included hats, scarfs and wigs, benefits advice, health and well-being advice, as well as facilities for families of in-patients to share intimate time. We observed ward staff referring relatives of end of life relatives. In one instance it was suggested that the family member obtain advice on will writing and power of attorney.

The trust was trialling the ‘butterfly scheme’ on Phoenix ward. This offered a visual sign to staff that a patient was at end of life. One of the benefits of this scheme was that relatives of end of life patients were easily identified and offered refreshments and support. It also meant that patients and their visitors were unnecessarily interrupted.

The trust had a ‘carers passport’ scheme for relatives of patients at end of life. This helped to set out information about flexible visiting hours and encouraged relatives to think about how much they want to be involved in the personal care of their loved one.

The wards provided supplies for relatives that wished to stay with a loved one overnight in the form of ‘comfort bags’. This was especially useful in the holiday season as often people were further away from their homes.

Staff on a ward helped to facilitate a wedding when a patient was at end of life. Wedding boxes with items for a wedding were available from the specialist palliative end of life team. We were told by staff that a wedding had happened on Lowen ward a couple of weeks prior to this inspection.

Emotional support

Staff provided emotional support to patients to minimise their distress. We observed staff treating end of life patients with dignity and respect, obtaining permission and consent for treatment and
working towards fulfilling patients’ wishes. We were given examples of staff going above and beyond their duties to fulfil the last wishes of patients in end of life care.

We saw thank you letters which included ‘we are grateful for the time and attention that you gave to our family. Your presence on the ward and your willingness to help when we were struggling to comprehend the situation made a real difference’.

Emotional support was available through the chaplaincy service and was accessible 24 hours a day, seven days a week. Ward staff told us the chaplaincy service were responsive to patient or relatives requests for visits. The chaplaincy service provided bespoke support to patients and those close to them in whatever faith was required or no faith at all. The palliative care team identified end of life patients to the chaplaincy team; we were told how the chaplain offered support to patients, families, and staff members.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment. Friends and family of end of life patients reported that they had been able to visit at any time.

We observed staff members consulting with patients about the care they were receiving and the drugs that were recommended. In one instance we observed a discussion about potential medication that could be trialled due to the fact the patient did not feel they were getting on with the current medication prescribed. The specialist palliative end of life nurse was clear and ensured the patient understood the correct dosage and the effects of the recommended medication.

One family member stated that they were informed about all aspects of their relative’s prognosis and care so that they understood what was happening and why.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Delivery of end of life care did not always meet the needs of local people. The data provided to us that addressed whether patients achieved their preferred place of care, suggested that this was a regular challenge to the service. The data at its lowest point in March 2018 stated that only 36% of end of life patients achieved their preferred place of care. The latest data in August 2018 stated that 55% of patients achieved their preferred place of care. When we asked about this, we were told that the most common reason for this was the difficulties in securing community-based packages of care, which is a known national issue. The monitoring of this challenge had improved since our last inspection and was informing a more collaborative approach with community-based services.

There were not enough side rooms at the trust to be able to accommodate patients at end of life, if that was their wish. We heard on Roskear ward, for example, that the small number of side rooms available were often needed for patients whose immunity was compromised. This meant that patients at end of life were often cared for in bays. This impacted the privacy of these patients and those close to them when they were at the end of their lives.

The mortuary served the whole population of Cornwall. The capacity of the mortuary was for 74 adult patients at any one time, plus contingency for a further 24 in the event the mortuary was full. The mortuary was not able to conduct post mortems on patients who were high risk. This was because the environment did not contain the safety measures needed to ensure these could be carried out safely. This meant that patients who died in the local area had to travel further if post mortems were required.
Medical input into the specialist palliative and end of life care service was covered by an in-reach programme in collaboration with the local hospice. However, this only equated to one whole time equivalent consultant providing specialist care at the acute trust. When we inspected in 2017, we heard how this level of consultant cover did not provide the levels of support required for patients of the trust. This situation had not improved with consultants still stretched to provide the levels of cover required. During our visit, a review of the in-reach working concluded that a further whole time equivalent consultant was required across services. This was confirmed by the executive lead confirmed.

On the wards we visited there were no designated rooms to accommodate the relatives or those close to patients at end of life. However, there was access to fold up beds, or comfy chairs should they wish to stay overnight.

The chaplaincy service was able to provide support to patients of different faiths, or those with none. We saw that there was provision in the physical environment of the chaplaincy service for washing where this was needed. Additionally, a variety of religious texts were available.

Meeting people’s individual needs

The service took account of patients’ individual needs although further work on encouraging staff to consider patient’s spiritual and religious needs was required.

There was a prompt on the end of life care pathway document that encouraged staff to consider patients’ spiritual, religious, psychological and social needs when providing care., When the documentation was audited by the SPEOL team, this showed that this section was rarely completed fully in the records audited. There was a risk therefore that patients did not have their individual needs assessed or met at the end of their lives.

The SPEOL benefitted from a close working relationship with the local hospice which meant that where this was the preferred place of care, the team could quickly identify if a bed was available. However, where patients’ preferred place of care was elsewhere in the community – either at home or a residential service for example, this could be more complex to arrange, and patients regularly did not achieve their preferred place of care in this instance.

Patients at end of life with learning difficulties could benefit from the services of the learning difficulty liaison nurse. This meant that for this group of patients, there was a provision of a service that aimed to meet their additional needs at end of life. However, none of the staff we spoke with had experience of this in practice.

People who were approaching the end of their life were not always supported to make informed choices about their care. We saw there was little recognition of patients who may be in the last year of life, and as a result there was a risk that these patients may not receive care and treatment options that met their individual needs. When we asked about advanced care planning, we were told this was an area for improvement that had not been addressed. Staff we spoke with on wards were not confident in their ability to support patients with advance care planning. We heard from patients who had not been made aware that their conditions were life limiting until further into their illness. They told us that had they been aware of this, they may have chosen different options for their care and treatment. We saw from the minutes that this issue had been raised in the end of life link group forum meeting in July. We were not made aware of any imminent plans to address the issue.

Patients in the last days of life could be assured that staff followed processes to decide at which point treatments or interventions were withdrawn. We saw that this was documented for patients
that we met, and staff spoke confidently about the decision to do so. We saw that this was managed sensitively, ensuring patients had a dignified death.

Patients at end of life entering the hospital were identified via the electronic system with a butterfly symbol. This enabled those accessing their records to identify their status easily, and we heard this worked well.

In the mortuary there were no facilities for patients of religions where ritual washing was required. This meant there was risk that for patients of a non-Christian faith, the requirements, post death of their religion could not be met. We were told that this didn’t cause any problems, and it had not been a service that had been requested.

**Access and flow**

People could access the end of life service when they needed it, however it was difficult for patients to achieve their preferred place of care at the end of life.

The specialist palliative and end of life service monitored the number of patients who achieved their preferred place of care at the end of their life. Data provided to us showed that in the 10 months from October 2017 to July 2018, patients achieving their preferred place of care ranged from 36% in March 2018, to 75% in November 2017 at their highest. We were told that the achievement of this outcome for patients depended on many factors outside the team’s control. However, the team were working hard with community partners to improve the numbers of patients achieving their preferred place of care.

The onward care team managed referrals for “fast track” funding for patients at end of life. The aim of fast track funding was to expedite the process of securing funding for patients at end of life to leave hospital and receive care in their preferred place. We heard that this was often a tricky process for staff with referrals being returned often. This caused additional delays to patients’ discharge. Staff told us that the referral form was difficult to complete. The SPEOL team were working to support staff with the completion of these referrals, and as a result this was an improving picture for patients achieving their preferred place of care. The trust also issued a ‘top tips’ guide for completing the fast track application and this was available on the intranet system.

The specialist palliative end of life team had been issued with smart phones since the last inspection. This had meant they were able to communicate effectively and respond to referrals without having to return to base to pick up messages. Ward based staff told us that the SPEOL team were responsive, and always replied quickly to referrals.

Whilst the SPEOL team responded in a timely way to referrals, we heard that the medical staff within it had little resilience in terms of cover for the team. This meant that absences within the medical team meant cancelled sessions, or phone cover rather than an “in person” service. Consultants were working at capacity, but this did not always meet the needs of the end of life service. This had been raised in previous inspections and was under review at this visit.

**Learning from complaints and concerns**

The trust had a patient experience team who managed all complaints received. Information was available to patients and those close to them, that informed them of how to make a complaint. The patient experience team triaged these complaints and made decisions about those that could be managed formally and informally.

**Summary of complaints**
From May 2017 to April 2018 there were two complaints about end of life care. The trust took 24 and 85 working days to investigate and close these complaints. Their complaints policy states complaints should be completed within 25 days.

The complaints related to:

- Trust admin/policies/procedures including patient record management
- Staff values and behaviours

(Source: Routine Provider Information Request (RPIR) - Complaints tab)

**Number of compliments made to the trust**

From June 2017 to May 2018, there were no compliments within end of life care.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Complaints regarding end of life care were discussed at the end of life care group meetings, which met bi-monthly. This aimed to provide a forum for discussion and learning. We looked at the meeting minutes and saw that the numbers of complaints were identified, and themes discussed. However, when we looked at these minutes we could not see where learning from these complaints was discussed or any evidence of how the information was disseminated.

**Is the service well-led?**

**Leadership**

Most leaders had the skills, knowledge, experience and integrity that they needed for the role. There was both local and executive leadership of end of life care at the trust. The chief nurse was the executive lead for end of life care, with the associate chief nurse providing the lead for end of life care. This ensured that end of life care had a presence at board level. At a local level, we saw high quality dynamic leadership from the bereavement and chaplaincy service, as well as within the mortuary and palliative care teams. Managers were truly visible to their teams and took the time to support them in their roles. Staff told us they felt encouraged to offer their views and empowered to make decisions. The specialist palliative and end of life team was a nurse led service. The trust had not been able to recruit to the band eight post for this team and so it had been offered as a development opportunity for nurses in more junior roles as a secondment. We saw that this was working well, with the local leadership of the specialist palliative end of life team held in high regard across the trust, as well as by the medical members of the team. These seconded leaders were being given the opportunity to develop into the roles.

We were assured at this visit that the executive lead for end of life care understood and was well sighted on the issues and performance facing end of life care at the trust. This was an improvement from our previous inspection. They discussed confidently the pertinent issues to end of life care, which reflected what we had been told by other staff within the service.

At the time of our inspection there was no non-executive lead for end of life care, due to the departure of the previous post holder. Portfolios were being reviewed at the time of our visit.

In the mortuary and bereavement service we saw that the skills of the manager ensured that staff were supported and skilled to carry out their responsibilities. On wards and in clinical areas we saw examples of where leadership was having a positive effect on patient care at end of life. For example, newly qualified nurses were learning from their senior colleagues about providing end of life care in line with national guidance.

However, the specialist palliative and end of life care team’s main focus was on patients at the very end of their life. There seemed to be little, front line leadership to support staff with caring for
patients who may be in the last year of life. This was reflected in the lack of focus of front line staff on patients in the last year of life or advance care planning.

Feedback from staff at all levels within the specialist palliative care and end of life team was that leadership was visible, approachable and worked in a collaborative way. This extended out of this team, where other staff felt able and confident to approach leaders within the end of life service for advice and support.

There was an end of life care group which was comprised of staff from several different specialties. The group had membership from medical, nursing, therapy, chaplaincy, bereavement office, Specialist Palliative and End of Life care (SPEOL), continuing healthcare and patient experience. There was nursing and medical representation from the hospice and community providers and a lay member to represent the patient and the family view. We saw that this group met regularly and discussed pertinent issues to end of life care.

**Vision and strategy**

The end of life strategy for the trust, set out their vision for the development of end of life care in the organisation. It was in draft format at the time of our inspection, and out for consultation. It linked with the overarching strategy produced by the Cornwall end of life strategy group. The strategy aimed to provide information about how care was planned to be delivered using the ambitions as described in the “Ambitions for Palliative and End of Life Care: A national framework for action 2015-2020”. It also had a focus on education and training provision for staff at the trust, together with raising awareness of the importance of end of life care. The final part of the strategy described the contribution that the trust would make to working with partner agencies to implement a co-ordinated end of life pathway for Cornwall.

The plan was that the SPEOL team would be actively involved in the implementation of key aspects of the strategy, for example raising awareness. However, we did not see any clear plans for exactly how the strategy would be launched and implemented.

The strategy referred to the outcome of previous inspections and detailed how it was intended to address the issues raised.

As the strategy was in draft form, we did not see any clear plans for how it’s progress would be monitored. However, it did contain specific information about ownership of aspects of it. Additionally, it sited the end of life care group as a key stakeholder who would also participate in the monitoring of its use and implementation.

None of the staff delivering care on wards had been involved in the drafting of the strategy or were aware of its planned launch. The end of life care lead had been involved in its writing, with the remaining members of the team asked to feedback to the draft.

**Culture**

Without exception, what we saw and what we heard from all staff was that patients at end of life were a priority. Staff spoke of feeling privileged to be involved with patients and those close to them at a deeply personal time. Staff felt respected and empowered to deliver end of life care in the best way possible – even during times of increased activity.

The specialist palliative and end of life care team were highly regarded and demonstrated a calmness and expertise throughout their work at the trust. Their aims were clearly understood by front line staff.

Most nursing staff that we spoke with felt able to challenge senior colleagues, or medical staff when discussing and making decisions for patients at end of life. The ultimate decision to put
patients on an end of life pathway, or to implement a treatment escalation plan lay with the doctors in charge of patients’ care. We heard that although this was the case, the decision was almost always a collaborative one, with the doctor providing the final sign off on the decision.

There was a culture of developing the skills of staff at all levels to be able to provide improved end of life care. For ward-based staff this was often informal and led by them in conjunction with the SPEOL team. For the SPEOL team itself, this took the form of advanced training to enable them to provide specialist support. For example, all the team were able to prescribe medicines for patients at end of life.

The SPEOL team provided support to each other which aimed to manage their need for resilience. The team worked closely and met at the start of each day to discuss the patients on their caseload. Likewise, the weekly multidisciplinary meeting used an effective and thorough format to ensure comprehensive delivery of specialist palliative care to all patients identified within the trust.

Staff we spoke with who provided end of life care told us they enjoyed their jobs and felt that they made a difference to patients and their families and carers at a crucial time and they felt supported by the colleagues and teams they worked with.

However, we did not see there was a strong emphasis on promoting the wellbeing of all staff providing end of life care, especially consultants. Demand was being met by these staff working at capacity, or over, daily, and was the result of demand outstripping supply of specialist palliative care consultants. While actions had been taken to try and address the lack of consultant provision, this had not resulted in any more consultant time. The actions focussed on working with a local hospice to share out the time of more than one consultant across both the hospice and the hospital with a focus on building in some resilience. The lack of consultant provision was an issue raised following previous inspections and we did not see that action taken had increased the number of consultant hours at the trust.

Within the bereavement and mortuary service we saw that there was a committed and well bonded team which sought to provide a sympathetic and responsive service that respected the deceased and supported those close to them. However, we did not see that this was echoed outside of the immediate leadership, with the mortuary service in particular having been apparently underfunded and somewhat neglected for a prolonged period.

**Governance**

Governance processes within end of life care had been strengthened since our last inspection, with a clearer structure that worked from ward to board. However, this was still a developing picture with the specialist palliative and end of life team only having recently become effectively staffed at a leadership level.

Since our previous inspection, end of life services had moved from within the cancer services division, into the corporate division. It was felt that this ensured a clearer oversight at board level of end of life services. The executive lead for end of life care met weekly with the end of life lead which provided assurance that current issues were kept live and on the agenda.

The end of life lead also chaired the end of life board, for which the executive lead received papers. This provided further relevant information about the status of end of life care at the trust. This was a more effective and robust system than was in place at our previous inspection.

Locally, within the specialist palliative care and end of life team, staff were clear about their roles and had a clear understanding of their responsibilities. However, due to the size of their workload it was not always possible for them to formally evaluate the service they provided or carry out any
tasks that were not clinically related other than education. We did not see evidence that the service was formally evaluated, or any plans for this to occur outside of the consultant cover.

The governance of the mortuary and bereavement service sat within the pathology division. We were not assured that there was sufficient oversight or management of the issues faced within the department. The issues with the environment in the post mortem room had been brought to the trust’s attention following a visit by NHS Improvement in July 2018, which identified the environment needed “urgent attention”. Reports from recent inspections had been aggregated and escalated from pathology to the divisional level in August 2018, with an outline of requirements and early indicative costs. At the time of our inspection these were not well enough developed to give sufficient assurance that action was being taken to address these problems. Following feedback to the trust, this issue was addressed after our visit.

At the time of our inspection a formal arrangement had not been made for the in reach working arrangements of consultants from the local hospice. Officially, one whole time equivalent consultant was employed by the trust, and the remainder by the hospice. We were told this was because it was a trial arrangement that was up for review with a view to it becoming a permanent way of working. Plans existed to formalise an arrangement once this way of working was confirmed. There were operational arrangements for the management and oversight of the consultants and their work plans. However, this arrangement carried the risk that the trust did not have a safeguard if issues arose in the service provided by consultants not employed by them or covered by any formal arrangement.

Management of risk, issues and performance

There were systems and processes which aimed to provide assurance in relation to the management of issues and performance in end of life care. Incidents were reviewed at the end of life care group meetings, and we saw evidence of evaluation of themes in the minutes of these meetings. Learning was disseminated via the SPEOL team, and link nurses. Staff on wards told us they were aware of key learning from end of life related incidents.

The end of life service had a risk register, but this was not comprehensive and did not clearly detail how risks could be managed and mitigated. The end of life executive lead, and clinical lead were aware that the risk register was not fulfilling its purpose. However, we were not assured that it took sufficient priority within the management of the service. This meant there was a risk that key issues, for example the completion of treatment escalation plans, were not managed, mitigated or sighted effectively by the trust.

There was a risk to the delivery of end of life care caused by insufficient numbers of consultants to cover demand. This meant that consultants were working beyond their capacity to meet demand and was not sustainable. This had been raised at previous inspections, but no increase in capacity had been secured at the time of our visit.

The end of life service took part in the national audit of care at the end of life (NACEL) and we saw evidence of a programme of clinical internal audit to monitor quality and operational pressures. However, of the audits that were completed, we did not see that they carried with them an action plan that identified actions to be taken as a result. The audits identified a “limited level of assurance” about the design and operation of controls.

The mortuary had a major incident plan, agreed in conjunction with the local county council and the trust’s incident planning lead. There were extra capacity spaces, which could take a further 24 bodies if needed, but this was often used during normal business, especially over bank holiday periods, and so the resilience of the mortuary to extra demand was limited.
Information management

We saw the specialist palliative and end of life care annual report, 2017 to 2018. This provided information about the composition and delivery of, the specialist palliative care team. Included in the report was information on staffing – both medical, nursing and allied health professionals. It also included information on the challenges to service delivery. This was provided to the trust and used to understand activity and plan for anticipated demand.

Staff completed up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update. Staff had access to the information they required to provide good patient care. Information about end of life care, for example anticipatory medicines, was available on the wards. Policies and protocols could be accessed through the trust’s intranet.

Engagement

We saw little evidence of engagement with the public, patients or relatives to gain feedback into the service. No surveys had been undertaken that asked the question about whether the end of life service had met the needs of patients, and so it was not possible to see how any involvement had helped to shape the service delivered.

The bereavement office collected feedback from comment cards given to those close to the deceased to record their thoughts. The information was evaluated monthly by the manager and used to inform improvements to the bereavement service.

We did not see any evidence of staff involvement in the shaping of end of life care at the trust. None of the staff we spoke with in clinical areas had been asked to give any feedback on the services that end of life patients received.

All the wards we visited had an end of life link nurse. The role of this nurse was to attend regular meetings and feedback key information about end of life care to their colleagues.

Learning, continuous improvement and innovation

To address the lack of resilience in the consultant cover within the SPEOL service, the trust had joined forces with the local hospice to form an “in reach” service. In effect this meant that trust and hospice used the consultants across both services to provide cover. Whilst this didn’t increase the level of medical cover within the team, it did allow for additional resilience within the service which minimised disruption.

The consultants in the SPEOL team had received a nomination for a British Medical Journal award, following a study addressing the benefits of early interventions for patients in oncology.

Since our last inspection, leadership and delivery of end of life care at the trust had improved. The learning from the CQC inspection and recommendations were built into an end of life improvement plan which was monitored by the end of life group and report on progress provided to the quality assurance committee. Leadership structure, and communication to and from leadership was more effective and clear. The increase in the size and reach of the SPEOL meant that it was better able to support the end of life delivery at the trust and focus more on the delivery of education to front line staff.

Outpatients

Facts and data about this service
Outpatient services are delivered by Royal Cornwall Hospitals Trust (RCHT) by the clinical divisions at the main hospital site, Treliske, and several community sites.

There is a central outpatient booking team which supports most of specialties (62%). The remaining areas are booked at a local level within the specialties.

There are three main outpatient departments within the trust accommodating several outpatient services and several specialties.

The majority of outpatient activity is delivered at the three main trust sites (Royal Cornwall Hospital, St Michael's Hospital and West Cornwall Hospital), with 85% of outpatient activity delivered across these sites. The remainder of care and treatment provided by the outpatient service included 13% from community hospitals and the remaining 2% from a variety of sites including health centres and GP practices.

Leadership of and responsibility for outpatient services by role across the trust is described as follows:

- Clinical/specialty lead – responsible for clinical delivery/risk.
- Directorate/senior manager – Responsible for managing capacity and demand;
- Nurse in charge/AHP lead – Responsible for the environment and line management of clinical staff

Outpatient services are delivered via numerous models such as advice and guidance, nurse led, one stop clinics and open access clinics.

(Source: Routine Provider Information Request (RPIR) - Acute Context)

During this inspection, across all three sites we spoke with 14 patients and their families and 32 members of staff at all levels. We also reviewed 18 sets of records.

**Total number of first and follow up appointments compared to England**

The trust had 533,400 first and follow up outpatient appointments from March 2017 to February 2018. The graph below represents how this compares to other trusts.

(Source: HES - Outpatient)
Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from March 2017 to February 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital (Treliske)</td>
<td>527,838</td>
</tr>
<tr>
<td>West Cornwall Hospital (Penzance)</td>
<td>57,186</td>
</tr>
<tr>
<td>St Michael's Hospital</td>
<td>44,796</td>
</tr>
<tr>
<td>St Austell Community Hospital</td>
<td>29,044</td>
</tr>
<tr>
<td>Bodmin Hospital</td>
<td>24,813</td>
</tr>
<tr>
<td>This Trust</td>
<td>751,457</td>
</tr>
<tr>
<td>England</td>
<td>105,591,489</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from March 2017 to February 2018. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Royal Cornwall Hospitals NHS Trust from March 2017 to February 2018 by site and type of appointment

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Staff were mostly up to date with their mandatory training. All staff had received training in health and safety through trust induction. Updated targets for most mandatory training modules were met. Where gaps did occur, this was due in part, to long term sickness or maternity leave. When all mandatory training was complete, and staff were fully complaint, they were fully informed of the latest practices, legislation and guidance.

The mandatory training package included health and safety, major incident awareness, accident reporting and minor incident investigation and basic life support. Staff we spoke with said there had been an improved drive on mandatory training and education throughout the trust.

Learning was delivered in various formats. This included e-learning and classroom sessions. Staff preferred classroom sessions and felt the e-learning packages did not embed their learning needs.
There was improved compliance with mandatory training compared to our previous inspection in July 2017, however the trust was still under compliant with six out of 12 mandatory training modules against the trusts target of 95% compliance. This is shown in the charts below. The trust had identified a need to improve on their patient manual handling compliance and had reached out to an external provider to facilitate further training.

Senior nursing staff confirmed they monitored training monthly and received notification when a staff member required an update. Staff also received an ‘update due’ e-mail.

**Mandatory training completion rates**

The trust set a target of 95% for completion of mandatory training.

**Trust wide**

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for nursing and medical staff in outpatients trust wide is shown below:

**Mandatory training completion by module – medical staff – Trust wide**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling - object</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for all but one of the 11 mandatory training modules shown above for medical staff. Adult basic life support training had the lowest completion rate with 50%.

(Source: Routine Provider Information Request (RPIR) –Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that the one member of eligible medical staff in outpatients trust wide had completed all the applicable modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Name of course</td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust Target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

Mandatory training completion by module – nursing staff – Trust wide

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation</td>
<td>4</td>
<td>3</td>
<td>133.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>60</td>
<td>60</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>68</td>
<td>68</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>68</td>
<td>68</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>68</td>
<td>68</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>67</td>
<td>68</td>
<td>98.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>63</td>
<td>68</td>
<td>92.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>62</td>
<td>68</td>
<td>91.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>62</td>
<td>68</td>
<td>91.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>61</td>
<td>68</td>
<td>89.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>60</td>
<td>68</td>
<td>88.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>37</td>
<td>68</td>
<td>54.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for six of the 12 mandatory training modules shown above for nursing staff. Resuscitation training had the highest completion rate with 133.3%, although this was based on four staff trained compared to three eligible staff.

The lowest module was manual handling (people) with 54.4%

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in outpatients trust wide met the target of 95% for eight of the 12 applicable modules, with an overall completion rate of 91.9%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>69</td>
<td>69</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>59</td>
<td>59</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>69</td>
<td>69</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>68</td>
<td>69</td>
<td>98.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>67</td>
<td>69</td>
<td>97.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>66</td>
<td>69</td>
<td>95.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>66</td>
<td>69</td>
<td>95.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>66</td>
<td>69</td>
<td>95.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>65</td>
<td>69</td>
<td>94.2%</td>
</tr>
</tbody>
</table>
A breakdown of compliance for mandatory courses from May 2017 to April 2018 for nursing and medical staff in outpatients at Royal Cornwall Hospital is shown below:

**Mandatory training completion by module – medical staff – Royal Cornwall Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling - object</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for all but one of the 11 mandatory training modules shown above for medical staff. Adult basic life support training had the lowest completion rate with 50%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that the one member of eligible medical staff in outpatients at Royal Cornwall Hospital had completed all the applicable modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Health and Safety (Slips, Trips and Falls) 1 1 100.0% 95% Yes
Infection Prevention (Level 1) 1 1 100.0% 95% Yes

(Source: Updated data provided by the trust)

Mandatory training completion by module – nursing staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>43</td>
<td>43</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>50</td>
<td>51</td>
<td>98.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>47</td>
<td>51</td>
<td>92.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>47</td>
<td>51</td>
<td>92.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>46</td>
<td>51</td>
<td>90.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>46</td>
<td>51</td>
<td>90.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>45</td>
<td>51</td>
<td>88.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>29</td>
<td>51</td>
<td>56.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for six of the 12 mandatory training modules shown above for nursing staff at Royal Cornwall Hospital. Manual handling (people) training had the lowest completion rate with 57%.

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in outpatients at Royal Cornwall Hospital met the target of 95% for five of the 12 applicable modules, with an overall completion rate of 90.8%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>52</td>
<td>52</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>42</td>
<td>42</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>52</td>
<td>52</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>51</td>
<td>52</td>
<td>98.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>50</td>
<td>52</td>
<td>96.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>49</td>
<td>52</td>
<td>94.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>49</td>
<td>52</td>
<td>94.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>49</td>
<td>52</td>
<td>94.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS\CSTF\Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>48</td>
<td>52</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>42</td>
<td>52</td>
<td>80.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>29</td>
<td>52</td>
<td>55.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS\CSTF\Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year</td>
<td>0</td>
<td>3</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
West Cornwall Hospital

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for nursing staff in outpatients at West Cornwall Hospital is shown below:

Mandatory training completion by module – nursing staff – West Cornwall Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>11</td>
<td>12</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>11</td>
<td>12</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>11</td>
<td>12</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>6</td>
<td>12</td>
<td>50.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>1</td>
<td>0</td>
<td>n/a</td>
<td>95%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

The 95% target was met for seven of the 12 mandatory training modules shown above for nursing staff at West Cornwall Hospital. Manual handling (people) training had the lowest completion rate with 50%. There was an additional member of staff which completed the resuscitation training module although none were eligible during this reporting period.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in outpatients at West Cornwall Hospital met the target of 95% for nine of the 11 applicable modules, with an overall completion rate of 94.7%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>10</td>
<td>12</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>7</td>
<td>12</td>
<td>58.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
St Michael’s Hospital

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for nursing staff in outpatients at St Michael’s Hospital is shown below:

Mandatory training completion by module – nursing staff – St Michael’s Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 95% target was met for all the 11 mandatory training modules shown above for nursing staff at St Michael’s Hospital.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in outpatients at St Michael’s Hospital met the target of 95% for 10 of the 11 applicable modules, with an overall completion rate of 96.4%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Resuscitation - Level 2 - Adult Basic Life Support - 1 Year</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>3</td>
<td>5</td>
<td>60.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

West Cornwall Hospital
Overall, staff at West Cornwall hospital were compliant with mandatory training. There was a lack of compliance by one member of staff out of 12 in infection control, fire safety and adult basic life support mandatory training modules. This was due to one staff member being off on long term sickness. Gaps in compliance for manual handling training included a member of staff on long term sickness and two members of staff who were not required to complete this training. This was due to their role within the department and not working clinically. The remaining staff were overdue for personal reasons this was due to be addressed at the first available opportunity.

Staff had access to their individual mandatory training record which were held electronically. The records identified whether they were compliant, non-compliant or needed to book onto a refresher course. Mandatory training compliance was reviewed and discussed at the monthly governance meeting.

St Michaels Hospital

Staff working for the outpatient department at St Michael’s hospital were fully compliant with mandatory training. Staff had access to their individual mandatory training record which was held electronically. The records identified whether they were compliant, non-compliant or needed to book onto a refresher course.

Safeguarding

Royal Cornwall Hospital

Staff had not completed level three safeguarding children training which did not ensure the safety of children attending the department. There were trust policies and procedures to ensure adults and children were appropriately safeguarded. These followed current legislation and national guidelines. We found in date polices for safeguarding women and children with, or at risk of, female genital mutilation and people at risk of domestic violence.

All staff knew their responsibilities to safeguard children and adults from abuse. This reflected relevant legislation and local policies and procedures. They could clearly describe an escalation process to ensure action was taken.

A safeguarding flow chart was displayed in various outpatient clinics which gave staff clear steps to follow if they had safeguarding concerns.

Information about how to report safeguarding concerns and further safeguarding adults’ information was displayed in outpatient clinics, for patients to follow, if they had concerns.

The safeguarding lead and safeguarding team were well known to staff in the outpatient clinics. Staff felt confident they could approach them for advice or concerns at any time.

West Cornwall Hospital

There were systems and processes to keep people safeguarded from abuse. Staff had access to safeguarding policies which reflected relevant legislation and local requirements. The policies provided a flow chart for staff to follow if they needed to raise a safeguarding concern. All staff had received child safeguarding training to level three.

Staff at West Cornwall Hospital were nearly fully compliant with mandatory training. Compliance with safeguarding adults level two was due to one member of staff not having attended the course due to being on long term sick.

St Michaels Hospital

There were systems and processes to keep people safeguarded from abuse. Staff had access to safeguarding policies which reflected relevant legislation and local requirements. The policies
provided a flow chart for staff to follow if they needed to raise a safeguarding concern. All staff had received child safeguarding training to level three.

Staff understood their responsibility to report safeguarding incidents and provided us with an example of a safeguarding concern they had recently reported.

Staff were provided with feedback regarding the outcome of safeguarding referral they had made. Staff were able to tell us the initial outcome for the patient and told us would be provided with further feedback once the case had been concluded.

**Safeguarding training completion rates**

Most staff were fully complaint with safeguarding training. Reduced compliance with safeguarding adults level two was due to of staff not having attended the course due to being on long term sick or maternity leave.

The trust set a target of 95% for completion of safeguarding training.

National guidance states that staff should be trained to a minimum of level three child safeguarding in clinical areas where children are directly treated by healthcare professionals. Children attended outpatient clinics across the three main hospital sites. Following the inspection, we requested compliance data for the outpatient department for level three safeguarding children training. Data provided did not identify compliance for the outpatient department staff across all three sites with this training, and only identified two nurses as eligible to carry out this training. Therefore, we were not assured that staff had the correct training to identify child safeguarding risks.

**Trust wide**

A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for nursing and medical staff in outpatients trust wide is shown below:

**Safeguarding training completion by module – medical staff – Trust wide**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 2)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 95% target was met for all four safeguarding training modules for which medical staff in outpatients were eligible.

*(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)*

Updated training data provided by the trust for the period April to August 2018 indicates that the one member of eligible medical staff in outpatients trust wide had completed all the applicable modules.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 2)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The 95% target was met for two of the four safeguarding training modules for which nursing staff in outpatients were eligible. Safeguarding children (level three) had the lowest completion rate as neither of the two eligible staff had completed the course. Safeguarding adults (level two) had the next lowest completion rate with 89.7%. This was due to long term sickness and maternity leave.

Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in outpatients trust wide met the 95% target for four of the five modules, with a compliance rate of 97.5% overall. Compliance improved for three modules when compared to the initial time period.

The 95% target was met for all four safeguarding training modules for which medical staff in outpatients were eligible.

Updated training data provided by the trust for the period April to August 2018 indicates that the one member of eligible medical staff in outpatients at Royal Cornwall Hospital had completed all the applicable modules.
The 95% target was met for two of the five safeguarding training modules for which nursing staff in outpatients at Royal Cornwall Hospital were eligible. Safeguarding children (level three) had the lowest completion rate as neither of the two eligible staff had completed the course. Safeguarding adults (level two) had the next lowest completion rate with 90.2%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in outpatients at Royal Cornwall Hospital met the 95% target for two of the five modules, with a compliance rate of 96.7% overall. Compliance improved for three modules when compared to the initial time period.

(Source: Updated data provided by the trust)

West Cornwall Hospital
A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for nursing staff in outpatients at West Cornwall Hospital is shown below:

(Safeguarding training completion by module – nursing staff – West Cornwall Hospital)
The 95% target was met for three of the four safeguarding training modules for which nursing staff in outpatients at West Cornwall Hospital were eligible. Safeguarding adults (level two) had the lowest completion rate with 91.7%.

Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in outpatients at West Cornwall Hospital met the 95% target for all four modules, with a compliance rate of 100%. Compliance improved for one module when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 2)</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

**St Michael’s Hospital**

A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for nursing staff in outpatients at St Michael’s Hospital is shown below:

**Safeguarding training completion by module – nursing staff – St Michael’s Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 2)</td>
<td>5</td>
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<td>95%</td>
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<td>95%</td>
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</tr>
<tr>
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<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 95% target was met for three of the four safeguarding training modules for which nursing staff in outpatients at St Michael’s Hospital were eligible. Safeguarding adults (level two) had the lowest completion rate with 80%, although this is based on a low number of staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated data provided by the trust for the period April to August 2018 indicated that nursing staff in outpatients at St Michael’s Hospital met the 95% target for all four modules, with a compliance rate of 100%. This was the same when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
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<tr>
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<td>100.0%</td>
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<td>Yes</td>
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<tr>
<td>Safeguarding adults (level 2)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

**Cleanliness, infection control and hygiene**
Royal Cornwall Hospital

Patients and staff were mostly protected against the risk or spread of infection. Cleanliness and infection control had improved significantly in areas where we found the greatest risk in our 2017 inspection. For example, the fracture clinic had received substantial investment to improve its overall infection control. This was done by replacing fixtures and furnishings that complied with infection and prevention control guidelines.

However, there were still concerns found in other clinics. The cancer care clinic in the sunrise centre had fabric chairs in treatment rooms which do not allow a deep clean and have the potential to retain infection risks. Additionally, there were chairs that had large tears in the fabric and the inner foam exposed. This was not in line with the Health Building Note (HBN) 00-09: Infection control in the built environment. We brought this to the attention of the nurse in charge at the time and they agreed this was a concern, however, no immediate action was taken to escalate this concern.

In ophthalmology, the seating area had high visibility, easy clean seating. However, these seats were aging and were beginning to show signs of accumulated wear and tear with an un-defined black residue on the seats. This posed an infection control risk to patients.

The department was not meeting the Department of Health, Health Building Note 00-10, Part- A, flooring. This document advises against the use of carpets in clinical areas. In cardiology, the cardiac pacing room had a worn carpet which was ingrained with dirt, despite the rest of the clinic having impervious and easy to clean flooring. Cardiology also had a mix of worn fabric chairs in treatment rooms alongside easy to clean non-fabric chairs.

Outpatient hand hygiene results were compliant across the clinics with most clinics scoring in the region of 98%-100%. Some staff we spoke with were aware of their clinic’s performance with regards to hand hygiene. Hand hygiene audits were displayed in some waiting areas, but not all.

Hand washing facilities and sanitising gel were available throughout the department and we observed staff using these regularly. All staff we saw were ‘bare below the elbow’ in clinical areas, in line with national guidance.

Regular environmental hygiene audits for the outpatient department were carried out. Audit results indicated that standards in June, July and August 2018 were between 90% and 100% within the outpatient department. The trust’s target for compliance was 85%. Information from these audits showed any required actions and ownership for those key actions where required.

We were told that precautions were taken in the outpatients setting and people with either known or suspected communicable diseases like infectious diarrhoea, tuberculosis or seasonal flu were placed at the end of the lists and deep cleaning was carried out when they left the room. Standards of cleanliness and hygiene were generally maintained within the outpatient’s department. For example, we saw cleaning schedules in various departments and observed cleaning of equipment. We saw the “I am clean” stickers on equipment that had been cleaned.

There were reliable systems to protect and prevent people from healthcare-associated infections. For example, the outpatient department had dedicated infection prevention and control nurses. We observed “I am clean labels” were used on all equipment in clinics and daily cleaning checks were documented.

There was sufficient personal protective equipment (PPE) throughout the department and it was used appropriately by staff when required.

West Cornwall Hospital
Standards of cleanliness and hygiene were maintained and there were reliable systems to prevent and protect people from health-associated infection. All areas we visited were clean, hygienic and clutter free.

Staff adhered to the trusts ‘bare below the elbow ’policy and applied good handwashing techniques. There were hand-washing sinks available in all departments and consulting rooms. At each sink there was liquid soap, paper towels and pedal bins. Hand hygiene audits were completed monthly, with 10 being completed each month assessing the nurses and the visiting clinicians. Audits for the last eight months between January and August 2018 identified 100% compliance with infection control practices.

Personal protective equipment (disposable gloves and aprons) were readily available in all departments and we saw staff using them appropriately. Cleaning wipes were available in consulting rooms to clean equipment between patients which we saw staff using.

Hand hygiene was promoted for visitors and patients. Gel dispensers and hand hygiene posters were clearly visible. We regularly saw visitors and patients use the gel dispensers when entering the department.

An external cleaning company attended the outpatient department in the morning daily and followed a daily cleaning schedule. This ensured the cleanliness of the department was maintained. An audit was completed between the nurse in charge and the cleaning company. Results for the audits completed in January, April and July 2018 demonstrated 100% compliance with cleaning schedules.

The service was compliant with internal weekly cleaning schedules carried out by staff within the department. There was a weekly cleaning schedule setting out cleaning tasks which had to be carried out. This was audited monthly, with the department demonstrating 100% compliance with weekly cleaning schedules.

Toys in the waiting areas were made from materials that were easily cleaned and the toys were washed weekly. Chairs in all waiting areas had wipe-clean surfaces.

St Michaels Hospital

Staff adhered to the trusts ‘bare below the elbow ’policy and applied good handwashing techniques. There were hand-washing sinks available in all departments and consulting rooms. At each sink was also liquid soap, paper towels and pedal bins. Hand hygiene audits were completed monthly, with 10 being completed each month assessing the nurses and the visiting clinicians. Audits for the last eight months between January and August 2018 identified 100% compliance in all but April and July 2018 which identified 50% compliance. Compliance was low due to clinicians not being bare below the elbow during clinics. This was addressed with the individual at the time of the both clinics.

Personal protective equipment (disposable gloves and aprons) were readily available to staff in all departments in line with national guidance.

An external cleaning company attended the outpatient department in the morning daily and followed a daily cleaning schedule. This ensured the cleanliness of the department was maintained. An audit was completed between the nurse in charge and the cleaning company. Results for the audits completed in February, May and August 2018 demonstrated 100% compliance with cleaning schedules.

The service was compliant with internal weekly cleaning schedules carried out by staff within the department. There was a weekly cleaning schedule setting out cleaning tasks which had to be
carried out. This was audited monthly, with the department demonstrating 100% compliance with weekly cleaning schedules.

**Environment and equipment**

**Royal Cornwall Hospital**

The facilities and premises of outpatients were designed in a way that mostly keep people safe.

Substantial improvements to environmental issues improved patient safety in fracture clinic. In July 2017 we found that the environment of the fracture clinic did not always keep people safe. During that inspection, we found that patients who had to keep a leg elevated due to the nature of their fracture were at risk of having their leg knocked into. This was because there was no provision to protect them. During this inspection, we found adequate amounts of leg supports and space to enable patients to keep their leg elevated safely.

Provision of suitable children’s waiting areas was available in most clinics. The fracture clinic offered a small area for children. This area had improved its environment and allowed staff to monitor the children’s areas via a mirrored security window. The children’s area also had partial screening to ensure privacy from being overseen by adult patients.

Issues with the air flow and high temperatures had been resolved and the fracture clinic was comfortable, bright and airy.

A business case was put forwards in November 2017 to potentially relocate the fracture clinic to another part of the hospital site. This was being developed and managed by the estates team and the service lead. This business case and proposal to move was still being reviewed during at the time of our inspection.

A member of the cardiology team had voiced the potential for both patient harm and environmental concerns at several governance meetings. Whilst this was minuted, they felt nothing was being done to address their concerns. Concerns were raised about the cardiac specialist nurse office was not fit for purpose and posed a risk of patient harm. During the inspection, we observed staff taking calls from patients. In an overcrowded and noisy office, cardiac specialists took calls from patients who were requesting support, advice or passing on cardiac anomalies to the receiving specialist. In an already noisy environment, the specialist was required to concentrate on the caller’s information and decide or diagnose and further advise the patient. Staff were concerned in this noisy environment that the use of a standard telephone handset did not protect the caller’s confidentiality or allow the specialist to hear properly due to noise and inappropriate equipment. This meant there was a risk that the clinician could miss hear or miss diagnose due to external distractions.

Most of the medical devices and equipment were in date with servicing and well maintained. There was a rolling schedule of planned preventative maintenance. We found a patient monitor in the cardiology department which had a sticker instructing staff not to use past July 2018, however, it was still in use. Staff told us they had informed the medical physics department of this and were still waiting for guidance. We could not be assured that this device was correctly calibrated to measure both a patient’s blood pressure or the amount of oxygenated blood in the patient’s cardiovascular system or pulse rate.

There were facilities in the gynaecology unit to perform minor invasive treatments such as hysteroscopy, the removal of fibroids or polyps, and colonoscopies. This meant patients who required these procedures could access them in a timely manner, without joining the trusts main surgical waiting lists.
Emergency equipment was well maintained. We found the resuscitation trolleys were all sealed with tamper-evident seals and all dates were correct and inspected regularly by clinic staff.

Hazardous waste and by-products were safely managed. We observed staff maintaining safe storage and management of clinical waste and sharps, such as hypodermic needles. For example, in the dermatology department, we saw clinical specimens and waste stored in line with national guidance.

Equipment we looked at was visibly clean and stored appropriately. The trust used “I am clean” stickers to identify clean equipment. We observed stickers on equipment in different outpatient areas that identified they were clean.

West Cornwall Hospital

The environment of the outpatient department was not ideal for all patient groups attending the department. These patient groups included patients attending in adapted wheelchairs or stretchers. Staff in the outpatient department were aware of the environmental challenges the department posed to providing good quality care. West Cornwall Hospital was an ageing building with tired facilities. The environmental layout of the building, including the small, narrow corridors and the narrow lift access posed an issue for patients attending the department in large adapted wheelchairs and on stretchers. Staff were very aware of this problem and proactively planned for patients attending the department who may not be able to access it. They did this by using facilities and clinic rooms in other areas of the hospital which were more easily accessible to these patient groups.

Staff provided us with examples of when they had used the facilities of another department to carry out appointments. Staff told us there was good collaborative working onsite with other departments to support them to manage this issue. Relatives we spoke with who had attended the department with the patient told us how they had not found access to the department easy due to the ageing facilities, particularly for one patient attending in a wheelchair.

There were ongoing maintenance issues at West Cornwall hospital which had been escalated to the corporate risk register. These included plumbing works to mend old leaking pipes above the outpatient department. At the time of the inspection work was ongoing to manage the problems. Staff told us the work had cause no disruption to services. Despite the issues, staff had made the best of the facilities they had, for example, by painting the waiting rooms bright colours.

The stock room was well organised and tidy, and equipment was not stored of the floor. This meant the room was easier to clean. Consumables were stored in labelled boxes on shelves and the sample of consumables we reviewed were all in date.

Individual clinic trolleys had been set up for clinics to manage limited space in the clinic rooms. Each trolley contained all the equipment and consumables which may be required during the clinic. This was moved to the clinic room prior to the start of the clinic. Staff were responsible for ensuring there was adequate stock on the trolley and that consumables had not reached their expiry date.

Resuscitation equipment was fit for purpose and daily checks on equipment were carried out. Monthly audits were completed regarding resuscitation trolley checks, the department had achieved full compliance between January and August 2018. We also saw records of daily checks which were signed once completed. Additional notes were made about equipment which was near it expiry date and any actions taken or which would be required. The resuscitation trolley was also fitted with a tamper evident seal to avoid patients or members of the public accessing medicines stored in the trolley.
Confidentiality was a problem in one waiting area of the outpatient department. We were told the building was ageing and the walls were thin and there was a risk that consultations in clinic rooms could be heard by patients in the waiting room. To overcome this problem, music was played into the area to reduce the risk of patient confidentiality being breached.

Clinical waste was managed appropriately to protect patients and staff. There were systems for managing hazardous waste in accordance with The Safe Management and Disposal of Healthcare Waste (Department of Health, 2013). When disposing of single use items, staff segregated clinical waste from general waste denoted by different coloured bin liners.

The lack of current electrical testing meant that electrical equipment in the department could impact on patient and staff safety. Portable electrical testing was out of date in the department. Stickers on electrical equipment identified checks had not been carried out on some equipment since 2015, 2016 and 2017. We raised this issue to the nurse in charge who escalated this, however we were provided with no feedback regarding any action which was going to be taken.

St Michaels Hospital

Facilities and premises of outpatients were being upgraded to improve the environment and facilities for patients. The refurbishment ensured the environment was fit for purpose to provide safe care and treatment for patients. Areas subject to building work were covered up and safety notices displayed. The building works had been carefully planned to ensure there was no disruption to outpatient services. The outpatient nurse leads confirmed there had been no impact to the department throughout the refurbishment works.

One of the outpatient department clinic areas, the porta cabin consulting area, posed an environmental challenge which made access difficult for some patient groups. However, staff were proactive in managing this issue. The corridors were too narrow for wheelchair users, however when staff were made aware that a wheelchair user was attending the clinic, an alternative consultation rooms was found for the patient. The porta cabin consulting area had undergone recent redecoration.

There was access to a resuscitation trolley which was stored in the vascular unit. This was checked daily to ensure all the required equipment was available and had not been tampered with. Daily checks were documented. The trolley was sealed with a tamper-evident seal. Audits completed demonstrated the department was fully compliant between January and August 2018 with their resuscitation trolley checks.

Equipment was regularly maintained, calibrated and serviced to keep people safe. We saw stickers on equipment with dates of when the equipment had been checked or when it was due to be checked. All equipment we saw were in date.

Assessing and responding to patient risk

Royal Cornwall Hospital

Processes to assess and respond to patient risk had improved but continued to place some ophthalmic patients at risk. Incidents identifying significant patient harm were still occurring which we also identified during previous inspections. Serious incident investigations identified four ophthalmology patients which had come to harm in 2018. Investigations into these incidents showed patients had come to harm due to delays associated with waiting lists. A new “fail safe” policy to identify the most at risk patients had only recently started and the results of its effectiveness had not yet been assessed.
Cardiology continued to improve in assessing and responding to patient risk. Patients were risk assessed based on an improved risk stratification process. This process cross referenced information associated with patients who were most at risk of harm. All patients when referred to the service were routinely vetted. This process enabled risks to be identified and alternative clinical pathways to be determined. All patients who went over their “to be seen” date were reviewed monthly to identify alternative pathways or to book an appointment.

Comprehensive risk assessments were carried out for people who used services in outpatients and risk management plans were developed in line with national guidance.

There were clear procedures for the care of patients who became unwell or patients who deteriorated while waiting at the clinic. Staff we spoke with told us about emergency procedures and the escalation process for unwell and deteriorating patients using the national early warning scores (NEWS). Staff had received training in the use of NEWS charts for identify and monitoring deteriorating patients. However, they stated this was not used often as the department did not often have acutely unwell patients.

Reception staff knew what to do if a patient’s health deteriorated in the waiting area. They said they would call for a nurse or phone for the emergency response team. Staff were able to give examples of this and described how they were fully supported by the nursing staff.

The hospital had systems and processes for responding to patient risk. Staff were available in all the waiting areas of the clinics, so they would detect patients who appeared unwell and needed assistance. Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for people living with dementia or learning disability, and elderly or frail patients with more than one medical condition. We were told patients were assessed during their first visit to the department and recorded in patient’s notes. This would include any flagged issues such as dementia or learning difficulties.

The World Health Organisation (WHO) Five Steps to Safer Surgery checklist, designed to prevent avoidable harm, was in use for patients undergoing invasive procedures, for example in dermatology. We found this was recently audited and the service was shown to be compliant. Actions were dated, and an individual was given ownership to ensure the action was completed.

All staff we spoke with knew where the nearest resuscitation trolley was and knew whose responsibility it was to get the trolley in an emergency.

West Cornwall Hospital

There were emergency call bells in the department and in each clinic room. This enabled staff to call for assistance if a patient started to deteriorate or a situation arose where they needed support from other staff within the department.

Risks to children using the service were assessed and monitored. The trust had a policy to manage the risks if a child was not brought in, had an appointment cancelled or an appointment for them was refused. The policy provided guidance to staff about how to manage these events. In turn this would support the staff to identify any risks or child safeguarding concerns. Staff were aware of this policy and had access to it via the staff intranet. The policy identified procedures which had to be followed in the event the above situations occurred, along with a list of the information which needed to be recorded and documented.

St Michaels Hospital

Risks to people using the service were assessed and monitored. In the pre-operative assessment clinic, nursing staff completed full patient assessment to identify their baseline condition. The
assessments included a full medical history, current medication and a full range of observations and other relevant tests required for the procedure they were being assessed for. This information was used to plan treatments and any special requirements the patient had prior to and post-surgery.

Risks to children using the service were assessed and monitored. The trust had a policy to manage the risks if a child was not brought in, had an appointment cancelled or an appointment for them was refused. The policy provided guidance to staff about how to manage these events. In turn this would support the staff to identify any risks or child safeguarding concerns. Staff were aware of this policy and had access to it via the staff intranet. The policy identified procedures which had to be followed in the event the above situations occurred, along with a list of the information which needed to be recorded and documented.

Staff received training in basic life support and had access to emergency resuscitation equipment in case a patient deteriorated whilst at a clinic.

**Staffing**

**Royal Cornwall Hospital**

Staffing levels mostly kept patients safe. One matron was assigned to oversee the management of the entire outpatient’s service across all the registered locations. On each hospital site the matron was supported by a team of sisters/charge nurses.

There was no requirement for a specific acuity or dependency tool to be used to determine staffing levels in the outpatient department. The outpatient clinics were staffed by registered nurses and health care assistants. Each clinic was run by registered nurses and was supported clinical nurse specialists and by health care assistants. There was a good range of staffing skill mix across the clinics.

Nursing staff working in the outpatient’s department felt there were sufficient numbers of staff to support the clinics. Specialities such as diabetes, ear nose and throat and dermatology supplied their own clinical nurse specialists to support clinics.

Agency and bank staff were not frequently used to fill vacancies. We were told in the event where agency staff were required, a local induction would be given to the agency staff.

**West Cornwall Hospital**

There was no requirement for a specific acuity or dependency tool to be used to determine staffing levels in the outpatient department. There were twelve members of staff working within the department. There was a skill mix including healthcare assistants, band five nurses and one band six member of staff who managed the department. All the staff had the required skills to run the clinics held at the department. There had to be a minimum of one band five nurse, one healthcare assistant and one receptionist available for every shift.

At the time of the inspection, the department was currently over established. This was due to a member of staff from another department joining the team to provide cover for the long-term sickness within the team. This member of staff had provided cover from May 2018 and was due to return to their department two weeks following our inspection.

**St Michaels Hospital**

There was no requirement for a specific acuity or dependency tool to be used to determine staffing levels in the outpatient department. There were six members of staff working within the department. There was a skill mix including healthcare assistants, band five nurses and one band six member of staff who managed the department. All the staff had the required skills to run the clinics held at the department. There had to be a minimum of one band five nurse, one healthcare assistant and one receptionist available for every shift.

At the time of the inspection, the department was currently over established. This was due to a member of staff from another department joining the team to provide cover for the long-term sickness within the team. This member of staff had provided cover from May 2018 and was due to return to their department two weeks following our inspection.
six member of staff who managed the department. All the staff had the required skills to run the clinics held at the department.

**Planned vs actual**

The trust has reported their staffing numbers below as at April 2018 for nursing staff in outpatients, with an overall staffing rate of 96.9%.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Planned WTE Staff</th>
<th>Number in post as at April 2018</th>
<th>Staffing rate (%)</th>
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</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>50.2</td>
<td>48.3</td>
<td>96.2%</td>
</tr>
<tr>
<td>West Cornwall Hospital</td>
<td>2.7</td>
<td>3.0</td>
<td>Over-established by 9.5%</td>
</tr>
<tr>
<td>St Michael’s Hospital</td>
<td>2.84</td>
<td>2.48</td>
<td>96.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>56.7</strong></td>
<td><strong>55.0</strong></td>
<td><strong>96.9%</strong></td>
</tr>
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</table>

* (Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From May 2017 to April 2018, the trust reported a vacancy rate of 12% in outpatients, compared to the trust target of 10% at March 2018 and 6% at March 2019. A site breakdown is below:

- Royal Cornwall Hospital: 14.1%
- West Cornwall Hospital: 4.1%
- St Michael’s Hospital: 0.36%

* (Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**West Cornwall Hospital**

There was a 4.1% vacancy rate within the department at West Cornwall Hospital. This vacancy was for reception staff. Recruitment was required to manage future changes to the department, for example extending the opening times until 5.30pm. There was a requirement to have two reception staff available on each shift. This was to provide cover during breaks and to manage the increasing demands of the role, for example management of the medical records at the end of clinics.

**St Michaels Hospital**

There was a 0.36 WTE vacancy within the department. We were told that this post would not be recruited into until a vacancy arose within the department where the hours could be added onto the 13.5 hours currently available. This was due to the post being more desirable with more hours to offer a new member of staff. There was enough staff currently working in the department to run the clinics and provide cover for annual leave or sickness if required.

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 10.2% in outpatients, compared to the trust level target range of 10-14%. A site breakdown is below:

- Royal Cornwall Hospital: 13.8%
- West Cornwall Hospital: 0%
- St Michael’s Hospital: 0%

* (Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From May 2017 to April 2018, the trust reported a sickness rate of 5.2% in outpatients, compared to the trust target of 3.8%. A site breakdown is below:
- Royal Cornwall Hospital: 4.3%
- West Cornwall Hospital: 5.4%
- St Michael’s Hospital: 15.6%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

St Michaels Hospital

Between May 2017 and April 2018, there had been a high rate of sickness at St Michaels hospital. This accounted for one member of staff who was on long term sick leave for six months and one member of staff who was on sick leave for six weeks. To ensure there was no disruption to the service, bank staff were used to cover the shifts. The service tried to use the same bank staff to ensure consistency within the department and to cause minimal disruption to the service.

Medical staffing

Royal Cornwall Hospital

There was sufficient medical staffing to keep patients safe. Individual medical and surgical specialities were responsible for arranging clinical support for their clinics. Due to the nature of how services were configured, medical and surgical staff were required to work across a range of sites to maintain outpatient clinics.

West Cornwall Hospital

Medical staff attended West Cornwall Hospital to run outpatient clinics to provide care closer to home for patients. Outpatient clinics were staffed by consultants whose main base was at Royal Cornwall Hospital. Clinics were arranged in advance and consultants had set clinic times where they attended the hospital.

St Michaels Hospital

Medical staff attended St Michaels Hospital to run outpatient clinics to provide care closer to home for patients. Outpatient clinics were staffed by consultants whose main base was at Royal Cornwall Hospital. Clinics were arranged in advance and consultants had set clinic times where they attended the hospital.

Vacancy rates

From May 2017 to April 2018, the trust reported an over establishment of 11.3% in outpatients at Royal Cornwall Hospital, compared to the trust level target of 10% at March 2018 and 6% at March 2019. However, this is based on very small numbers which have inflated the rate.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From May 2017 to April 2018, the trust reported a turnover rate of 0.0% in outpatients at Royal Cornwall Hospital, compared to the trust level target range of 10-14%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 8.9% in outpatients at Royal Cornwall Hospital, compared to the trust target of 3.8%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage
From May 2017 to April 2018, the trust reported no shifts filled by locum staff or left unfilled in outpatients.

(Source: Routine Provider Information Request (RPIR) – Bank Agency Locum)

**Records**

**Royal Cornwall Hospital**

Patient records were not always completed in a timely way. Due to staffing issues in oncology outpatients, letters sent to the patient’s doctors were getting delayed. In July 2018 there were 1010 delayed letters, of which 40% were delayed over seven days. The longest delay for a letter was 27 days. This could impact on the care arranged by the GP once the hospital has sent their diagnosis or treatment plan. In response to this, the trust had brought in temporary staff to manage the backlog.

The 18 Individual care records we reviewed were written and managed in a way that kept people safe. The trust continued its path towards a completely digital records system. However, in the records we reviewed, not all patients had height or weight recorded. In five records out of 18 we found this information to be missing.

Patient records took account of medical and social history, which was clearly recorded. There was also documentation of patient information, next of kin and clear information if the patient had carers. Multidisciplinary team involvement was fully recorded and rationale for clinical decisions were clearly described.

Confidential patient notes were stored securely in the clinic areas we visited. Records were locked in secure trolleys. We also noted that computer monitors had security features to obscure patient information from people who were close to the computer user. This ensure the confidential of patient records.

There were systems for managing records. These systems were monitored, and expansions planned. Space and storage of paper notes remained a significant pressure for the trust. The trust had aimed to be completely paper free by March 2018. This would have meant all patient records were electronically scanned and archived resulting in improved data management, security and retrieval for files and notes. However, this has not happened due to investment and software issues.

There was system to ensure patient information was available in the absence of patient notes. Staff demonstrated the practice of generating a temporary folder when paper files were not available in clinics by obtaining the relevant information from the electronic copy. This could mean appointments would take place with all the relevant information which might be important for their care or treatment.

**West Cornwall Hospital**

Individual care records were not always stored securely in the outpatient department. Records were brought up to the department either the day prior or on the day of the outpatient clinic. Patient records would remain in the reception office until they were collected for each individual clinic appointment. There was no lock on the reception door, however the reception office was never left unattended at any stage throughout the day. However, at night, notes would be left in an unlocked office meaning there was a risk to patient confidentiality.

Confidentiality of patient’s individual records was maintained when notes were in use during clinic. The hospital had a system of placing the patient records face down so that no information was on
display. When the consultant had finished with the record, the record would be placed faced down or put straight into a record bag so that the information remained confidential.

There was a system to ensure consultants had access to patient’s recent records when records were not available for clinics. Staff were aware of the system to follow if records were not available. This involved making a temporary paper folder and extracting available information from the electronic system. At the end of the clinic, this information would be sent to medical records to be filed in the main patient record. We requested audit results following the inspection to identify the availability of clinic records for clinics held. We were told that this was not monitored for the outpatient clinics held in the community hospitals due to the records being prepared by community hospital staff.

We looked at 11 patient records from a selection of outpatient clinics. Care records were accurate, complete, legible and up-to-date. Alert stickers highlighting allergies were visible on records and details entered within the inside cover.

St Michaels Hospital

Patients individual care records were managed and stored in a way which kept people safe. Most outpatient clinics used paper records, however, orthopaedics had recently introduced an electronic record for patient notes. This was due to happen across all specialities for the outpatient service, however staff were unaware of the timeframe for this.

Individual care records were stored securely. Records were brought up to the department either the day prior or on the day of the outpatient clinic. Patient records would remain in a locked office (with keypad entry on the door). The office was never left unattended during the day. If the receptionist needed to leave the office, a nurse would provide cover, so the office was never unattended. At the end of a clinic, notes were returned to medical records.

There was a system to ensure consultants had access to patient’s recent records when records were not available for clinics. Staff were aware of the system to follow if records were not available. This involved making a temporary paper folder and extracting available information from the electronic system. At the end of the clinic, this information would be sent to medical records to be filed in the main patient record. We requested audit results to identify the availability of clinic records for clinics held. We were told that this was not monitored for the outpatient clinics held in the community hospitals due to the records being prepared by community hospital staff.

Individual care records were stored securely in the outpatient department in lockable trollies. The main reception area used computer records to book patients in when they arrived for their appointment. The computer screen was not visible to patients and the paper clinic list was covered so they could not be seen by patients.

People’s individual care records we saw were accurate, complete, legible and up-to-date. We looked at 10 patient records from a selection of different outpatient clinics. All records contained relevant contact details and allergies were highlighted by stickers, if applicable.

Medicines

Royal Cornwall Hospital

Medicines were prescribed, administered and supplied to people in line with current relevant legislation.

All medicines we checked were stored safely and securely. This included medical gases. We checked medicines’ refrigerators and found temperatures were checked and recorded in line with
trust policy. Staff spoke to pharmacy if the temperatures were outside the permitted range. We found there were timely actions taken if this occurred.

NHS prescription forms (known as FP10’s) were securely locked away when not in use. When a prescription pad was needed, it was signed for and returned at the end of the clinic to ensure all prescription pads were accounted for. We checked these records and found no prescription pads missing. In oncology, there was an electronic prescription system.

Nursing and medical staff were aware of policies on administration of controlled drugs as per the Nursing and Midwifery Council (NMC) – Standards for Medicine Management (CSF).

Pharmacy undertook ongoing monitoring of all refrigerators in the trust including those in outpatients via a Wi-Fi temperature monitoring system. We found evidence of this being completed and actioned.

Emergency medicines were available on resuscitation trolleys. These were recorded as being checked daily. We checked emergency medicines which were in date.

The ophthalmology service had information guides for patients about medicines, such as eye drops. These leaflets described how to take medicines, the purpose of the medicines being prescribed, and which side effects to look out for. These were available in different languages and in large print where needed which were provided to patients along with their medicines.

West Cornwall Hospital

The management, storage and administration of medicines in the outpatient department kept patients safe. Medicines were stored in a locked room and only accessible by the nursing staff who accessed the keys from a locked safe in the reception area. Medicines were stored in a locked cupboard and refrigerator. No controlled drugs were administered from the outpatient department.

Refrigerator temperatures were monitored daily. We reviewed documentation of completed checks between May and August 2018 which had all been completed. There was a procedure for staff to follow if refrigerator temperatures fell outside the expected range. A document was located next to the fridge to remind staff of the procedure to follow, which staff were familiar with.

Prescription pads (FP10) were used in the main outpatient department and were stored securely in a locked cupboard, in a locked room, along with the medicines. Each speciality within the department had their own specific prescription pads. There was a system which ensured individual records of each prescription issued were maintained. This meant that prescriptions would be traceable in the event of a problem.

The traceability of FP10s was poor, however the trust was aware this was a problem and ongoing work was being carried out to address this. We reviewed the records of the issued FP10s, of which we identified a small number of FP10s missing. This meant these FP10s were not traceable and there was no record of how these FP10s had been used.

A recent audit presented to the medicine practice committee in August 2018 had identified issues in following up on missing FP10s and minutes of meetings identified this issue had been discussed at the medicines safety committee. We saw evidence of a discussion held at the medicine practice committee and a discussion between the chief pharmacist and medical director. We also saw the copy of the letter sent to divisional leads on 31 August 2018. The letter detailed the new procedure and outcome of compliance was not met with the new procedure to ensure traceability of all the FP10s. We also saw the updated FP10 standard operating procedure reflecting the change to procedures.
We found two oxygen cannisters which were out of date from 2016 and 2017 in the department. We escalated this to the lead nurse during the inspection. Action was taken immediately to replace the oxygen. We returned the following day and saw two new in date cannisters had been provided to the department.

St Michaels Hospital

The management, storage and administration of medicines in the outpatient department kept patients safe. Eye drops, for example, used in the outpatient department were appropriately stored and accessible only by departmental staff. The outpatient department did not administer controlled drugs, and therefore, did not store controlled drugs. Of the samples we checked, all medicines were in date.

Refrigerator temperatures were remotely monitored by pharmacy on the main site. There was a procedure for reporting temperatures outside of the normal range and the staff had procedures for storing medicines from the refrigerator until it was repaired.

Prescription pads were used in the main outpatient department and were stored in a locked cupboard, in a locked room. Prescription pads were issued and stored by speciality and there was a procedure for signing in the prescription pads when they arrived. Each speciality was allocated an audit sheet whereby when a prescription was written the sheet was completed with prescription number, NHS number, date and consultant signature.

The traceability of FP10s was poor, however the trust was aware this was a problem and ongoing work was being carried out to address this. We reviewed the records of the issued FP10s, of which we identified a small number of FP10s missing. This meant these FP10s were not traceable and there was no record of how these FP10s had been used.

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Incidents

Royal Cornwall Hospital

Staff understood their responsibilities to raise concerns, including how to record safety incidents and near misses and then report them, although not all staff felt empowered to report all incidents. Also, there was still issues of patient harm being reported as identified during our previous inspection in June 2018.

A formal process was used for reporting, investigating and learning from incidents, errors or near miss situations. Nursing and other clinical staff we spoke with described the system they used and the investigating process. For example, we were told by staff that incidents were recorded on the trust wide electronic reporting system and externally to the National Reporting and Learning System (NRLS). The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports.

Staff reported patient safety incidents, via their local risk management systems. Individual incidents were discussed in meetings and minutes of the meetings confirmed there was shared
learning because of incident reporting. We saw corroborating evidence of this in trust governance meeting minutes.

Incidents were identified through medical records audits. We were told that medication errors went to the medical safety group and errors were extracted, fed back trust wide and shared for learning.

Clinical governance and departmental meetings provided staff with the opportunity for discussion of incidents. All incidents were investigated using a root cause analysis tool, considering the factors which may have contributed to the incident. The managers we spoke with confirmed information relating to reported incidents was collated and discussed at clinical governance meetings.

Not all staff felt empowered to support all incidents. During the inspection, some staff told us they had been reprimanded for reporting incidents they felt were appropriate to submit. This meant staff were less likely to report an incident regarding patient safety so learning and actions could not be taken to make improvements to improve the quality of the service and service delivery.

The Strategic Executive Information System (STEIS) captured all Serious Incidents. Where an incident in outpatient serious incident reporting 2015 criteria, it was managed through the trust’s Serious Incidents investigation process as per the ‘Serious Incidents Framework’. More information can be found below. The most common theme for outpatients was delays in treatment causing patient harm or death, this included the incidents described below.

Incidents identifying significant patient harm were still occurring which we also identified during previous inspections. For example, serious incident investigations identified four ophthalmology patients which had come to harm in 2018. Investigations into these incidents showed patients had come to harm due to delays associated with waiting lists. Following this, the trust had acted to reduce the risk of harm to patients. However, at the time of the inspection, we were unable to ascertain if this system was successful. This was because the actions taken had only recently been implemented and there was not enough data to identify the effectiveness of the action taken.

Staff demonstrated knowledge and understanding of the duty of candour regulations during our inspection. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Serious incident reports showed that the duty of candour requirement had been considered. For the serious incidents we reviewed, we could see duty of candour had been applied to these incidents.

Staff we spoke with were able to describe what the duty of candour involved, and the actions required, even if they did not understand the terminology. Staff were also aware of the trust’s guidance and how to access this.

West Cornwall Hospital

Staff understood their responsibilities to raise concerns, to record safety incidents and near misses. Staff told us about a recent incident which had occurred in the department involving control of substance hazardous to health (COSHH). This was shared with the whole team the following day at the morning safety huddle. Other incidents which staff reported included clinic cancellations.

Staff received feedback regarding incidents which had occurred in the department. We saw information which had been raised at the daily huddle meeting with regards to the COSHH incident which had occurred recently in the department.
There had been six incidents reported by the outpatient department between March and August 2018. These incidents included two health and safety incidents, one documentation issue, one appointments and booking issue, one laboratory investigation issue and one incident related to infrastructure and resource. Out of the six incidents, four were ongoing awaiting final investigations.

No serious incidents had occurred at St Michael’s hospital within a year prior to our inspection.

Staff demonstrated an understanding of their responsibilities with regards to the duty of candour and could discuss what this meant. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Information was available around the department about duty of candour and this had recently been a ‘Hot Topic’ sent around to the staff via the senior management team to remind staff of the responsibilities regarding the duty of candour. There had been no incidents in the last year where duty of candour had been applied at West Cornwall Hospital.

St Michaels Hospital

Staff understood their responsibilities to raise concerns, to record safety incidents and near misses. There had been three incidents reported by the outpatient department between March and August 2018. These incidents included a documentation issue, clinical assessment and treatment and an occupational health issue. Only one incident remained open and was awaiting final approval and sign off.

No serious incidents had occurred at St Michael’s hospital within a year prior to our inspection. Staff demonstrated an understanding of their responsibilities with regards to the duty of candour and could discuss what this meant. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Information was available around the department about duty of candour and this had recently been a ‘Hot Topic’ sent around to the staff via the senior management team to remind staff of the responsibilities regarding the duty of candour. There had been no incidents in the last year where duty of candour had been applied at St Michael’s hospital.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From June 2017 to May 2018, the trust reported no incidents classified as a never event for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from June 2017 to May 2018. These were for:

- Treatment delay meeting SI criteria: eight, (66.7% of all incidents)
- Medication incident meeting SI criteria: two (16.7% of all incidents)
- Surgical/invasive procedure incident meeting SI criteria: one (8.3% of all incidents)
VTE meeting SI criterial: one (8.3% of all incidents)
(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

Clinical teams within cardiology, dermatology and the fracture clinic were all seen to have access to and utilised a range of best practice guidance from the National Institute of Health and Care Excellence, Royal Colleges and other national best practice sources. For example, in dermatology, there was evidence of adherence to best practice guidelines and National Institute for Health and Care Excellence standards. We also found forms and protocols in line with guidance for example from the British Association of Dermatology.

Outpatients clinics used evidenced based care and treatments. We saw evidence that specialities within outpatient department delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and other national guidelines. For example, we looked at notes in the cardiac unit and saw that patients were consented for procedures. We also found in the pain clinic that patients were given a diary to record their individual pain scores and this was further used to carry out patient centred pain assessments.

Staff had access to trust policies and procedures. They demonstrated how to access policies and procedures on the trust intranet. We were shown policies and procedures on pain management, equality and diversity and safeguarding.

Staff described how they flagged urgent reports to GPs and followed this up to ensure the report and its recommendations had been followed up. We saw the department had a standard operating procedure to deal with unexpected findings. Staff were aware of this and competent in its use.

West Cornwall Hospital

Care and treatment provided was underpinned by the relevant standards, legislation and evidence-based guidance. For example, national Institute of Health and Care excellence guidance was used to optimise care and treatment for patients at the falls clinic (CG161).

Staff had access to policies and procedures via an internal internet system. All staff could access the online documents and we observed staff referring to the trust policies to ensure the appropriate care was given.

St Michaels Hospital

The outpatient services used relevant evidence based best practice guidance and standards to develop how services, care and treatment was delivered.

Best practice guidance had been used to develop criteria to determine patient consideration for anaesthetic review at the pre-assessment clinic. The American Society of Anaesthesiologists ASA physical status classification system was used, along with National Institute of Health and Clinical Excellence guidelines. The ASA standards are a physical status classification system for assessing the fitness of patients before surgery. This ensure that care and treatment provided is safe for each individual patient. The evidence based surgical outcome risk tool (SORT) was also used to determine risk factors for surgery. We were told there no audit was carried out to identify compliance against the guidelines or to identify areas for service improvement.

Staff had access to policies and procedures via an internal internet system. All staff could access the online documents and we observed staff referring to the trust policies to ensure the appropriate care was given.
Nutrition and hydration

Royal Cornwall Hospital

The outpatient departments helped maintain the nutrition and hydration needs of patients. The outpatient departments had systems to provide sandwiches for patients waiting in the department either post procedure or waiting for transport home.

People’s nutrition and hydration needs were assessed and met. For example, we observed that caffeine free drinks and vegetarian food was offered to patients with specific dietary requirements.

Water was available for patients who attended outpatient clinics which was easily accessible in the patient waiting areas. This meant patients could keep themselves hydrated whilst waiting to be seen by a clinician. Staff also offered food and drinks to patients who had been waiting for long periods of time for their appointment from their arrival at the clinic.

West Cornwall Hospital

The nutritional and hydration need for patients and their relatives attending the hospital were met. Patients and their relatives had access to the hospital canteen. They also had access to a vending machine in the department waiting room. Volunteers worked in the department five days a week and provided tea and coffee to patients waiting for their appointments.

St Michaels Hospital

The nutritional and hydration need for patients and their relatives attending the hospital were met. Patients and their relatives had access to the hospital canteen. Free coffee, tea and biscuits were provided to patients who had waited more than 30 minutes for their appointment at the department.

Pain relief

Royal Cornwall Hospital

Patient’s pain was assessed and managed effectively during outpatient clinics. There was a dedicated pain clinic, which took referrals from GPs, consultants and other departments within the hospital. This service was well used, with a multidisciplinary approach to pain management.

A holistic approach to pain management was taken by the multi-professional pain management service which included nurses, physiotherapists, occupational therapists, clinical psychologists and pharmacy. They used self-rated pain assessments and visual analogue questionnaires (a measurement tool usually between one and ten where patients rate their pain on the scale) to monitor pain. These were adapted for children to be more accessible to them, for example the use of carton faces to indicate pain levels experienced by the child.

Pain was assessed and managed for each individual patient in a variety of different ways. For example, patients in the pain management department were given a pain diary and a 12-week telephone follow-up appointment. During the telephone appointment, the effectiveness of patient’s injection treatment and diary results was discussed. This meant patients were clearly able to articulate if their pain had reduced, if they slept better, if their mobility had improved and if their quality of life had improved.

West Cornwall Hospital

Patient’s pain was assessed and managed effectively during outpatient clinics. Staff could demonstrate methods available to them for the management of patient’s pain and how to escalate complex pain management problems. We saw regular pain management interactions, including pain scoring and referral to pain clinics and pain relief was prescribed within the clinics and then
dispensed at the pharmacy. We saw patients were provided with information about managing their pain.

A consultant described having a holistic approach when managing a patient’s pain and explained that they worked closely with other colleagues when managing pain. We observed a patient in the fracture clinic discussing continuing pain and the consultant discussing options for pain relief, including reducing duties at work.

Staff could explain that a person’s pain could be assessed and managed for those people where there were difficulties with communication. Staff explained that they had access to interpreters and patients with learning difficulties were prioritised in the clinic and an advocate would be available, through the community, to assist those with additional needs.

**St Michaels Hospital**

Patient’s pain was assessed and managed effectively during outpatient clinics. There was no formal pain assessment in use in the outpatient department and pain was assessed using informal methods including direct questioning and observation during assessments and consultations.

We saw a consultant using pain as a diagnostic factor and relating this pain to the patient’s condition. We heard the consultant discuss treatment options to reduce the pain and providing further information on the treatment and pain relief options.

Staff in the outpatient clinic were seen reconfirming pain relief options after the patient’s appointment and providing information leaflets where necessary.

Staff could demonstrate methods available to them for the management of patient’s pain and how to escalate complex pain management problems. We saw regular pain management interactions, including pain scoring and referral to pain clinics. We saw patients provided with written guidance to support management of their pain.

Pain relief was managed, and reviewed, in the outpatient clinics we visited. Pain relief was prescribed within the clinics and then dispensed at the off-site chemist.

**Patient outcomes**

**Royal Cornwall Hospital**

There was no specific patient reported outcome measure data collected for the overall outpatient service, however each speciality collected their own clinical data for monitoring and national benchmarking. For example, in dermatology, patient outcomes were completed for every patient. New patients were asked to complete a survey regarding lifestyle and the preferred outcome from treatment. This would then be used to assess improvements and initiate discharge from the service if outcomes were achieved.

Outcome data remained confusing between the outpatient specialities, as we found in the 2017 inspection. For example, in general outpatients, it was hard for staff to demonstrate how a given clinic’s outcome data reflected how well the clinic was performing. Staff said this was due to many clinics being under the surgical specialties management rather than outpatient specific clinics.

Outpatient clinics participated in both local and national audits, benchmarking, accreditation, and peer review. From these audits, we saw actions were taken to improve patient outcomes. For example, the department had introduced more effective ways to inform patients of their appointments. The aim of this was to reduce the number of patients which did not attend clinic appointments.

**West Cornwall Hospital**
Patient outcome information was collected for each clinic, however, despite this data being recorded it was not used routinely to review patient outcomes and identify areas for service improvement. This meant there was a missed opportunity to identify areas for service improvement.

Information was collected by staff at the start and end of each clinic. This included information about the arranged start time and the actual start time and identified patients who waited over 30 minutes and over an hour for their appointments. Data was then entered onto a spreadsheet which was held electronically to provide an overview of clinics which regularly ran late and how long patients were having to wait for their appointments.

We were told that this data was not routinely requested to provide a better understanding as to the challenges faced with the clinics in the department. We were given an example of how the data was used recently to support a review of the ophthalmology clinics as these were repeatedly over running. Changes were made to the schedule and improvements were seen, however these were short lived due to the addition of a junior member of staff carrying out clinics and the consultant needing to provide support.

**St Michaels Hospital**

Information about the outcomes of patients care and treatment was not routinely collected and monitored to identify service improvement. We asked what information was collected to identify patient outcomes which could identify areas for service improvement. We were shown the friends and family test which had been introduced in the department. This had been introduced only a matter of weeks prior to our inspection. No data was collected regarding individual patient outcomes following clinics or about appointment waiting times.

**Follow-up to new rate**

From March 2017 to February 2018, the follow-up to new rate for Royal Cornwall Hospital (Treliske) was lower than the England average.

The follow-up to new rate for West Cornwall Hospital (Penzance) was higher (better) than the England average and for St Michael's Hospital the follow-up to new rate was like the England average.

**Follow-up to new rate, Royal Cornwall Hospitals NHS Trust**

(Source: Hospital Episode Statistics)
Competent staff

Royal Cornwall Hospital

Staff were competent within their roles. The trust’s appraisal policy stated all staff were required to have an annual appraisal using the job description and person specification for their post. Staff we spoke with told us they had received appraisals.

Managers discussed training needs at annual appraisals and nursing staff told us opportunities to develop their knowledge and skills were available for which they received support from the trust. For example, specialist nurses were supported to re-validate their roles and access appropriate training.

Staff were encouraged to attend courses to develop their knowledge and skills. For example, we spoke to senior staff who told us they were going to do the nurse prescribing course next year.

The cardiology clinic had two staff who were supported on their master's degree in cardiac science. The cardiac department had recently been nationally recognised and awarded as an accredited training department by the National School of Healthcare Science. This meant the trust was recognised as a place of excellence for cardiac education.

The cardiology department trained all staff who use an electro cardiogram (ECG) in their work. This was linked to the in-service staff training plan and showed as a red flag when they were due to refresh their training.

Knowledge and skills were shared to optimise care and treatment for patients. We observed a range of specialist nurses including ophthalmology, oncology, and dermatology working within the outpatient departments providing nurse-led clinics alongside medical colleagues. Staff shared their clinical skills and knowledge with other members staff which made for a productive working environment and a better patient experience.

Staff completed trust and local induction specific for their roles. We saw completed documentation in staff files showing successful completion of local induction.

West Cornwall Hospital

Staff had access to role specific training if required. Training was carried out in-house for each speciality when required. For example, the nurses had recently received training from the lead respiratory nurse regarding the use of a new spirometer (a device to help diagnose and monitor certain lung conditions) which had been introduced to a clinic. Two sessions were carried out to capture all staff to ensure their competency and their ability to carry out their role within the specific clinic.

An appraisal system was used to identify the learning needs of staff. At the time of our inspection only one member of staff within the department had not completed their yearly appraisal. This member of staff was on long term sick leave. Nursing staff also received support and advice about their revalidation for the nursing and Midwifery Council.

Staff were encouraged to develop within their roles. The lead nurse for the department attended mentor training to provide mentorship support for a member of staff in the department training for an assistant practitioner role.

St Michaels Hospital

Staff had access to inhouse training to develop their knowledge and skills. Staff told us any training they required for any speciality was carried out within the department by the speciality.
There was no formal induction for staff joining the department, however staff could work supernumerary shifts (additional staffing to the workforce on a specific shift) as part of their induction into the department. During the inspection one member of staff was carrying out their second shift. They told us working as a supernumerary member of staff was a good way to get used to the department and to understand what was required. We were told new staff carried out supernumerary shifts for one week on joining the department, however this could be extended if required until the member of staff felt confident.

An appraisal system was used to identify the learning needs of staff. At the time of our inspection all staff within the department had completed their yearly appraisal. Nursing staff also received support and advice about their revalidation for the nursing and Midwifery Council.

The pre-assessment clinic nurses attended study days to ensure they maintained their competencies to carry out their role. A local study day was held twice a year at which staff would be provided with the most up to date information and training to carry out their role effectively. Outside of the study days, staff spoke highly of the attending consultants to the clinic and the support they provided with complex patients. Staff had also received in-house training to read blood results and had been provided with training and support cards for triage of echocardiograms (a scan which can show how well the heart is working).

**Appraisal rates**

**Trust wide**

Up to August 2018, 86% of nursing staff and the one member of medical staff within outpatients at the trust had received an appraisal compared to a trust target of 95%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ambulance service staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>19</td>
<td>21</td>
<td>90.5%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>42</td>
<td>49</td>
<td>85.7%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>52</td>
<td>61</td>
<td>85.2%</td>
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<tr>
<td>Qualified Allied Health Professionals</td>
<td>51</td>
<td>61</td>
<td>83.6%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

**Royal Cornwall Hospital:**

At Royal Cornwall Hospital, 80.0% of nursing staff and the one member of medical staff within outpatients had received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
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<tbody>
<tr>
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<tr>
<td>Qualified Healthcare Scientists</td>
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<td>100.0%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>19</td>
<td>21</td>
<td>90.5%</td>
</tr>
</tbody>
</table>
Support to doctors and nursing staff | 31 | 37 | 83.8%
Qualified Allied Health Professionals | 51 | 61 | 83.6%
Qualified nursing & health visiting staff | 36 | 45 | 80.0%
Other Qualified Scientific, Therapeutic & Technical staff | 3 | 6 | 50.0%

St Michael’s Hospital:
All five nursing staff within outpatients at St Michael’s Hospital had received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

West Cornwall Hospital:
At West Cornwall Hospital, all 11 nursing staff within outpatients had received an appraisal compared to a trust target of 95%.

<table>
<thead>
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<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
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<td>11</td>
<td>100%</td>
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<tr>
<td>Support to doctors and nursing staff</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Royal Cornwall Hospital
Staff worked together to assess and plan ongoing care and treatment in timely manner. For example, we were told that multidisciplinary meetings were held in the dermatology department and were usually attended by skin cancer consultants, plastic surgeons and specialist nurses.

There were multidisciplinary one-stop clinics, such as in urology and the breast clinic. At these clinics, patients could access consultations, diagnostics, results and clinical nurse specialists in one appointment. This made for a better patient experience and due to the provision of more joined up working.

Staff worked together to assess and plan on-going care and treatment in a timely way. This included when people were due to move between teams or services, including referral, discharge and transition. This was confirmed by a patient who felt that their consultant had managed their care very well, whilst liaising with another healthcare provider.

Oncology teams worked closely with other specialities and ran joint clinics to enable patients to see both specialists at the same time. This made better use of time and resources and a better experience for the patient. The clinics were supported by specialist nurses who were also able to give support and advice to patients, providing a more holistic approach to care and treatment.

The cardiac and respiratory physiologists worked closely with the medical specialists to ensure the appropriate investigations were performed at the right time.

West Cornwall Hospital
There was evidence of effective multidisciplinary working within the outpatient team. Staff were involved in assessing, planning and delivering patient care and treatment.
A consultant told us that during monthly governance meetings that learning was shared. They told us that they felt able to approach other disciplines to ensure a good outcome for their patient.

Staff worked well with different teams to provide effective care for patients. Staff told us of the Acute Liaison Team for patients with learning disabilities to provide support to patient attending outpatient clinics. They explained that they could contact them for support and advice when caring for a patient with learning disabilities.

St Michaels Hospital
Staff readily shared, and sought, knowledge with other departments in the hospital to improve patient care. The outpatient lead explained that she would readily contact other departments if they felt they needed additional support in the outpatient department.

Staff told us of the Learning Disability Team in the community who would support patients with severe learning disabilities during their outpatient appointment and told us they knew how to access this support.

Recently staff had worked at the main hospital site to update their skills. They told us that they had shared these new skills and knowledge with their local colleagues.

**Seven-day services**

Royal Cornwall Hospital
Not all outpatient services were available seven days per week. There was, however, provision for additional clinics to be provided on Saturdays to assist with outpatient backlogs. For example, the ophthalmology service provided day clinics on Saturday to help manage demand.

Main outpatient clinics ran from 8am until 6pm Monday to Friday, with further clinics on Saturdays and Sundays to meet demand as required.

The oncology outpatient service did not provide weekend or evening clinics, but there was an out of hours oncologist available 24 hours per day, seven days a week.

West Cornwall Hospital
The outpatient services at St Michael’s hospital ran Monday to Friday between 9am and 5 pm. No weekend or out of hours services were provided.

St Michaels Hospital
The outpatient services at St Michael’s hospital ran Monday to Friday between 9am and 5 pm. No weekend or out of hours services were provided.

Health promotion

The trust provided a wellbeing service for patients to support patients to manage their health and wellbeing. Patients referred to this service were given advice and support on a range of issues. These included smoking cessation, weight loss, being more active, drinking less alcohol, and support to manage lifestyle changes.

There was a team of staff who could be contacted to provide additional support and advise health coaching programmes. For example, managing alcohol or diet.

West Cornwall Hospital
Information was provided in the department to support national priorities to improve the local populations health and wellbeing. This included health promotion smoking cessation and health and wellbeing.
St Michaels Hospital
Information was provided in the department to support national priorities to improve the local populations health and wellbeing. This included health promotion smoking cessation and health and wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Royal Cornwall Hospital
Staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity. Staff demonstrated a knowledge and understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Patients were given appropriate time to consent and relatives with power of attorney would consent. For example, a young patient attended a clinic with her father who had parental responsibility and consented for her.

Patients gave verbal consent in the outpatient clinics for dressings and examinations. For example, in the ophthalmology children’s clinic in West Cornwall hospital, we saw staff gaining consent from both the child and adult before undergoing examination.

The trust had a policy and protocols for obtaining consent before medical treatment was given. We observed a patient consultation in the outpatient department where the clinician gave comprehensive explanations of the treatment required prior to gaining the patients consent. The nurse also checked the patients understanding.

Nurses could clearly articulate an understanding of Deprivation of Liberty Safeguards (DOLs) and the Mental Capacity Act (MCA) and described what they would do if they had a patient that required MCA or DOLs.

West Cornwall Hospital
Staff demonstrated an understanding of consent and decision-making requirements under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act and Deprivation of Liberty Safeguards training was incorporated into the safeguarding training.

Staff said that patients had consent procedures explained to them by the consultant, or specialist nurse at the time of consultation. We saw staff gain consent during the fracture clinic and saw a consultant reconfirm consent when they felt that the consent might not have been understood.

Patient consent was gained at the time of the patient’s consultation in the outpatient department. For example, in the ophthalmology children’s clinic, we saw staff gaining consent from both the child and adult before undergoing examination.

Patients were adequately supported to make decisions about their care. We observed clear explanations from consultants who explained information to patients in a variety of ways, depending upon the patient’s age and understanding. Nursing staff provided reassurance when patients had further questions about processes and procedures.

Patients with mental health, dementia or learning disabilities were supported to make decisions. Where necessary staff knew where to seek help or advice from the Learning disability team, mental health team or dementia specialists within the trust.

St Michaels Hospital
Staff demonstrated an understanding of consent and decision-making requirements under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act and Deprivation of Liberty Safeguards training was incorporated into the safeguarding training.
Patients had consent procedures explained to them by the consultant, or specialist nurse at the time of consultation. During our visit we saw a consultant gain consent during an examination.

Patients with mental health, dementia or learning disabilities were supported to make decisions. Where necessary staff knew where to seek help or advice from the Learning disability team, mental health team or dementia specialists within the trust.

There were no patients detained under the Mental Health Act. Staff understood where they should seek advice if they needed it.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that from May 2017 to April 2018 Mental Capacity Act (MCA) level one training has been completed by 100% of staff within outpatients trust wide, including two members of medical staff who were both based at Royal Cornwall Hospital.

A breakdown by site for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
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</thead>
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</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level 1 training had been completed by all staff within outpatients at the trust.

<table>
<thead>
<tr>
<th>Site</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
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<td>24</td>
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<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Updated data provided by the trust)

**Is the service caring?**

**Compassionate care**

Royal Cornwall Hospital

Throughout our inspection, we saw patients were treated with compassion, kindness, dignity and respect. Staff also respected patients’ social, cultural and religious needs.

Staff took the time to interact with people who use the service and those close to them in a respectful and considerate way. We heard staff introduce themselves, using the ‘hello my name is…’ to both patient and those supporting the patients.

Patients and relatives told us staff were kind and they introduced themselves to patients attending the clinics. We observed positive interactions between staff, patients and relatives. We saw staff taking the time to interact in a considerate and sensitive manner. We saw how frequent or long-term patients attending clinics had built up relationships with staff. These patients told us they felt at ease in their care.

We spoke with 12 patients and relatives from outpatient clinics including fracture, dermatology, ophthalmology, medical oncology. They all spoke highly of the care they had received and
described staff as ‘brilliant’ and ‘supportive’. Two patients said staff were caring, knowledgeable and had a passion for their work.

Patients had their dignity maintained. Patients were directed to separate waiting areas and discreet changing facilities for appointments which required hospital gowns, to protect their dignity. We saw staff respecting patients’ privacy and dignity, for example by knocking on doors to consultation rooms.

Staff explained their role and responsibilities as recommended in the National Institute for Health and Care Excellence (NICE) QS15 patient experience and adult NHS services.

Patients were given the opportunity to be accompanied by a friend or relative for their outpatient appointment and there were chaperones available when personal care was provided. For example, female nurses or healthcare assistants were available to act as chaperones in all appointments in the breast clinic.

Staff were aware that patients had differing cultural, social and religious needs and were able to explain what this meant for their care. For example, staff told us how patients with different faiths needed appropriate places to worship and access to food to meet their dietary requirements.

Staff did their best to make patients and their relatives feel at ease. Staff supported patients to use the electronic booking in system and directed them to other departments.

Throughout our inspection we observed care being provided by nursing, medical and other clinical staff. We saw examples of staff being friendly, approachable and professional. For example, when people became lost staff would accompany people to the area in which they should be.

When patients experienced physical pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way. For example, a patient told us that a member of staff had offered to hold their hand during a procedure.

Volunteers assisted patients to the correct waiting areas and sign-posted to other departments. We saw staff and volunteers walk with patients to waiting areas, so they understood where they had to wait.

**West Cornwall Hospital**

Staff took the time to interact with people who use the service and those close to them in a respectful and considerate way. We heard staff introduce themselves, using the ‘hello my name is…’ to both patient and those supporting the patients.

We heard staff explain their role and responsibilities as recommended in the National Institute for Health and Care Excellence (NICE) QS15 patient experience and adult NHS services.

We saw staff and volunteers assisting patients and directing patients to the correct waiting areas and sign-posting to other departments. We saw staff walk with patients to waiting areas, so they understood where they had to wait.

Staff were respectful when patients, and those supporting patients, approached the reception desk. We observed dignity and privacy for these patients by the receptionist lowering their voice, so they could not be overheard. We saw staff smile compassionately at patients and those supporting the patients and being helped.

We observed a clinician show understanding and respect to the cultural and personal needs of a parent with their baby. The clinician responded compassionately to the mother’s concern and took time to explain the care required and the procedure required that day, several times over to ensure that the mother understood exactly what was being said to her.
Staff understood that there were several clinic rooms which were not the most confidential and there was a chance the patient could be overheard. The staff ensured the privacy by playing a radio to ensure privacy.

We saw information offering a chaperone service in the outpatient department. Staff said that there was always a chaperone available.

Patients that we spoke to said that they were treated with dignity and respect. They said that they thought the staff were caring and understood their anxieties.

St Michaels Hospital

We heard staff introduce themselves, using the ‘hello my name is…’ to both patient and those supporting the patients and we heard staff explain their role and responsibilities as recommended in the National Institute for Health and Care Excellence (NICE) QS15 patient experience and adult NHS services.

Volunteers assisted patients to the correct waiting areas and sign-posted to other departments. We saw staff and volunteers walk with patients to waiting areas, so they understood where they had to wait.

We saw staff being respectful when patients, and those supporting patients, approached the reception desk. We observed dignity and privacy for these patients by the receptionist lowering their voice, so they could not be overheard. Staff smiled compassionately at patients and those supporting the patients and being helped.

We observed a clinician respect the physical limitations of a patient and offer to assist them. The clinician was able to signpost the patient to relevant services that was able to offer further support to the patient. The clinician explained the options for treatment and allowed time for the patient to ask questions.

Staff understood that there were several clinic rooms which were not the most confidential and there was a chance the patient could be overheard. The staff ensured privacy by placing patients in alternate rooms, so they could not be overheard.

We saw information offering a chaperone service in the outpatient department. Staff said that there was always staff available to chaperone patients in clinics.

During examinations we saw patients being offered privacy and examined with dignity. Patients were covered appropriately during examinations and consent gained before being examined. Patients that we spoke to said that they were treated with dignity and respect. They said that they thought the staff were caring and understood their anxieties. One patient stated that they thought the staff ‘were very caring and I cannot fault them’.

Emotional support

Royal Cornwall Hospital

Staff throughout the department understood the need to provide emotional support for patients. Patients and relatives told us they felt their emotional wellbeing was cared for at the department. We observed staff providing additional support to patients who seemed anxious, for example when waiting for a mammography (a specialised medical imaging which uses a low-dose x-ray system to see inside the breast).

Consultants were responsible for breaking bad news to patients and described examples of arranging additional support for these patients. For example, patients with cancer had access to a clinical nurse specialist for additional support.
We saw a clinician provide emotional support for a mother and child during their consultation. We heard the clinician discuss treatment options and timescales and the clinician actively encouraging the mother to be part of the decision-making process. We also heard the clinician discuss support networks, including family members, GP, support groups and further clinicians to provide further external support for the family.

Staff treated the patients as individuals and a patient told us ‘it is a very tight-knit community and we all know each other’. We saw another patient being greeted with warmth, staff explained that this patient was an integral member of the community.

Staff spoke kindly to patients and reassuring them during their consultations and procedures.

There was a multi-faith prayer room and a chapel of peace that patients and relatives could access, and services were held for Christians, Buddhists and Muslims.

**West Cornwall Hospital**

Staff in the busy clinics understood the impact that a person’s care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially, and offered emotional support when needed.

We saw a clinician provide emotional support for a mother and child during their consultation. We heard the clinician discuss treatment options and timescales. We saw the mother being encouraged to be part of the decision-making process. We heard the clinician discuss support networks, including family members, GP, support groups and further clinicians.

We observed clinicians interacting with young patients with empathy and support during examinations. Clinicians acknowledged a young patient’s concerns and anxieties.

Staff were able to promptly identify anxious patients and provided emotional support, including enlisting the assistance of volunteers to reassure patients.

Staff treated the patients as individuals and a patient told us ‘it is a very tight-knit community and we all know each other’. We saw another patient being greeted with warmth, staff explained that this patient was an integral member of the community.

**St Michaels Hospital**

In the outpatient clinic a nurse was observed offering emotional support to an elderly patient attending a clinic on their own. The nurse offered to sit with them while they waited for their appointment.

The outpatient department were able to identify patients with individual needs and respond to those needs appropriately. One staff member explained how they would greet a patient with dementia at the front reception and personally walk with them to their waiting area.

**Understanding and involvement of patients and those close to them**

**Royal Cornwall Hospital**

Staff understood the impact that a person’s care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. We heard the clinician discuss treatment options and timescales. We saw the mother being encouraged to be part of the decision-making process. We heard the clinician discuss support networks, including family members, GP, support groups and further clinicians.

Staff communicated with patients and families in ways they could understand, and patients felt they had been encouraged to make their own decisions. For example, patients in the
ophthalmology department told us their condition had been explained to them and they had sufficient information to understand their condition.

After their appointments, most patients were aware of when they would receive test results or next appointment dates.

All the patients we spoke with told us that their care was discussed with them in detail, and in a manner, that they were able to understand. They said, if they had any queries regarding appointments, they would contact individual clinics or medical secretaries.

Patients were given the time to ask questions about their care and treatment to ensure they understood what was happening. This also ensure patients played a central part in their care and treatment. Staff told us that a letter detailing information about their consultation was sent to the patient and their GP following their outpatient consultation.

West Cornwall Hospital

Staff understood the impact that a person’s care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially. We saw a clinician provide further emotional support for a mother and child after their consultation. We heard the clinician discuss treatment options and timescales. We saw the mother being encouraged to be part of the decision-making process. We heard the clinician discuss support networks, including family members, GP, support groups and further clinicians.

Patients were involved in their care and decisions taken. Staff explained in a way they could understand. We heard a consultant explain to a patient why the treatment options for a fracture. These options were explained in several different ways. The patient was given the opportunity to explore these options, with further questioning, and to decide which treatment pathway would suit their living arrangements.

Patients told us that they felt they could access the information, including information given to them during a clinic, to make informed choices. They said they felt confident in raising concerns or asking further questions of any staff member.

St Michaels Hospital

Staff understood the impact that a person’s care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially. We heard staff checking that the patient, or those supporting the patient, understood the information they had been given during their consultation. We saw patients being given the time to understand the information and, if necessary, for this information to be repeated in a different way to ensure that they understood the information given to them.

We heard a clinician wish a wife of a patient ‘happy anniversary’ when the consultation with the husband had finished. This prompted a discussion between the patient, visitors and other staff members about how wonderful the event was.

People were empowered and supported, where necessary, to use and link with support networks so that it will have a positive impact on their health, care and wellbeing. We saw patients, and those supporting the patient, being given information about their treatment and any additional sign-posting.

Patients were given the time to ask questions about their care and treatment to ensure they understood what was happening and to ensure they played a central part in their care and treatment. Staff told us that a letter detailing information about their consultation was sent to the patient and GP following their outpatient consultation.
Staff communicated in a timely way with patients, so they were kept informed. We heard staff explaining to patients where they needed to go and about any clinics which were running late.

Staff understood patients with additional needs and how to provide a person-centred outpatient appointment. Staff explained that if they knew of a patient with mental health, learning difficulties or dementia was due at a clinic that patient would be given priority and taken into the clinic so as not ensure the patient did not become too anxious.

Is the service responsive?

Service delivery to meet the needs of local people

Royal Cornwall Hospital

Services were planned to meet the needs of the local population. For example, to accommodate patients across Cornwall and the Isle of Scilly, outpatient services were provided from Royal Cornwall Hospital and peripheral sites such as West Cornwall Hospital, and St Michaels hospital.

During our inspection in 2017 it was identified that the outpatient department did not always have the capacity to run additional clinics to meet the demands on the service. Since then, the trust had provided additional clinics for outpatient services, such as ophthalmology and cardiology which had seen a noticeable reduction in waiting times. Managers and staff told us they could not always run additional clinics due to staffing and availability of facilities. The trust recognised the issue and was continually reviewing how they utilise their facilities.

Patients were given a choice of which location they preferred to attend when their GP made their referral or via the NHS e-referral service. NHS e-referral service was a national electronic referral system which allowed patients to choose which hospital or clinic they attended and the time of their first outpatient appointment.

The facilities and premises were not always appropriate for the services that were planned and delivered. For example, the environment the outpatient department at RCHT’s fracture clinic did not always allow patient confidentiality to be maintained. Clinic rooms were not all soundproof and patients could be overheard when in consultations. During the inspection, we observed practice and could hear patient confidential information from adjoining rooms.

Provision of suitable children’s waiting areas was available in most clinics. The fracture clinic offered a small area for children. This area had improved its environment and allowed staff to monitor the children’s areas via a mirrored security window. The children’s area also had partial screening to ensure privacy from being overseen by adult patients.

Car parking facilities were available at each site; however, the number of parking bays did not meet demand. There were a limited number of disabled bays which were located at a distance from the outpatient’s department. All patients we spoke with told us that car parking was an issue and added to the anxiety around their appointment. Relatives and patients who had mobility issues told us they found it difficult to get disabled parking and had experienced problems getting to the department.

The main reception had staff to assist patients find clinics, and signs to the department had improved. However, not all patients we spoke with found the department well signposted. Two patients described occasions when they had been late for appointments due to not being able to find the clinic.

Patient appointments were booked around times available for them. Staff discussed how appointments were flexible to suit the patient’s needs. If a patient was unable to drive or get public
transport to their appointment, the hospital car service (for patients who were mobile enough to get in and out of a car) and patient transport was available on request.

Follow-up appointments were offered via telephone in departments such as cardiology and trauma and orthopaedics, to allow patients to access services from their own home.

There was a café and shop at the main reception and waiting areas had water dispensers and vending machines.

**West Cornwall Hospital**

The service provided reflected the needs of the population served and ensured choice, flexibility and continuity of care. Patients living in local communities appreciated the hospital because they could receive care and treatment closer to home rather than having to make the long journey to the main Royal Cornwall site. Patients were offered a choice of appointments at a time to suit them and were able to see their consultant which ensured continuity of care.

When patients’ needs were not met staff used information available to them to improve services. Staff had identified the ophthalmology clinic was always running late meaning patients were experiencing long waits for their appointments. Staff in the department used the information they collected regarding patient outcomes for each individual clinic to escalate the problem to the senior management team. Following this, clinic appointment times were revised.

The environment was patient centred. There were good facilities for people. For example, there was a spacious reception area with an open reception desk which was at a low height, therefore accessible to wheelchair users. In the main outpatient department there were toys available in waiting areas, for children who were waiting for appointments. There were toilets available for patients’ use in all outpatient departments. They included toilets accessible for patients with a disability. There was a café run by volunteers open most week days and vending machines that were stocked with snacks and hot and cold drinks.

The department was clearly signposted and there was a reception desk in the main entrance from where staff could direct patients. The entrance led patients straight to a reception desk from where patients were directed to their waiting area. Each waiting area was colour coded with the signage and the walls being the same colour to help patients identify where they needed to be.

There was sufficient car parking available at the hospital, however parking was limited outside the main outpatient entrance. There was a pay and display car park with spaces allocated for people with a disability outside the main entrance to the hospital. Parking at the entrance to the main outpatient department was limited, with an ambulance turning area taking up a large portion of the area.

**St Michaels Hospital**

The service provided reflected the needs of the population. The hospital brought care closer to home for patients. Consultants from the main Royal Cornwall Hospital site travelled to the hospital so patients did not have to travel so far to see them. There was an open reception desk which was at a low height and therefore accessible to wheelchair users. Toilets were available for patients’ use in all outpatient departments and included the availability of toilets accessible for patients with a disability.

The outpatient department was clearly signposted in the main reception area and there was a receptionist based at the reception desk in the main entrance also directing patients to the department. Waiting areas were numbered within the department, however, as part of the ongoing
refurbishment work, waiting rooms were going to be colour coded with matching signs to make it easier for patients to find where they needed to wait.

Did not attend rate

From March 2017 to February 2018, the ‘did not attend’ rate for Royal Cornwall Hospital (Treliske) was lower than the England average. This was good for patients as the trust had taken steps to improve systems to ensure more patients did not fail to attend their appointments.

The ‘did not attend’ rate for St Michael's Hospital was lower than the England average and for West Cornwall Hospital the ‘did not attend’ rate was lower than the England average, except for October 2017 when the rate was slightly higher than the England average.

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, Royal Cornwall Hospitals NHS Trust

![Graph showing proportion of patients who did not attend appointment](chart.png)

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

Royal Cornwall Hospital

Services were mostly planned, delivered and coordinated to take account of people’s individual needs.

There was a system to notify staff if people required additional support, such as people living with a learning disability, dementia or mental health problems, people with physical difficulties, and people who required an interpreter or advocate. This information was added to the patient’s information, so the department could make any necessary adjustments prior to their appointment. This enabled patients to be fast tracked through the system to avoid unnecessary distress.

When patients with learning disability or dementia arrived for appointments with no prior information or staff suspected patients may have an undiagnosed condition, staff said they contacted the trust's specialist learning disability nurse for advice.

The trust had a mental health and learning disability team who could provide care and advice for patients living with a variety of disorders and disabilities. These included depression and anxiety, eating disorders, learning disabilities, autism, attention deficit hyperactivity disorder (ADHD) and personality disorder. The trust also provided a specialist gender identity clinic and alcohol and substance misuse support.
The trust had access to cancer support services for patients. This was to assess, maintain and promote physical, social, psychological and spiritual wellbeing to improve quality of life. This included providing information, advice on symptom control, welfare advice or emotional and spiritual guidance.

There was written information in treatment rooms and waiting areas on a variety of conditions and treatments. Examples included ‘Helping you decide for breast screening’ and ‘Information on full pulmonary function tests’. However, these were available in other languages but unavailable in large print.

Bariatric equipment could be accessed if required. We saw bariatric seating, examination couches and wide-bore MRI scanners which were designed for bariatric use. Wide-bore MRI scanners could also be used for claustrophobic patients.

Translation services were available, including written information in other languages, telephone interpreters and face-to-face interpreters to attend appointments if required. Staff could give examples of when they had used face-to-face and telephone interpreters to ensure patients fully understood their treatment.

Not all patients we spoke with had received written information before their appointment and two patients said they had missed appointments due to miscommunication. Both patients’ appointments had been rescheduled.

Staff members and patients told us that contact details on letters from the outpatient services were not always correct. This had caused difficulties for patients who needed to contact the department for advice or additional support.

Care and treatment did not always meet the needs and requirements of some patients. We identified examples in incident reports we reviewed of situations where patients experience delays in receiving care and treatment where their condition had deteriorated as a result. For example, in dermatology and ophthalmology.

Not all clinics were suitable for wheelchair users. We found waiting rooms to be small and limited the mobility of wheelchairs. The patient would have to wait in an area where movement of the chair was unhindered but not necessarily within the waiting area.

West Cornwall Hospital

Staff were aware of how to access interpreting services for patients. They told us that if they were using an interpreter to book an appointment the interpreter would automatically be booked to attend the same appointment with the patient. Interpretation services were available for patients whose first language was not English. This was flagged up at the booking stage and the appropriate arrangements were made to support the patient.

Reasonable adjustments were made for patients with physical disabilities and who used mobility aids, however clinics were not always accessible to patients attending in adapted wheelchairs or on a stretcher. Corridors were narrow with little room for manoeuvrability. Alternative arrangements were made for these patients when staff were made aware they would be attending the clinic.

Bariatric equipment was available to support patients visiting outpatient areas. Specialist chairs were available in department. Patients also had access to raised chairs and chairs with arms to help them get up into a standing position.
There was a chaperone service available for all patients attending the department. Posters were displayed for patients around the waiting rooms to make patients aware they could request this service.

One member of staff told us that outpatient department staff would make a special effort to adapt their approach to meet the needs of individual patients, particularly those with learning difficulties. This would include rearranging the scheduling of the clinics to ensure that patients who may become stressed by noise or long waiting times would not be delayed too long.

Staff in the outpatient fracture clinic explained how they would adapt their communication with a person living with dementia. The consultant explained how they would make a point of making sure that a person living with dementia understood the treatment plan by repeating the plan in many ways to ensure they had understood them.

**St Michaels Hospital**

Staff met the needs of anxious patients to ensure they received care and treatment. Staff gave us examples of patients who had attended the department but had felt too anxious to remain in the waiting room whilst waiting for their appointment due to the noise and levels of activity. Staff told us how they had encouraged the patient to go and wait in their car and how they had gone to get the patient when the consultant was ready to see them. Staff told us they also kept patients verbally informed if their clinic was running late to help with their anxiety.

Staff met the individual needs of people who experienced long waits on the day of their appointment. If clinics were running late, staff would let the team responsible for managing car parking know and the patient would not have to pay a further fee for car parking. If clinics were running over one hour late, tea, coffee and biscuits would be provided for patients.

The pre-assessment clinic managed patient’s expectations by proving them with information about the service. Prior to their appointment at clinic, patients were sent information about the clinic and what to expect. One patient told us they had attended the clinic before and knew what to expect but had found the information useful for their initial appointment.

Interpretation services were available for patients whose first language was not English. This was flagged up at the booking stage and the appropriate arrangements were made to support the patient.

Reasonable adjustments were made for patients with physical disabilities. Clinics were easily accessible, and staff supported patients who used mobility aids.

Bariatric equipment was available to support patients visiting outpatient areas. Specialist chairs were available in department. Patients also had access to raised chairs and chairs with arms to help them get up into a standing position.

Information sent to patients prior to their appointments was available in different formats for example large print or alternative languages.

The needs of patients with complex needs were managed effectively. When staff became aware that a patient with a learning difficulty or dementia was attending the department, they would look to get that patient into clinic first, where possible. This ensure these patients did not become distressed by having to wait or by the busy and noisy environment.

**Access and flow**

**Royal Cornwall Hospital**

People did not always have timely access to initial treatment, test results, diagnosis or treatment.
The trust was monitoring their RTT performance as part of their improvement plan. Figures submitted showed that most patients were being seen within 18 weeks, although below the national standard of 92%. Despite this, there had been an improving trend with performance data and the trust was on track to achieve their target Q4 in 2018. This target had been agreed with the local clinical commissioning groups.

Patients who were at risk of breaching cancer waiting times were reviewed and prioritised by the cancer services team. Patients who were not on the two-week waiting list but had a positive diagnosis from a routine or urgent investigation, were flagged to the cancer team in daily emails.

The trust’s action plan for reducing their waiting lists included running additional clinics to meet the demand for outpatient services. However, we found this was not always possible in practice. For example, there were 1287 patients waiting for ophthalmology glaucoma appointments and 24 waiting for WARM injection services. The trust was unable to provide additional clinics, such as injection clinics, due to lack of space and there were examples of additional weekend clinics being cancelled due to lack of appropriate staffing. The trust recognised this was an issue across the service and were conducting a capacity and demand analysis to identify how they could improve.

The trust monitored the number of patients affected by short notice clinic cancellations in less than six weeks of the clinic appointment using the Clinic Cancellation & Additions Tool (CCAT). The main reasons for cancellations as reported by the trust were annual/study leave, clinicians required at meetings, sickness, staff shortages, changes to clinic rules and industrial action.

Patients were not always kept informed about how long they would be kept waiting in the department. Areas such as the fracture clinic had whiteboards showing the expected delay, but we observed other areas which did not display this information. For example, we spoke with patients in the ophthalmology clinic who had been waiting 40 minutes for their appointment but had been given no information. Neither was there any information displayed on monitors or information boards to explain the delay.

Patients found it difficult to contact outpatient services to book, cancel or reschedule appointments via the telephone. Reception and administration staff told us that they did not have the time to answer the phone due to other work pressures, such as organising medical notes. They told us that patients and relatives often got angry and could get verbally abusive when they could not get through to the department. Staff reported these occasions as incidents.

There was an emergency eye service. This was staffed by trained nurses and medical staff for emergency referrals. A daily booked clinic ran between the hours of 9am and 5pm. This service was designed to manage the flow of emergency eye patients through ophthalmology and not block other ophthalmology clinics.

The trust provided two-week wait services via electronic referrals and provided advice and guidance services in renal, cardiology, haematology, neurology and dermatology. The advice and guidance services allowed GPs to access rapid advice and/or treatment without the patient necessarily needing to be seen in an outpatient setting.

Other clinics had been developed to improve accessibility for patients such as, rapid access chest pain clinics (RAPAC) were provided via electronic referrals. Patients were assessed and able to go directly to CT, MRI or into general RAPAC clinics.

A rapid access neurology service was available for emergency department and ambulatory care patients, or patients discharged from a ward.
An accelerated access clinic for primary joint replacement surgery was run by trauma and orthopaedics. This clinic ensured patients that required this service were moved promptly and freed up clinic slots for waiting patients.

The ear, nose and throat service held an emergency clinic in general outpatients. This helped reduce the number of patients presenting in the emergency department.

Gastroenterology and hepatology both ran "hot" clinics for patients identified with cancer. Hot clinics were consultant or associate specialist run and used to evaluate GP referrals.

For breast cancer patients the Mermaid Centre ran symptomatic multi-disciplinary clinics to better manage patient demand.

There were two areas in speech and language therapy (SLT) outpatients, head and neck specialist SLT service and specialist palliative SLT service. The head and neck specialist SLT responded to urgent swallow, voice and laryngectomy valve issues and could be as rapid as the same day if critical to the patient’s wellbeing.

The palliative SLT service responded within a week for urgent swallow issues that related to palliative care or end of life.

Specialities such as urology and the breast clinic had set up one-stop clinics to reduce the number of appointments patients had to attend and facilitate timely access to care. One-stop clinics combined consultations, diagnostics and results.

The fracture clinic used a ‘virtual clinic’ where medical staff would clinically review referrals to prioritise those with the most urgent needs. Appointment times would then be scheduled based on the consultant’s recommendation, for example the following day.

The Trelawny outpatient’s clinic for transient ischemic attacks (TIA) moved to a more patient accessible Friday. It now allows scanning and the facility for an electro cardiogram in the same clinic. This has reduced patient waits for both diagnosis and treatment.

In Dermatology the appointment of band seven clinical nurse specialists now allows direct referrals from GP’s. This has reduced routine waiting lists and now allows patients with a known diagnosis to access the service (such as acne, psoriasis and eczema).

The new specialist nurse service for rapid chest pain and heart failure had shown to have had a significant impact on the reduction of waiting lists with cardiology outpatients. The specialist nurses assist in early diagnosis and detection of acute and chronic chest conditions.

West Cornwall Hospital

The percentage of cancelled outpatient clinics at West Cornwall Hospital was monitored by the trust. We requested data to identify the percentage of clinics cancelled within six weeks of the clinic. The data provides details regarding the combined percentage of clinics cancelled at West Cornwall and St Michaels Hospital.

Clinics cancelled within six weeks of the clinic date. March 2018 7.2%, April 2018 6.9%, May 2018 6%, June 2018 5.4%, July 2018 5.6% and August 2018 4.8%.

Clinics cancelled over six weeks of the clinic date. March 2018 10.9%, April 2018 14.6%, May 2018 11.7%, June 2018 11.2%, July 2018 12.9% and August 2018 18.4%.

The trust monitored the number of patients affected by short notice clinic cancellations in less than six weeks of the clinic appointment using the Clinic Cancellation & Additions Tool (CCAT) for West Cornwall Hospital. The main reasons for short notice clinic cancellations were annual leave and clinicians having other clinical priorities. We requested data to identify the number of short notice
clinics cancelled and the number of patients affected. Data showed in March 2018 two clinics were cancelled and 12 patients were affected, in April 2018, seven clinics were cancelled and 38 patients were affected, in May 2018, three clinics were cancelled and two patients were affected, in June 2018, seven clinics were cancelled and 45 patients were affected, in July 2018, 11 clinics were cancelled with 47 patients affected and in August 2018, seven clinics were cancelled and five patients were affected.

If cancellations occurred, patients were informed and booked onto the next available clinic or added back onto the waiting list. This then impacted on future clinics and their ability to run on time. One clinician told us one of the biggest challenges was capacity in clinics. Clinics invariably ran late due to having to add patients on to the clinic lists to accommodate for waiting lists and cancelled clinics. The clinician said that if they did not add the patients to the lists then there would be huge backlogs of patients.

Data provided showed the number of new patient assessments and follow up outpatient appointments carried out at West Cornwall Hospital. Between March and August 2018, a total of 19,392 patients were seen in the department. Of these patients, 6,214 were new patient appointments, with 13,178 being follow up appointments.

Patients could access care and treatment at a time to suit them. Appointments were booked via a referral management service. Patients received their referral and were then contacted to book an appointment. Consultants then reviewed the referrals. Patients who were unsuitable for an outpatient appointment would be contacted to have their appointment cancelled. A letter was then sent to their GP explaining the reason for the cancellation and any action or additional information required.

Patients were reminded via an automated telephone call a week before their appointment or by a text message, two days before their appointment. This gave patients the option to change their appointments at this time if they were unable to attend.

St Michaels Hospital

The percentage of cancelled outpatient clinics at West Cornwall Hospital and St Michaels Hospital was monitored by the trust. We requested data to identify the percentage of clinics cancelled within six weeks of the clinic. The data provides details regarding the combined percentage of clinics cancelled at West Cornwall and St Michaels Hospital.

Clinics cancelled within six weeks of the clinic date. March 2018 7.2%, April 2018 6.9%, May 2018 6%, June 2018 5.4%, July 2018 5.6% and August 2018 4.8%.

Clinics cancelled over six weeks of the clinic date. March 2018 10.9%, April 2018 14.6%, May 2018 11.7%, June 2018 11.2%, July 2018 12.9% and August 2018 18.4%.

The trust monitored the number of patient affected by short notice clinic cancellations in less than six weeks of the clinic appointment using the Clinic Cancellation & Additions Tool (CCAT) for St Michael's Hospital. The main reasons for short notice clinic cancellations were annual leave and clinicians having other clinical priorities. We requested data to identify the number of short notice clinics cancelled and the number of patients affected. Data showed in March 2018 two clinics were cancelled however no patients were affected, in April 2018, six clinics were cancelled and 60 patients were affected, in May 2018, 16 clinics were cancelled and 89 patients were affected, in June 2018, six clinics were cancelled and 21 patients affected, in July 2018, nine clinics were cancelled with 14 patients affected and in August 2018, six clinics were cancelled and 14 patients were affected. If cancellations occurred, patients were informed and booked onto the next
available clinic or added back onto the waiting list. Nurses told us clinicians would often add extra patients to clinic lists to make sure they kept up with the high demand for the service.

Nurses in the department told us that clinics didn’t always run to capacity. Following the inspection, we requested data on clinic capacity at the hospital, the data which was provided did not provide us with planned compared to actual clinic capacity. Data provided demonstrated the number of new patient assessments and follow up outpatient appointments were available for patients at St Michael’s Hospital. Between March and August 2018, a total of 14,977 patients were seen in the department. Of these patients, 3,854 were new patient appointments, with 11,123 being follow up appointments.

Appointments were booked via a referral management service. The GP submitted referrals to the Referral Management Service at the trust via an electronic system. The patient was then contacted and offered a choice of appointments. Consultants then reviewed the referrals. Patients who were unsuitable for an outpatient appointment would be contacted to have their appointment cancelled. A letter was then sent to their GP explaining the reason for the cancellation and any action or additional information required.

Patients were reminded via an automated telephone call a week before their appointment or by text message two days before their appointment. This gave patients the option to change their appointments at this time if they were unable to attend.

No data was collected at the outpatient department to identify patient waiting times for individual clinics at St Michael’s hospital.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From May 2017 to November 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways was consistently better than the England overall performance. However, from December 2017 to April 2018, performance was slightly below the England average.

The latest figures for April 2018 showed 86.8% of this group of patients were treated within 18 weeks versus the England average of 87.9%.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Royal Cornwall Hospitals NHS Trust**

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

Thirteen specialties were above the England average for non-admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>100%</td>
<td>92.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>97.4%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>97.2%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>95.9%</td>
<td>93.3%</td>
</tr>
</tbody>
</table>
Other          95.2%           91.4%
ENT            95.0%           87.2%
Trauma & orthopaedics  92.5%           86.9%
Oral surgery    92.3%           84.9%
Gastroenterology  92.0%           85.1%
General surgery  91.5%           89.1%
Urology         90.5%           87.7%
Ear, nose & throat (ENT)  87.4%           85.6%
Neurology       82.1%           81.4%

Four specialties were below the England average for non-admitted RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>87.9%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>86.1%</td>
<td>88.1%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>85.8%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>71.5%</td>
<td>86.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From May to July 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways was better or similar to the England overall performance. However, from August 2017 to April 2018, performance was worse than the England average and declined steadily over the period.

The latest figures for April 2018 showed 79% of this group of patients were treated within 18 weeks versus the England average of 87%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Royal Cornwall Hospitals NHS Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Five specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks):

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>100%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>94.8%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>92.2%</td>
<td>88.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>90.0%</td>
<td>87.4%</td>
</tr>
<tr>
<td>Neurology</td>
<td>89.3%</td>
<td>87.8%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

(Source: NHS England)
Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Royal Cornwall Hospitals NHS Trust**

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Royal Cornwall Hospitals NHS Trust**

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

**Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Royal Cornwall Hospitals NHS Trust**
Learning from complaints and concerns

Royal Cornwall Hospital

Complaints were not always handled in line with the trust policy. The outpatient manager dealt with initial complaints that had not been resolved by individual managers in the Trelawny outpatient department. If they were unable to deal with a patient’s concerns satisfactorily they would be directed to the Patient and Family Experience (Complaints) Team. However as shown below, they often exceeded their 25-day completion target.

From May 2017 to April 2018 there were 43 complaints about outpatients. The trust took an average of 65.2 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 25 days.

Forty-three complaints (93%) occurred at Royal Cornwall Hospital, two (4.7%) at St Michael’s Hospital and one (2.3%) at West Cornwall Hospital. There were no complaints received relating to medical care.

The most prevalent types of complaints were those relating to clinical treatment (37.2%) and communications (20.9%).

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Staff were aware of the local complaints procedure and were confident in dealing with complaints if they arose. However, not all managers and senior staff we spoke with could describe recent complaints from their department or any themes or actions taken as a result.

Feedback forms were available and accessible across the outpatient service. Information on Patient and Family Experience (Complaints) was included. Patients we spoke with knew how to complain.

Number of compliments made to the trust

From May 2017 to April 2018 there were 383 compliments within outpatients. One compliment was for St Michael’s Hospital and the remaining 382 compliments were for Royal Cornwall Hospital.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

West Cornwall Hospital

From May 2017 to April 2018 only one complaint was received at West Cornwall hospital.

Information about how to make a complaint displayed and Patient and Family Experience (Complaints) Team. leaflets available in the main entrance to St Michael’s hospital.

St Michaels Hospital

From May 2017 to April 2018 two complaints were received at St Michaels hospital.
Information about how to make a complaint displayed and Patient and Family Experience (Complaints) Team leaflets available in the main entrance to St Michael’s hospital.

Is the service well-led?

Leadership

Royal Cornwall Hospital

Not all leaders had the skills, knowledge, experience and integrity they needed to lead their departments. There was a variable level of understanding of both the acute processes for governance and how they integrated into the wider health economy.

Several clinical staff working in the outpatients had worked at the hospital for many years. Nursing staff spoke unfavourably about the senior leadership and management styles of their line managers.

Not all leaders were visible, approachable or compassionate towards staff. Staff described how they didn’t feel they could have open and honest conversations with managers (including with the executive team) whenever an issue arose. Staff told us that their band six leaders were visible and approachable but leaders above this were not visible or approachable.

A high number of senior staff at the outpatient department told us they felt disengaged from the board and that they were left to manage issues alone. They told us the executive team were not visible on site and they would not know how to approach them if they wanted to raise concerns.

There were plans to develop and ensure sustainable management of services. As an example, the development of clinical nurse specialists had encouraged leadership skills and developments. It had led to improvements for services which had high patient demand. This included the ophthalmology services, where nurses were being trained to increase and develop their skills to reduce the workload of consultants.

West Cornwall Hospital

Staff were complimentary about their local line managers and told us they were supportive and approachable. They said they felt informed about what was happening within the department at West Cornwall Hospital.

The lead nurse for the department had the knowledge and skills to lead the department. The manager spoke passionately about providing a high-quality service and understood the challenges to providing good patient care at a local level. The environment posed challenges to the department and the ability of some patient groups to access clinics. We were given examples of how the department proactively managed these patients to ensure they received their care and treatment whilst ensuring their privacy and dignity in a different environment during a consultation.

St Michael’s Hospital

There was dedicated leadership within the outpatient department. The manager of the outpatient department had worked at St Michael’s hospital in a variety of nursing roles over 21 years. The manager understood the role of the staff and spoke of the staff as a family as the team was so small. The manager also spoke passionately about providing high quality patient care and was proud of her team for the patient orientated environment in which they worked.

Staff within the outpatient department were complimentary about their local line managers and how they were visible, approachable and encouraged supportive relationships among staff. Staff told us they met as a team each morning at the start of the shift to discuss issues from the previous day, the plan for the shift and any other matters which needed to be discussed. However,
staff told us senior management above their local line manager were not visible. We were told they could contact them if required and senior managers would be supportive.

The outpatient manager understood the challenges to providing good patient care at a local level. The department was challenged due to patients waiting for appointments when clinics were running late, and the nature of the busy environment could pose a challenge to some anxious patients. The manager gave us positive examples of how these issues were managed to ensure the best experience for the individual patient.

Vision and strategy

Royal Cornwall Hospital

The trust had a clear vision and a set of values which most of the staff we spoke with knew were familiar with. Staff could explain how they used the values in their day to day work. The values were displayed throughout all outpatient services. The vision was ‘working together to provide outstanding care.’ The trust values were care and compassion, inspiration and innovation, working together, pride and achievement and trust and respect.

The outpatient strategy had been reviewed to manage the challenges faced by the service. Cardiology and ophthalmology clinics had a strategy to improve the backlog of follow up appointments and a better risk assessment process. Data showed the actions taken to manage the issues had been successful. This was reflected in the current waiting list numbers.

Senior staff understood the strategy for outpatient services and their role in achieving it. Plans were challenging whilst remaining achievable. Senior staff could give examples where they had developed services in high risk areas such as cardiology and ophthalmology.

There were several projects ongoing which were aligned with the trusts strategy. This included multiple projects to improve risk management of patients waiting for an appointment and working differently within clinics to make them more efficient. The use of virtual clinics, access to advice and guidance services, and patient-initiated contact were also being enhanced.

West Cornwall Hospital

The trust had a clear vision and a set of values. The vision was ‘working together to provide outstanding care.’ The trust values were care and compassion, inspiration and innovation, working together, pride and achievement and trust and respect.

Staff were not familiar with the vision and values for the trust, despite these being displayed around the department. Despite not being aware of the values, the care we observed at West Cornwall Hospital demonstrated the values of care and compassion, working together and trust and respect.

St Michaels Hospital

The trust had a clear vision and a set of values. The vision was ‘working together to provide outstanding care.’ The trust values were care and compassion, inspiration and innovation, working together, pride and achievement and trust and respect.

Staff understood the vision and values for the trust and their role in achieving the strategy. Staff were able to discuss the plan for St Michael’s hospital being turned into a centre of excellence for orthopaedics. They were also familiar with the trust values and demonstrated them during interactions with patients which we observed and generally when going about their daily duties.

Culture

Royal Cornwall Hospital
A culture of intimidation and fear remained in several outpatient departments we visited. Staff called the culture “toxic” and one of “fear.” Staff had gone off sick due to some issues related to the culture. We contacted some of these staff members following our inspection to understand their concerns. Staff also told us they had been reprimanded for reporting incidents they felt were appropriate to submit. This meant staff were less likely to report an incident for patient safety and learning.

Local staff and teams worked collaboratively, resolved conflicts quickly and constructively and shared responsibility to deliver good quality of care. For example, senior sisters told us that they were proud of their teams and were always looking at the patients’ journey. However, they also told us that they struggled with increased capacity.

Staff attended the safety huddle and took part in daily discussions. Regular staff meetings were held. Staff said this gave them a better picture of the days challenges and required levels of patient care.

**West Cornwall Hospital**

Staff we spoke with felt respected and spoke of a positive working culture. They were proud of the patient-centred care they provided and talk about patients as part of their extended team.

Staff felt supported and valued. They interacted well with each other and spoke highly of the team and working together as a family. Staff told us how they had been flexible and supportive to other members of staff in the team who had needed support which was ongoing. The team was supportive of each other and flexible when required.

Staff we spoke with across most of the community hospitals felt they worked for a service with an open culture and could raise any issues concerning them with the senior nurse in the department. Staff felt comfortable to approach their ward managers to discuss any concerns or issues they had.

There was a lack of integration between West Cornwall Hospital and the main Royal Cornwall Hospital site. Many staff described a longstanding ‘self-sufficient’ culture with limited communication from the main site and senior management team. They felt the reasoning for this due to the ‘all-consuming pressures’ at the main Royal Cornwall site.

Staff told us they did have good working relationships with some of the staff in the outpatient department at the main Royal Cornwall site who they would call for support or advice if required.

**St Michaels Hospital**

Staff felt supported and valued and told us of the positive culture in which they worked in the outpatient department. Staff interacted well with each other and spoke highly of the team. Staff told us they were supportive of each other and were flexible when required.

Staff spoke highly of the care and commitment to their patients within the department. We saw positive interactions with patients attending the department and saw how staff adopted a friendly approach to make patient feel at ease.

There was a positive approach to staff well-being. Staff told us their line manager was very supportive and felt they could speak to them if needed. Staff and the manager spoke of an open-door policy. Staff told us the manager had a balanced approach towards wellbeing. For example, if staff had worked late to cover a clinic, they would be able to leave early if a clinic had finished early and staff had completed their duties. This meant staff were able to go to take back their time back.
There were mixed thoughts about the working culture at St Michael's Hospital. Some staff told us the department worked very much in silo and felt detached from the main Royal Cornwall site and the wider trust. They felt communication was limited, but despite this were committed to providing a good quality service for the local community. However, some staff told us that since the new leadership team had come into post, they had seen a culture shift and had felt that there had been more inclusion of St Michael's Hospital into the wider trust. Some staff told us the ‘team talks’ had helped with this. The team talks were monthly talks held at the hospital where the members of the executive team attended to talk to the staff about what was happening in the trust and give them the opportunity to have their questions answered.

**Governance**

**Royal Cornwall Hospital**

There was an improving governance framework to support the delivery of quality patient care. There was a straightforward governance structure which saw the outpatient department meeting feed into the divisional governance and business meetings, through to the quality governance group and then to the quality assurance committee.

There was a dedicated governance board for administration which met once a month and an information governance committee which met once every six weeks. The records team delivered data to these meetings relating to security, operational issues such as appraisals, turnover of staff, data protection, issues regarding the patient administration system and the data quality dashboard. We could see where actions had been taken or risks added to the risk register from meeting minutes provided by the trust.

There were procedures to maintain clinical governance and risk management. For example, a monthly outpatient service dashboard detailed performance information tracking. This tracked various performance systems including mandatory training, appraisals, complaints and response times.

Staff were clear about their roles and could demonstrate what they were accountable for. Also, the general managers had better oversight of the day to day working and had improved oversight on waiting lists and staffing issues within ophthalmology.

There were procedures to maintain clinical governance and risk management. For example, a monthly outpatient services dashboard detailed performance information tracking. This tracked various performance systems including statutory and mandatory training, appraisal rates, complaints and response times, medical records performance with twice daily audits and quality and safety meetings.

Governance procedures to monitor waiting lists, waiting times, frequency of cancelled clinics, and RTT timelines for patients were improving, but still required ongoing work to ensure effective service delivery. This was due to continuing delay for patient to access clinic appoints for high demand specialities. For example, we found the clinical leads had more oversight of the waiting lists for their specialties this included data on delays for follow up appointments. This meant the impact on patients’ safety was better understood.

The outpatient transformation programme had been re started to better address the challenges faced by the departments. We saw evidence in the meeting minutes for this group where patient groups and external primary care providers have been involved. The outcome of these meetings was shared with the department managers with information being further disseminated in team meetings.
Decisions to put on additional clinics to manage the waiting lists were dependent on clinicians having the time available for additional clinics, clinic space and nursing capacity available to run clinics. We attended a rostering meeting which used multi-disciplinary staff to ensure clinics were staffed appropriately within ophthalmology.

West Cornwall Hospital

There were effective structures, processes and systems of accountability at West Cornwall Hospital to support the delivery of good quality care. There was a monthly governance meeting held at West Cornwall Hospital. The lead from each department, including the outpatient department attended the monthly meeting.

If a representative was unable to attend, they would complete a form summarising issues around quality, safety and performance which would be feedback at the meeting by another member of staff. Topics included incidents, complaints, safeguarding and serious incidents, infection control and risk. This ensured there was full oversight of each department within West Cornwall Hospital and an understanding of the pressures and issues within each department. Representatives from the senior leadership team for the division would also attend the meeting. Minutes of this meeting were also sent to the governance team at the trust to feed into the governance system.

St Michaels Hospital

The governance framework did not ensure good oversight of safety, quality and performance of the outpatient department to support and ensure the delivery of good quality care. A governance meeting was held bi-monthly, which was attended by representatives from the senior leadership team. The outpatient lead nurse did not attend this meeting, but we were told the clinical nurse lead for the hospital would feed any issues from the outpatient department into the meeting as required.

We observed three sets of meeting minutes from February, April and June 2018. None of the three sets of minutes showed any discussion around any aspects of the outpatient service. This meant there was no oversight about how the outpatient department was performing in terms of quality and safety and no identification of service pressures and areas which may require improvement.

Management of risk, issues and performance

Royal Cornwall Hospital

There was an improved oversight and management of risks to patients. This was reflected in departmental risk registers and the management of high risk patients of waiting list for specialities. However, risks remained to patients in ophthalmology due to staffing issues and mailing errors and as mentioned in the incidents section, harm to patients due to ongoing waits.

The management of the outpatient backlog was improving. There was a risk register which risk assessed backlogs and the risk of harm to patients. Ophthalmology, with the highest number of patients waiting was deemed as the service with the highest risk. Actions to manage the risk included detailed and regular monitoring of the patients in the backlog and the management of staff recruitment. However, despite actions being taken to manage the risks, we saw evidence that incidents and patient harm were still occurring.

The ophthalmology team had introduced an in-house dedicated booking team for service. This was to address the need to have 100% focus on clinic bookings to avoid unbooked clinic slots and management of follow up risk to patients. The leader of this team also helped to build the fail-safe policies and procedures to ensure all booking rules are applied and patients managed to locally agreed procedures.
Continued monitoring of wet age related macular degeneration and glaucoma patients was ongoing. A review of the risk register showed that substantive staff had been appointed to commence in November 2018. A locum was being sourced to fill any gaps between now and November 2018.

Improvements had been made to address the shortfall in the follow up capacity in ophthalmology clinics, however further work was required to reduce waiting lists and waiting times for patients. Actions which had been taken to address the issues included, using locums, collaborative working with local GP surgeries and service improvements within the wet age-related macular degeneration clinics. There had been a significant reduction in waiting times, however the loss of two ophthalmology locums had meant the numbers waiting had risen a little. The trust was in the process of recruiting to fill those positions.

Staff were not aware of the key performance indicators set for their clinics and how they performed in relation to them. This meant staff were unaware as to whether service delivery was effective and optimised for patients.

**West Cornwall Hospital**

There was a system to identify, record and manage risks associated with the outpatient department. There was an ongoing problem with the plumbing above the department. There had been incidences in the past of pipes leaking and damaging ceilings in the department. Work was ongoing to rectify this issue. This had been escalated to the corporate risk register. Risks associated with the outpatient department were discussed and had been recently reviewed in terms of the level of risk and the controls to manage the risks in August 2018.

There was a systematic programme of audit to monitor quality and operational processes which identified any areas which required improvement. There were several audits which were carried out in the outpatient department on a monthly or quarterly basis. These included cleaning audits, hand hygiene audits and resuscitation trolley check audits. Audit data was captured on an electronic system. Audits we reviewed for the service demonstrated 100% compliance in all areas.

There was a business continuity plan for the trust which identified procedures and processes which needed to be carried out in the event of a failure within the department which staff were aware of. The policy identified the manual processes which needed to be implemented in the event of a loss of electronic systems. Information was also provided about procedures which would be implemented for outpatient booking services if systems were to fail and the role and responsibilities of the staff within the outpatient department should such an event occur.

**St Michaels Hospital**

There was a system to identify, record and manage risks associated with the outpatient department. St Michaels Hospital maintained its own individual risk register and risks were reviewed and discussed at the bi-monthly governance meeting as required and there was a full review of all risks on the risk register which was completed yearly. One risk associated with the outpatient department was to do with cleaning practices for endoscope used during clinics. Actions had been identified to manage the risk and further actions had been identified to review these actions to enable continuous monitoring of the risk.

Risks were held on an electronic system which the lead outpatient nurse did not have access too. The band 7 clinical lead nurse for the hospital had access to this system. There was ongoing discussion and work at the bi-monthly governance meetings to look at giving the lead nurses for the outpatient department access to the system to be able to play a more active role in the management of risk and updating the risk management plan.
There was a systematic programme of audit to monitor quality and operational processes which identified any areas which required improvement. There were several audits which were carried out in the outpatient department on a monthly or quarterly basis. These included cleaning audits, hand hygiene audits and resuscitation trolley check audits. Audit data was captured on an electronic system. Most audits we reviewed for the service demonstrated 100% compliance however, we were shown an example of two audits where compliance was only 50%. These were the only two which did not demonstrate 100% compliance since January 2018. In these instances, the issues were addressed locally at the time of the audit.

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Information management

Royal Cornwall Hospital

Staff had access to patient information to support with outpatient clinics and decision making. Dependant on their role and need to access patient information, some staff had access to electronic systems containing additional patient information. These systems included access to orthopaedic clinic letters, access to blood results and access to GP records and information. Staff requiring access had individual log-in details and a password which was required to access the information.

Staff working in the departments had access to information about quality, safety and performance daily at the morning huddle. The meeting covered a standard agenda and updates provided included information about recruitment, mandatory training compliance, annual leave, appraisals and incidents. This provided staff with an oversight into issues in the department and current performance.

Daily meetings were held in the morning prior to each shift to discuss aspects of service delivery including quality and safety. We were told the morning meeting was an opportunity to discuss issues including mandatory training and audit results and any other safety information which had been circulated to teams.

Arrangements for the safe distribution of clinic letters to patients did not ensure information was sent and received effectively. In April 2018, approximately 476 Ophthalmology discharge letters did not reach a GP surgery due to a failure in the electronic mailing process. A consultant had been informed about the letters which did not reach the surgery which could have led to patient harm. At the time of inspection, and following the inspection, we requested information relating to any patient harm following this incident. Information provided showed there had been no patient harm identified. However, despite information requests, not further information was provided as to the actions being taken to mitigate the risk of this incident reoccurring.

West Cornwall Hospital

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**Engagement**

**Royal Cornwall Hospital**

People who used the services, those close to them and their representatives were actively engaged and involved in decision-making. For example, the NHS Friends and Family Test questionnaires were available for patients in clinic waiting areas and we saw posters displayed, which encouraged patients to leave comments about the service.

The views of patients were actively sought within outpatients using the NHS Friends and Family Test and the patients wonder wall. The patients wonder wall encouraged patients to attach comments on “post-it notes” on to a board within the departments with suggestions to improve or compliment the service.

Patient and Family Experience (Complaints) Team information was available on notice boards in waiting areas. These informed patients of the Patient and Family Experience (Complaints) Team service and invited patients to provide feedback and comments.

Staff were engaged so that their views could be reflected in the planning and delivery of services. Staff meetings were held in the specialities and in the main outpatient department to ensure that points of view were gathered and, where it was right to do so, acted upon. Most staff said that these were a positive open forum and encouraged team working. They also said they felt they felt listened to by their immediate managers.

Despite the views of staff being sought, there was a lack of communication as to the actions taken by the trust to address areas of service delivery which required improvement. Staff in outpatient areas were not able to clearly articulate what actions the trust had taken to prioritise and risk assess those patients waiting over 18 weeks for appointments. Neither were they able to tell us about the action taken by the trust to reduce the backlog of patients waiting more than 18 weeks for appointments. There was no oversight of risks and staff awareness of the impact of risks affecting their service.

**West Cornwall Hospital**
There was an active League of Friends who, at the time of the inspection were actively raising money to fund a new dishwasher in the department. Numerous fundraising events had been held and their work was displayed in the waiting areas of the hospital for the local community to see.

Patients’ views about the general outpatient department were gathered via the NHS Friends and Family Test questionnaire. Results were displayed in the department for patients. However, the data was not in the most user-friendly format for patient to read. The lead nurse was looking into how this could be improved to provide clearer, more informative feedback for patients.

A Community Forum run by the public and people from local communities met bi-monthly. People who attended included hospital staff, members of the hospital’s League of Friends, Healthwatch, the local Member of Parliament and local councillors. Key performance indicators were used to discuss the ongoing hospital performance. Plans for the hospital were discussed and attendees were able to put forward their thoughts and ideas about the hospital.

St Michaels Hospital

Patients attending the outpatient department had the opportunity to provide comments and feedback following their appointment. There was an area of the waiting room where patients could write a comment following their care and treatment at the clinic. Positive comments about the outcome of appointments had been put up on a notice board. Any negative comments would be dealt with individually by the lead for the service.

Patient’s views about the outpatient department were gathered via the ‘friends and family test’ questionnaire. This had recently been introduced only a few weeks prior to our inspection. The department planned to use the feedback to identify areas which required improvement.

Staff were actively engaged with in the monthly team talk which was held at St Michaels hospital. Staff from all the departments, including outpatients, had the opportunity to attend the talk which was presented by the chief executive and the chief nurse. The team talk was a forum for the executive team to engage with staff and to provide information about changes and future planning for the trust. The team talk also provided staff with the opportunity for an open forum to ask the chief executive questions which they wanted answering. We attended the team talk during the inspection which had received a good turnout of staff. Staff were encouraged to ask questions and there was a friendly and relaxed atmosphere. Staff told us they valued the team talk and felt refreshed by the openness and honesty of the chief executive.

Learning, continuous improvement and innovation

Royal Cornwall Hospital

During the inspection in 2017, we found that some environments within the outpatient’s department were not fit for purpose, clinical areas were small and clinical rooms were not soundproof. During this inspection, we found there had been improvements and the areas were still being upgraded for the services delivered. However, issues remained in some areas and ongoing monitoring and improvement would be required.

Training of voluntary staff to support patients, relatives and friends ensured they could support people. Volunteers added a great deal of value to the patient experience and as a talent pool for the future workforce.

An outpatient transformation programme had been recently created. The purpose of which was to develop the outpatient’s department to provide high quality care and be efficient and cost effective to meet the needs of its patients and commissioners. Meetings were held monthly, and patient groups sat on the panel to ensure the patient voice was heard and experiences were gained.
Primary and secondary care providers as well as GP’s were also included in the programme. These meetings are fed back to the board as part of the governance meeting.

West Cornwall Hospital

We did not identify any areas of innovation at West Cornwall Hospital.

St Michaels Hospital

St Michaels hospital, including the outpatient department, was being redesigned and reconfigured to provide a more up to date environment and facilities. Works had included a new privacy door in one of the outpatient clinic rooms and seating and signage was due to be replaced. The refurbishment had been ongoing for over one year with further work still to be completed. This included an interactive children’s waiting area.

Diagnostic imaging

Facts and data about this service

Clinical imaging services at Royal Cornwall NHS Trust (RCHT) were delivered across three local sites. Further provision at another eight sites was commissioned by the local community hospital NHS trust. The Trust provided diagnostic imaging to a local population of over half a million and was centrally managed from RCHT Treliske in Truro where we focussed our inspection. The clinical imaging directorate formed part of the Clinical Support and Cancer Division at the trust.

RCHT offered a full range of diagnostic imaging services including:

- X-ray (plain film)
- Computerised tomography (CT)
- Magnetic resonance imaging (MRI)
- Obstetric and non-obstetric ultrasound
- Interventional radiology including cardiology and a nursing team delivering vascular access and paracentesis services.
- Fluoroscopy
- Mammography
- Nuclear Medicine
- Dual energy X-ray absorptiometry (DEXA) (D) scanning.

An in-house medical physics service supported the imaging teams.

Our inspection was part of an announced inspection, during which we reviewed the following five questions:

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive? and
- Is the service well led?
The service was previously inspected in July 2017 as part of the outpatients and diagnostic imaging core service framework and was rated as inadequate. We found the service inadequate for safe, and well-led; good for caring, and requires improvement for responsive. We inspected but did not rate effective for that core service.

During this inspection, we spoke with 41 staff, including radiographers, mammographers, sonographers, radiologists, radiography assistants, nursing and administrative staff. We also spoke with five patients and relatives.

The inspection team consisted of a lead inspector and a specialist advisor with expertise in a radiography.

Is the service safe?

Mandatory training

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses from May 2017 to April 2018 for medical/dental and nursing staff in diagnostics at Royal Cornwall Hospital is shown below:

Mandatory training completion by module – medical and dental staff – Royal Cornwall Hospital

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>13</td>
<td>15</td>
<td>86.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>13</td>
<td>15</td>
<td>86.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>13</td>
<td>15</td>
<td>86.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>13</td>
<td>15</td>
<td>86.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>13</td>
<td>15</td>
<td>86.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>12</td>
<td>15</td>
<td>80.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for four of the 11 mandatory training modules shown above for medical staff. Conflict resolution training module had the lowest completion rate with 80%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that medical staff in diagnostics at Royal Cornwall Hospital met the target of 95% for 10 of the 11 applicable modules, with an overall completion rate of 97.7%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Course name</td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust Target (%)</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>---------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety 2 years</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Economy management training</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>6</td>
<td>0</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for 10 of the 11 mandatory training modules shown above for nursing staff. Manual handling - People training module had the lowest completion rate with 66.7%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated training data provided by the trust for the period April to August 2018 indicates that nursing staff in diagnostics at Royal Cornwall Hospital met the target of 95% for five of the 11 applicable modules, with an overall completion rate of 86.9%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>16</td>
<td>19</td>
<td>84.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>16</td>
<td>19</td>
<td>84.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>16</td>
<td>19</td>
<td>84.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
The clinical imaging service employed 26 radiologists; 132 radiographers (including mammographers and sonographers); 73 radiographic assistants and healthcare assistants; and 36 clerical staff.

We asked the service to provide a breakdown of mandatory training compliance for each professional staff group.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>89.77%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>81.25%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>95.20%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>95.54%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>88.54%</td>
</tr>
</tbody>
</table>

The service provided mandatory safety training in key skills to all staff. Staff we spoke with were clear about their mandatory training requirements and there was a system which ensured staff and their line managers were notified when mandatory training updates or refreshers were required. Staff explained they were given enough time to complete all their mandatory training. This had included training in the new updated Ionising Radiation (Medical Exposure) Regulations IR(ME)R introduced in early 2018. Team leaders told us that they reviewed the mandatory training data for their respective teams at their weekly meetings and ensured rotas allowed for staff to access training when necessary.

**Safeguarding**

Staff had training on how to recognise and report abuse and they knew how to apply it.

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from May 2017 to April 2018 for medical/dental and nursing staff in diagnostics at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>12</td>
<td>15</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>12</td>
<td>15</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for three of the five safeguarding training modules for which medical staff in diagnostics were eligible. Safeguarding adults (level 2) and safeguarding children (level 2) had the lowest completion rates with 80% each.
Updated data provided by the trust for the period April to August 2018 indicated that medical staff in diagnostics at Royal Cornwall Hospital met the 95% target for three of the five modules, with a compliance rate of 93.8% overall. Compliance improved for two modules when compared to the initial time period.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>30</td>
<td>32</td>
<td>93.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>26</td>
<td>32</td>
<td>81.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for all the four safeguarding training modules for which nursing staff in diagnostics were eligible.

Staff provided us with the most up to date (September 2018) figures for safeguarding adults and safeguarding children level 2 training for the whole service as follows:

<table>
<thead>
<tr>
<th>Course name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Staff provided us with the most up to date (September 2018) figures for safeguarding adults and safeguarding children level 2 training for the whole service as follows:

<table>
<thead>
<tr>
<th>Clinical Imaging Directorate</th>
<th>Safeguarding Adults Level 2</th>
<th>Safeguarding Children Level 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>88.55%</td>
<td>87.67%</td>
</tr>
</tbody>
</table>

The system had sent reminders out to individuals who were not up to date, and their managers. We were assured that staff who missed any training could catch up at the earliest opportunity.
Staff explained that the imaging service provided two bespoke mandatory training days per year and staff who missed those could sign up to the next available trust wide equivalent training session. All the staff we spoke with told us that the bespoke directorate mandatory training sessions were the preferred choice.

There was a safeguarding link in each of the imaging areas, who supported the CT and MRI leads with providing information for patients. There was a list of training updates available to the link workers and quarterly sessions were available with links worker expected to attend at least two per year.

The intercollegiate document ‘Safeguarding children – Roles and Competencies for Healthcare Staff ‘ published by the Royal College of Paediatrics and Child Health 2014, states, ‘All clinical staff working with children, young people and/or their parents/carers, and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person; where there are safeguarding/child protection concerns’, should be trained in safeguarding for children level one, two and three. The lead radiographer for paediatrics, the safeguarding lead for the ultrasound team, an interventional radiographer who was the lead for paediatrics, the paediatric specialist radiographer in the trauma and general x-ray service and two consultant radiologists who specialised in paediatrics and were trained to level 3 in children’s safeguarding. Staff told us that there were radiographers in the other hospitals who were also trained to level three in safeguarding children.

Children and their parents who did not respond or attend appointments were added to the Trust safeguarding database for monitoring.

Female genital mutilation was included in the safeguarding level 3 training and the lead sonographer for safeguarding cascaded to the whole team at training events. The ultrasound team performed trans-vaginal scans as part of their service and if they suspected any safeguarding concerns had contact numbers for the trust safeguarding team available to them.

**Cleanliness, infection control and hygiene**

The service controlled infection risks well. Staff kept themselves, equipment and the premises visibly clean. Control measures to prevent the spread of infection were available and practiced by staff, patients and visitors.

Hand hygiene audits took place monthly and audit data showed high levels of staff compliance with good hand washing practice. (See table 1 below.)

We observed safe hand hygiene practices were followed to minimise the risk of cross contamination between patients. Posters in waiting areas and other communal areas advised patients and visitors to disinfect their hands using cleaning products provided. Hand sanitiser units were located throughout the department and staff consistently used these as they left and re-entered treatment rooms. All staff we observed in clinical areas were ‘bare below the elbow’ in accordance with the national institute for health and care excellence (NICE) guidance. There were adequate supplies of personal protective equipment (PPE) including gloves and apron dispensers available.

In CT cannulation is used to inject contrast media, the service provided data which showed that audits of practice took place monthly and the staff were 100% compliant with best practice.

When treating patients who had a communicable infection such as tuberculosis, flu or scabies, all attempts were made to ensure their investigation was prioritised to reduce time spent with other patients. Where possible, appointments were booked for quieter times within the departments. Patient times in imaging rooms were minimised to reduce the risks of cross infection.
Environment cleaning was completed at regular intervals. Departmental staff were happy with the level of cleaning. We saw daily cleaning schedules were completed and up-to-date. We found clinical and patient waiting areas were visibly clean and free from dust and debris.

### Table 1

**Infection Prevention and Control Audits Sept 2017 - Aug 2018**

<table>
<thead>
<tr>
<th>Site/ modality</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
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<td>1</td>
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</tbody>
</table>

Table 2 shows how the service monitored cleaning performance throughout the departments and achieved a score of 95%, above the trust target of 85%. Staff told us the cleaning staff were responsive and prompt when called.

### Table 2

**Element Results for Most Recent Audits by Department**

<table>
<thead>
<tr>
<th>Audits</th>
<th>Elements</th>
<th>Passed</th>
<th>Failed</th>
<th>Total</th>
<th>Average Audit Score %</th>
<th>Average Target Score %</th>
<th>All 23 Locations were Audited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passed</td>
<td></td>
<td>347</td>
<td>20</td>
<td>367</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Failed</td>
<td></td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>23</td>
<td>20</td>
<td>43</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Note:** Cancelled and N/A Audits (and their associated Elements) and any N/A Elements are not included.

* Elements Points is the cumulative total of points that have been assigned to Elements.

* Score is calculated by dividing the Passed Elements Points by the Total Elements Points.
Staff were responsible for cleaning equipment in-between patient contact, and we saw this was completed using disinfectant wipes.

Staff in the mammography department had put together a weekly equipment cleaning rota. This ensured that all pieces of equipment had a thorough clean whether it had been used or not. General cleaning staff were not allowed to handle clinical equipment.

In the ultrasound department we saw a software-controlled chamber which provided high-level disinfection of ultrasound transducers. The device consisted of a sealed disinfection chamber and operated in conjunction with a multi-dose cartridge of concentrated hydrogen peroxide disinfectant. Pre-cleaned and dried ultrasound transducers were placed within the chamber and disinfected by means of an automated disinfection and aeration cycle. Following this cycle, the disinfected ultrasound transducer was removed from the chamber ready for immediate use. This decontamination process reduced the risk of ultrasound-related cross-infection, and the closed system minimised patient exposure to chemicals.

There were some toys for children to play with in the main waiting area, these met with infection prevention and cleanliness guidelines and were cleaned regularly.

Staff appropriately segregated waste products into hazardous and general waste bags. Bins were not overfilled and regularly removed from the departments. Sharps bins were assembled correctly and safely used, with openings restricted affording access to the contents within. All sharps bins were labelled with date of assembly and signed by the relevant staff member.

Cleaning materials were stored securely in line with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation which requires employers to control substances which are hazardous to health.

Environment and equipment

The service had suitable premises and equipment which was maintained to ensure it remained safe for use. The physical layout of the department was well designed and afforded privacy to patients. We saw a designated reporting area which was ergonomically designed to reflect the needs of the staff reporting on the images; some stations contained monitors that were for those who wished to stand while reviewing the images, some were at desks; and the room was dimly lit to aid reviewing on the screens.

Resuscitation equipment was observed to be in good working order and checked regularly for fitness of use. Staff completed daily checks which were documented. Staff in each area had easy access to the resuscitation equipment.

We saw oxygen cylinders accessible throughout the service. In each area they were chained to the wall for safe storage.

There was good security of the imaging rooms, it was managed via swipe card and only authorised staff had access. All imaging rooms were clearly signposted with “Do Not Enter” warning lights to ensure staff or patients did not enter rooms whilst imaging was taking place and receive exposure to ionising radiation.

Each treatment room had details of what activity was performed in each room.

Equipment calibration dates were seen in the clinical rooms and folders were maintained in the mammography rooms which detailed the daily, weekly, and monthly quality assurance (QA) folders which were fully completed by staff. We were assured that all equipment was properly maintained and fit for purpose.
Quality assurance testing of equipment was completed at regular intervals in line with the Institute of Physics and Medical Engineering. This work was undertaken by the medical physics team supported by radiographers and included generator checks and lightbox alignment.

Waiting areas were clear of clutter with suitable numbers of chairs available to meet patients’ needs.

Staff wore lead aprons where appropriate. These were screened annually to ensure they were not damaged. Staff also wore radiation exposure devices, which were analysed every three months to ensure staff had not been exposed to radiation.

The service had 24-hour support for their Picture Archiving and Communication System (PACS), the system used to store patient images. This was vital as a PACS failure this would significantly impact on service availability. The staff responsible for the system were based within the department and were an integral part of the team.

Equipment in the department was maintained in line with manufacturers’ requirements. There were maintenance and repair contracts. The service provided a comprehensive asset register of all their equipment detailing the specifications and purpose of each piece with costings and contracts.

Two MRI scanners had been served end of life notices by the manufacturer, this meant that should any of the parts fail they could not be replaced. Both scanners produced good image quality and there were no other issues with downtime, however there was a contingency if this became an issue. We learned that replacement of these machines was dependent on a plan which involved a capital building project to include an oncology ward located on top of an imaging department housing replacement MRI scanners. The outline plan was with the local sustainability and transformation partnership (STP) and the trust expect to know the outcome by the Autumn 2018. There were credible plans in place for all eventualities.

The old MRI scanners were in a basement area and the corridor leading to them was dark, unwelcoming and generally not patient friendly. Ceiling tiles needed replacing and the entrance and waiting area were gloomy and oppressive.

The third relocatable scanner was easily accessible to out-patients. The MRI team specially designed the environment for this scanner, it was bright and welcoming, and there were adequate seating and changing areas. The reception was unmanned; patients and staff had to read a notice asking them to call the radiographers. During our visit we saw that the phone was answered immediately, and a member of staff came straight away. A nurse call bell system was available for patients and there was CCTV monitoring of the room.

MRI equipment and devices were clearly labelled in accordance with Medicines and Healthcare Products Regulatory Agency (MHRA) 2015 recommendations. Rooms were clearly identifiable and controlled areas highlighted. There were wheelchair tether points for MRI unsafe chairs to prevent them being taken into the magnetic field area. All items within the controlled area were labelled according to MRI safety standards.

We saw well maintained and up to date radioactive waste records in the nuclear medicine department. Solid waste monitoring and recording was automated by a system designed by the medical physics expert (MPE) for the area called the decay store wizard. The MPE also designed a bespoke system to check for radioactive contamination of staff hands. This was automated and ran reports for each individual.
In the ultrasound and mammography departments staff said technicians were always responsive when required for advice or for fault repairs. We saw the records of daily equipment checks undertaken by the sonographers and mammographers.

The administration office was tidy, well organised and with minimal clutter although this was a busy area. The atmosphere was calm and pleasant. There was a system of telephone call management so there was sharing of calls allowing staff to work without distraction.

**Assessing and responding to patient risk**

The service used information to improve the service. Risk assessments were kept on the electronic quality management system and easily accessible to staff. We saw risk assessments for patients and staff attending or working in the service based on national guidance and updated at regular intervals according to any changes in national guidance. There were risk assessments for each clinical area in the Royal Cornwall Hospital Trust, and for other clinical and non-clinical sites. For example, ‘Safety needle risk assessment for the Mermaid Centre’ where breast clinics and mammography were carried out, and ‘manual handling; chair to bed’

The radiation protection team had recently updated the Ionising Radiation (Medical Exposure) Regulations 2017 IR(ME)R procedures and standard operating procedures as required under the Regulations from 2018, along with the Health and Safety Executive (HSE) Ionising Radiations Regulations (IRR17). A bespoke IR(ME)R training package with a power point presentation was available to staff online; and face to face sessions were available for non-medical referrers e.g. nurses working in the minor injuries unit (MIU). The radiation protection advisor told us they were planning to update training to provide a complete on-line package. We were told that much of IR(ME)R 2017 changes were already in place, for example, ‘machine breakdown and seeking advice’. The service was still considering how they wished to respond to the employer’s procedures requirements such as provision of appropriate information for patients to explain the risks involved with the imaging procedure they were receiving.

Local rules as required under IRR17 were displayed throughout the department. All areas which utilise medical radiation in hospitals are required to have written and displayed local rules which set out a framework of work instructions for staff. Staff were required to review these annually and when legislation was updated.

The service had designated, clearly identifiable radiation protection supervisors (RPS) to provide guidance and support to staff. The trust’s radiation protection advisor (RPA) was available on site to provide guidance and support. Staff told us that RPS and RPA were accessible and responsive to their needs.

Staff described action they would take if a patient became unwell or distressed while waiting for or during an investigation. Staff provided examples which showed they took appropriate action according to the situation. Patients whose condition deteriorated whilst in the department received initial care by the staff in the department and were quickly transferred to the emergency department if required.

Radiographers used a screening process to identify any pre-existing clinical conditions which may affect performance an investigation. For example, patients with an impaired kidney function received a reduced dose of contrast media. Contrast media are substances which increase the contrast of structures or fluids within the body used in certain types of radiological investigations. Staff checked patients, who required a contrast media, were not allergic to any substances prior to administering the medicine. During the inspection, staff routinely asked patients to confirm their previous medical history.
Before any preparation agents were sent to patients, screening questions were included within the referral order system. Risk of contrast-induced nephropathy was considered and patients at risk were reviewed by the radiologists. All radiologists regularly did this according to speciality, usually the same day or the next day following allocation, and identification checks by the bookings team.

Staff acted to minimise patients repeat exposure to radiation for investigative procedures. For example, staff identified when duplicate requests for CT scans were submitted. The completion of these requests placed patients at risk of repeated and unnecessary radiation exposure. Staff identified this as a concern and shared this with the referrers when necessary.

In interventional radiology we watched the daily team ‘safety huddle’. This included a review of the previous days’ team brief and de-brief reports. The team leader asked everyone how they were, which had been shown to be very beneficial to wellbeing and useful to be aware if there are issues at home that may affect how that team member is performing; the team included medical staff, nurses and radiographers.

Patients were referred to the departments by several methods, including via the patients’ GPs or consultants. On receipt of the referral the request was screened for appropriateness by the radiographers to ensure the right investigation was being requested according to the patient’s complaint. If there were any concerns about the request there was a radiologist on duty (ROD) available to provide advice.

There was a process for the assessment of patients who may be pregnant, and we saw staff checked the history with the patient. Posters, in all waiting areas, asked patients to talk to staff if they suspected they may be pregnant. A checklist was used to assess any potentially pregnant patient prior to the investigation being completed and patients were asked to confirm, sign and date they were not pregnant. We saw the 10-day rule was used in CT when patients were unsure. The 10-day rule recommended that, in women of child-bearing potential, non-urgent x ray examinations that entailed pelvic irradiation should be restricted to the first 10 days of the menstrual cycle.

To safeguard patients against experiencing the wrong investigation they were asked to confirm their identity prior to an investigation being completed. Information relating to the patients’ name, address, date of birth and expected investigation technique was discussed between the patient and the member of staff on arrival to the department. The Society of Radiographers (SOR) ‘pause and check’ process was used across all areas, with posters displayed. Pause and check refers to the SOR operator check list which prompts radiographers to confirm the patient and investigation using the prompts below.

| P | Patient | Check the exam is justified  
Check examination history for recent studies and duplication  
Confirm patient ID, always use unique identifiers  
Confirm pregnancy status  
Confirm the patient expected the exam  
Confirm patient has been given adequate information and understands and agrees to examination |
|---|---------|-----------------------------|
| A | Anatomy | Select the correct anatomical area  
Select the correct laterality  
Place the correct anatomical marker within the primary beam |
| U | User checks | Confirm the exam is being completed at the right date and time |
Confirm the exposure has been authorised
Confirm the correct modality
Check radiation safety measures for staff and/or carers
Communicate appropriate instructions to patient, carer and team

| S | Systems and settings | Select correct patient (unique ID) and exam date/time
|   |                     | Select correct imaging protocol / technique
|   |                     | Select optimal exposure factors (ALARP) (and adjust if required)
|   |                     | Select correct detector/bucky, AEC & grid as appropriate

| E | Exposure | Record dose and reference DRL
|   |          | Evaluate images, confirm necessity for repeat or additional views

| D | Drawer to a close | Add image comments or flags as appropriate
|   |                      | Complete RIS record
|   |                      | Confirm PACS images are stored accurately
|   |                      | Tell patient how to get results and where to go next
|   |                      | Adapted by kind permission of the Royal Free NHS Foundation Trust, London
|   |                      | “It is your legal responsibility as the IR(ME)R operator to ensure that these checks are carried out BEFORE (and after) an exposure is undertaken”

Patients who were unable to confirm their identity were referred to the requesting clinician. Staff told us if a patient was unable to confirm their identity they would not complete the requested investigation. If the patient wore an identity bracelet, the patient’s identity would be confirmed against this and if inpatients were accompanied by a member of staff to the relevant departments they would also be asked to confirm the correct patient had been brought for investigation.

We saw MRI safety implant checking procedures in place and the MRI safety policy was clear in what is contra-indicated for MRI and how the implant checks were to be carried out and documented. This was thorough and met the Medicines and Healthcare Products Regulatory Agency (MHRA) guidelines.

Patients were provided with MRI safety questionnaires and a contact number to a radiographer which enabled them to call if they had any implants, so these could be checked. Patients changed into gowns when required and were asked to remove all metal items.

There was a procedure to enable the safe scanning of MRI compatible pacemakers: this ensured those patients were not disadvantaged and did not have to travel to another centre for this. However, this was a time-consuming process so there was a referral vetting procedure to ensure the request was warranted.

There were many safety procedures to ensure that any staff not normally working in MRI from wards or other departments were made aware of MRI risks, including projectile and risk of burns. This training was provided to consultants and anaesthetists that may be present during scanning.

There was a protocol for when sonographers saw ‘significant pathology’ they could refer to a radiologist without delay.

The RCHT catheter laboratory and interventional suite were one of the pilot sites for the ‘Scan4safety’ initiative run by the Department of Health. This safety initiative ensured easy tracking of all items used or implanted during procedures to each patient. It also provided a ‘live’
stock control and ensures that no expired items were used. The interventional suite had a large stock turn over as most procedures used many items on a single patient. The re-order process used to be time consuming for trained staff. ‘Scan4safety’ had taken over the entire process allowing for a streamlined, safer process that the team embraced. Any tracking required from safety alerts were easily managed with a report of which patients may be affected. The clean utility and clinical stock was exceptionally well organised and managed through this new system.

We saw good use of the WHO safety check list in the interventional suite and we witnessed a daily team ‘safety huddle’. This included a review of the previous days team brief and de-brief reports. A one-page report was produced from each meeting and uploaded to the surgical governance shared drive. A monthly report was then compiled and sent back to the interventional team lead who used this at the monthly staff meeting to ensure all actions and points raised had been addressed or completed. This was seen to be excellent example of “closing the loop”.

We saw the radiologists’ daily huddle attended by all the consultant radiologists, including radiologists in training where they discussed operational issues that needed an immediate response and ensured that there was sufficient cover for the service.

**Nurse staffing**

The department employs nine registered nursing staff which makes a whole time equivalent (WTE) of 8.3. This was 0.5 WTE below the number service leads told us that they would like to recruit to.

**Vacancy rates**

From May 2017 to April 2018, Royal Cornwall Hospital reported an over-establishment of 0.8% in diagnostics, compared to a target of 10% at March 2018 and 6% at March 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 0% in diagnostics, compared to a target range of 10-14%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 3.03% in diagnostics, compared to a target of 3.8%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

From May 2017 to April 2018, the trust reported no bank or agency shifts were filled by registered nurses or nursing assistants in diagnostics at Royal Cornwall Hospital and there were no shifts unfilled.

(Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)

**Medical staffing**

**Planned vs actual**

The trust reported their staffing numbers as at April 2018 for medical staff in diagnostics as a whole at Royal Cornwall Hospital, with an overall staffing rate of 86.6%. Data was not provided solely for diagnostic imaging.
<table>
<thead>
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<th>Ward/Site</th>
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<th>Number in post as at April 2018</th>
<th>Staffing rate (%)</th>
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<td>Royal Cornwall Hospital</td>
<td>54.4</td>
<td>47.1</td>
<td>86.6%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From May 2017 to April 2018, Royal Cornwall Hospital reported a vacancy rate of 11.1% in diagnostics, compared to a target of 10% at March 2018 and 6% at March 2019. Data was not provided solely for diagnostic imaging.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From May 2017 to April 2018, Royal Cornwall Hospital reported a turnover rate of 3.5% in diagnostics, compared to a target range of 10-14%. Data was not provided solely for diagnostic imaging.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From May 2017 to April 2018, Royal Cornwall Hospital reported a sickness rate of 0.8% in diagnostics, compared to a target of 3.8%. Data was not provided solely for diagnostic imaging.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

From May 2017 to April 2018, the trust reported no shifts filled by locum staff in diagnostics and one consultant shift for clinical imaging staff that was unfilled.

The trust stated in their RPIR that they do not keep information regarding bank shifts filled centrally and so do not have the information available, which has highlighted the need to collate this and will work on this for the future.

(Source: Routine Provider Information Request (RPIR) – Bank Agency Locum)

The Diagnostic Imaging Service provided staffing numbers for their service see table below:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Radiologists</td>
<td>26</td>
</tr>
<tr>
<td>Radiographers (allied health professionals -AHPs)</td>
<td>132</td>
</tr>
<tr>
<td>Healthcare assistants and assistant practitioners</td>
<td>73</td>
</tr>
<tr>
<td>Administrative staff</td>
<td>36</td>
</tr>
</tbody>
</table>

The service provided a breakdown of staff vacancies at the time of the inspection:
The service regularly used a local staff bank, mainly for clinical imaging assistants (CIAs) and some radiography support. Some of the RCHT substantive team worked on the bank so sometimes filled gaps in the rota. Any agency use was mainly for sonographers.

The senior leaders told us staffing continued to be the biggest challenge and the biggest frustration for front line staff. The vacancies were described as “healthy” and retention good “but still work to do”. The service senior manager was looking at apprenticeship pathways up to assistant practitioner level and then a program to support progression to level 5 and registration. This enabled the service to capture local people wishing to start a career in radiography proactively and creatively to meet the workforce challenge.

Records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. Documentation was particularly detailed for patients attending the nuclear medicine department.

The service used two electronic record systems. The computerised radiology information system (CRIS) and picture archiving and communication system (PACS). CRIS was a password protected record of patient’s demographics and could be used to book patients into vacant investigation slots. PACS was the system for storing completed images and the associated reports. This system was also password protected and accessible only to radiology staff for reporting and clinicians who had requested the image.

The service maintained comprehensive electronic patient records on PACS, with details of all investigations and their findings, and all radiation exposure details.

Electronic records were secure. All computers observed were password protected and locked when not in use. If computers were sited close to patient areas, they were turned to prevent patients reading confidential information.

Patient records contained information for staff if a patient required additional support whilst under investigation. This included highlighting if the patient had mobility issues or presented an infection risk. This information was reviewed at the point of investigation by the radiographer. The system made sure all relevant fields of information were completed and that results were easily accessible to relevant personnel. Reports were available digitally and were part of the electronic patient record.

Referrals to the service for imaging were completed in two different ways, by paper referral or by electronic referral.

Medicines

The administration of contrast media and specific medicines in computerised tomography (CT) Magnetic resonance imaging (MRI) and nuclear medicine was via patient group directives (PGD). A PGD is a written instruction for the supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. PGDs allow specific health care professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The health care professional working within the PGD is responsible for assessing the patient fits the criteria as identified in the PGD. We saw a comprehensive list of PGDs maintained within the quality management system. The documentation was regularly reviewed and revised to reflect changes in practice. Staff read and signed all PGDs and confirmed they read associated policies within the system.
Patients receiving a gadolinium contrast agent for their MRI scan were screened appropriately to ensure there was low risk of causing nephrogenic systemic fibrosis (NSF), and reduced risk of gadolinium deposition in the brain and tissues. Low risk agents were used within this department, except for one contrast media agent used for scanning the liver. This was the only available agent and was medium risk.

There were risk assessments relating to the use of all the contrast media agents. All rooms where medicines were stored were well organised with dedicated lockable cupboards. We saw that all cupboards were locked. Staff maintained a record of medicines being stored and used, contrast media was stored appropriately and accessible by key members of staff.

The nuclear medicine staff used the administration of radioactive substances advisory committees (ARSAC) diagnostic reference level charts signed by the ARSAC holder. The dose of radiopharmaceutical (medicines used) was calculated according to the procedure being completed. This meant that the risk to patients was minimised and there was minimal wastage.

The CT team had a link radiographer who carried out medicines management and audit. This was carried out monthly and included drugs and contrast storage as well as staff training and policy knowledge. Protected time was available for this role, which meant that a busy clinical workload was not compromised, and outcomes could be monitored effectively and efficiently.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported no incidents classified as never events for diagnostics at Royal Cornwall Hospital.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in diagnostics at Royal Cornwall Hospital from June 2017 to May 2018 which met the reporting criteria set by NHS England. Both incidents related to radiology. One incident was for medical equipment/ devices/ disposables and the other incident was a treatment delay.

*(Source: Strategic Executive Information System (STEIS))*

**Radiation Incidents**

In 2018 up to the end of August the service reported four incidents involving inappropriate exposure to radiation.

- One related to an incorrect referral.
- Three involved radiographers working in plain film selecting incorrect imaging detectors. Two of these involved agency radiographers. As a result, there were changes made to staff training which ensured a thorough induction into each piece of equipment within the area that the radiographer would work. The radiographer was assessed before sign-off to ensure competence.

We reviewed a sample of investigations following reportable incidents from 2017 which showed that incidents were reported appropriately with root cause analysis carried out and actions to minimise further events put in place. The level and type of incidents reported by this trust was not viewed as exceptional by CQC IR(ME)R experts.
All incidents were reported on the electronic reporting system accessed by all staff. The governance lead for the service trends and themes all reported incidents monthly. Incidents were reviewed at monthly directorate meetings which included service and modality leads and all radiologists. The service manager meets weekly with by the section leaders where actions and learning from incidents was shared and cascaded to their teams.

The quality and service improvement lead for clinical imaging was working with the leads for the trust wide electronic reporting system to recategorize the incident codes. The goal was to align the codes with the radiology quality management system for the imaging service incident reporting. Staff had a trigger list to help them code correctly in both the reporting systems.

We were provided with examples of learning from reported incidents. Following an incident in the MRI scanner the control room was always locked down for improved security, and we saw that all staff who have received training in understanding MRI wore a green lanyard, making them quickly identifiable. MRI safety week was highlighted to all trust staff recently with a banner on the greeting screen as they logged into the trust computer network.

Staff who needed to enter the MRI scanner area signed and dated a safety questionnaire record to ensure there was no risk to them entering the magnetic field. This was in the form of a book completed in alphabetical order with a statement of safety on the front page. This log formed a measure of continuing safety in the area.

Following an incident in the CT scanning room, where contributing factors showed that there were multiple distractions when scanning, a CT coordinator role was created; all staff agreed that this was an improvement to the working environment. At the time of our visit we saw that all calls were taken in a separate office staffed by the coordinator radiographer who vetted referral forms following radiologist justification and authorisation. This was done to ensure no relevant information was missed about a patient.

One staff member described a security incident when a patient’s partner trapped them in the scanning room and was rude and aggressive because he was asked to wait outside the scanning room with their small child until the scan was completed. This event led to an update in the lone worker policy and more detailed focus on risk assessments by sonographers particularly when they go to the smaller hospital sites.

The clinical imaging service had a lead for the duty of candour who ensured that patients involved in incidents had the impact of the error explained to them with an apology.

**Is the service effective?**

**Evidence-based care and treatment**

The service was subject to the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists (RCR), the College of Radiographers and other national bodies. We saw local policies referenced this legislation and guidance.

Policies and procedures were reviewed and stored on the directorate’s quality management system (QMS) and reflected current national guidance. There was a system to ensure policies were reviewed in line with guidance changes and prior to policy expiry. The consultant radiologists had standardised protocols and all scanners were programmed accordingly. These protocols were backed up externally in case of scanner breakdown.
There was a named radiation protection advisor (RPA) whose role was to advise on the development, implementation, monitoring and review of the policy and procedures to comply with IR(ME)R regulations.

The trust’s medical radiation physics team provided scientific support, advice and guidance on IR(ME)R regulations concerning the use of imaging equipment and monitored the radiology equipment and any staff radiation doses. The main legal requirements enforced by the Health and Safety Executive (HSE) were the Ionising Radiations Regulations 17 (IRR17). In line with IRR17, the imaging department appointed radiation protection supervisors (RPS) whose role was to ensure staff followed the trust standard operating procedures and adhered to the radiation protection procedures. IRR17 requires employers to keep exposure to ionising radiations as low as reasonably practicable.

National diagnostic reference levels (DRLs) were displayed in the imaging areas. DRLs are typical doses for examinations commonly performed in diagnostic imaging departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses. However, they can be used as a signpost to indicate to staff when equipment is not operating correctly or when the technique is poor. Staff audited radiation dose levels and we saw records of this.

A quality assurance programme monitored image quality daily and there was continual feedback from radiologists which was logged. Recent trends showed patient specific (weight) based contrast dosing for CT scanning was not showing adequate enhancement on all patients. This was a change brought in to reduce contrast induced nephropathy by increasing the strength of iodinated contrast and reducing the volume required. In response to this feedback trend further changes to scanning protocols were in progress.

The imaging department had an audit programme and provided data and outcomes of completed audits during the year up to July 2018, examples of audits included those undertaken in the smaller departments outside the main service at the Royal Cornwall Hospital. Examples we saw were:

- An audit of pelvis exposures
- Patient dose optimisation for lumbar spine plain film x-rays
- Paediatric chest imaging

Each of these audits were presented with conclusions and actions

We attended the monthly clinical audit meeting chaired by the lead radiologist for clinical audit. The meeting was attended by radiographers of all grades, radiologists and radiologists in training. An attendance list was circulated, and records are maintained with actions noted. The meeting started with the action log from the previous month and the status of the audits presented. Comments and questions were welcomed after each presentation. There was respect between each of the professional groups and was healthy debate and feedback after each presentation. There were six radiographer presentations; one by a radiologist in training and one by a consultant radiologist.

Audit outcomes were saved into the electronic quality assurance (QA) folder which was accessible to all imaging staff. The presenters explained that they always fed back to staff either verbally to individuals or in writing and put into the QA folder.

**Nutrition and hydration**
Patients were advised on whether they could eat or drink prior to their treatment in their appointment letters. If staff had concerns about a patient who had not eaten and had a health condition such as diabetes, they could provide a light snack, however staff told us this almost never happened as patients came prepared and waits in the department were usually short.

Some patients were prescribed intravenous fluid prior to their scan to guard against nephropathy (kidney damage).

**Pain relief**

Pain relief was not routinely used in diagnostic imaging, except for when patients were attending for invasive procedures. Staff provided patients with pain control specific to the investigation being undertaken.

Staff told us some patients were advised when procedures may be uncomfortable, and time was taken to reassure the patients and keep them informed of the length of time remaining for procedures.

Staff ensured patient comfort prior to completing simple diagnostics, such as ultrasound scans, and x-rays. We saw patients were assisted to reposition themselves if they reported they were uncomfortable, and reassured during procedures.

**Patient outcomes**

At the time of our inspection, the imaging department had completed their preparation for Imaging Services Accreditation Scheme (ISAS) accreditation. ISAS auditors were on site to undertake their assessment of the service. Auditors carry out checks on the quality of the service provided prior to awarding the accreditation. ISAS was developed to support diagnostic imaging services to manage the quality of their services and make continuous improvements.

Radiologists conducted a discrepancy meeting every fortnight as set out in the Royal Colleges of Radiologist (RCR) standards. Radiologists and registrars attended these meetings where discrepancies in reports were subject to discussion; the reporting radiographers were also invited and expected to attend the meetings. Learning points and actions were evidenced; this was standard practice to look at minor discrepancies through peer-review and personal development.

The consultant radiologist presented the annual discrepancy meeting report as per the Royal College of Radiologists (RCR) guidelines at the monthly audit meeting in September during our inspection.

There was a reject analysis presented for all 10 hospital imaging sites in Cornwall; the reject rate was 8% and therefore below the World Health Organization (WHO) threshold.

**Competent staff**

**Appraisal rates**

Up to August 2018, 91.5% of staff within diagnostics at Royal Cornwall Hospital had received an appraisal. 85.7% of medical staff and 100% of nursing staff had received an appraisal, compared to a trust target of 95%.

A split by staff group can be seen in the tables below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>9</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>27</td>
<td>27</td>
<td>100%</td>
</tr>
</tbody>
</table>
Qualified Allied Health Professionals | 84 | 87 | 96.6%
---|---|---|---
Support to Scientific, Therapeutic and Technical Staff | 55 | 61 | 90.2%
Medical & Dental staff - Hospital | 24 | 28 | 85.7%
Qualified Healthcare Scientists | 13 | 18 | 72.2%

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Data supplied by the service for June 2018 showed that the appraisal compliance overall was at 90.76%

All staff we spoke with told us they had received an appraisal within the previous year and it was useful. Modality team leads reviewed the appraisal rates at their weekly meetings and carried out appraisals with their team in a timely way wherever possible. All team leads had received appraisal training. New starters received a mini appraisal after they had been in post three months, to check that competencies were progressing and they were settling in.

All staff administering radiation were appropriately trained. Those staff who were not formally trained in radiation administration were adequately supervised in accordance with legislation. Each area within the imaging department had lead radiographers. This was a senior practitioner to ensure delivery of recommended standards as recognised by the Society of Radiographers (SoR).

New staff were expected to go through the comprehensive induction programme; this ensured they gained competencies for their job role in all modalities of diagnostic imaging. Induction involved three days corporate induction followed by local induction within the area of practice. The service provided a comprehensive local induction pack designed by the team leads for each area. The new staff were able follow this guidance for all the procedures in the area they were assigned to work and gain competency in the procedures for sign off by the modality lead and the training lead. We reviewed the induction pack provided to new staff. Two that we spoke with told us it was the best they had ever received. We saw the training/induction pack for each of the interventional rooms based on the equipment. There was a paediatric competence section in the staff folder for staff who saw children as part of their role. Training folders were seen to be completed and signed off.

The training pack in the CT scanning area included all pieces of equipment and competency required and the use of pressure injectors.

All MRI Radiographers were competent to inject gadolinium contrast and they received intermediate life support (ILS) training. These staff were provided with epi-pens to enable immediate adrenaline injection in the event of anaphylaxis. All the radiographers working in the MRI scanning area had achieved competence in intravenous (IV) cannulation training.

All non-medical referrers received training in MRI safety. This included a half day within the unit to appreciate the limitations for certain groups of patients within the bore of the magnet.

There was provision for new staff training in MRI to be supernumerary for the first four weeks. MRI training records were reviewed for staff and detailed and thorough. The records covered the modality equipment and competence.

Any bank staff who were brand new to the department would receive a bespoke training pack for sign-off for the areas in which they work only and could be expanded to cover other areas as and when required.

Several radiographers were advanced practitioners and the service had two consultant radiographers; one in the breast service and one in the gastro-intestinal fluoroscopy service. The consultant in the breast service was the family liaison mammographer, they worked closely with...
the genetics team and received peer support from the Peninsula Clinical Genetics (PCG) group. The PCG provided a genetic assessment and counselling service which covered all types of genetic conditions, including cancer genetics. Clinical guideline [CG164] covers care for people with a family history of breast, ovarian or another related (prostate or pancreatic) cancer. The consultant breast mammographer told that they had capacity to provide the service according to the NICE guideline. They carried out biopsies with support of the radiologists.

All sonographers and mammographers had a post graduate certificate; one sonographer had just completed training to carry out fine needle aspirates (FNAs) and was continuing their training to undertake biopsies. At the time of our inspection there were four advanced practitioners in ultrasound providing specialist services; another was training in musculoskeletal scanning. Sonographers stored all the images on the picture archiving and communication system (PACS) and peer reviewed each other’s reports. There was a monthly education session which included students providing a very good learning opportunity. Applications specialists provided annual presentations from which staff gained further expertise in current practice and software updates.

Radiographers working in the dual energy X-ray absorptiometry (DEXA) scanning service were trained appropriately for their roles. A DEXA scan is a type of X-ray that can measure tiny reductions in bone mineral density (BMD). This makes it possible to diagnose osteoporosis in its early stages, before fractures occur. A DEXA scan also uses a low dose of radiation, which means the risks to health are much lower than standard X-rays. There was an assistant practitioner who had completed the DEXA technician course. This meant they were competent to perform scans independently. Two staff including the DEXA lead also reported on these scans and were encouraged to attend various conferences and regional meetings.

There were three radiographers within the trauma and general imaging team who were competent to report on axial and appendicular musculoskeletal imaging. There were another three radiographers who had gained competency in appendicular musculoskeletal imaging. Radiographers told us they were very pleased with the opportunities they had been offered but frustrated by the lack of dedicated protected time for their reporting. Some were preparing job plans to present to their line manager to negotiate protected time for reporting.

All radiographer reporters were audited and worked very closely with the supporting radiologists. They attend the multidisciplinary team meetings for their specialist areas which enables them to contribute to the wider team and understand the consequences of their clinical decisions.

The clinical imaging assistants and radiology assistant practitioners demonstrated a range of skills including cannulation, monitoring and clinical observations. The staff we spoke with were very positive about the opportunities for development open to them. Some had progressed from administrative roles to practitioners for example in nuclear medicine.

A theme emerged within the radiology service; staff could develop due to supportive consultant radiologists. There were four CT colonography trained radiographers, one of whom was also a consultant radiographer undertaking various other fluoroscopy procedures and endoscopy (initially barium enemas), a service which has been allowed to grow. An advanced practitioner in interventional radiography carried out a radiographer-led hysterosalpingogram (HSG) service. The HSG examination is an intimately invasive and emotionally challenging procedure to ascertain tubal patency in women who are failing to conceive.

This clinical group carried out self-audit and peer review audit to ensure quality and competence. This group also acted as practitioners, reviewing CT colon images followed by a chest scan if any pathology was seen.
All assistant practitioners worked under a defined scope of practice.

Staff training for the administrative team was exceptional. Individuals were given a folder on their first day that provided structure and detailed training in all areas and competence assessments. It demonstrated that staff were valued and welcomed into the team.

**Multidisciplinary working**

We saw doctors, radiographers, radiography assistants, clinical imaging assistants (CIAs) and administration staff worked collaboratively to assist with the patients experience in the departments. Conversations between all staff were respectful and considerate. We saw good working relationships between the imaging department and the radiation protection team and with staff in the emergency department.

Radiologists were fully participating in cancer multidisciplinary team meetings (MDTMs).

One new consultant radiologist told us he chose to take up a post in this department because of the especially good team working amongst the radiologists and the radiographers. He had worked in several other hospitals previously and found that they worked very differently.

The service quality and governance lead told us that they had begun to work more closely with their counterpart in the radiotherapy department to share ideas and they completed an IR(ME)R audit together. They were also developing closer links with the trust governance leads for support.

**Seven-day services**

At the time of our inspection, imaging services at the Royal Cornwall hospital imaging department were provided every day of the year, 24 hours a day. This meant patients had good access to emergency imaging and reporting.

Imaging services in West Cornwall hospital were provided every day of the year between 8am and 11pm. In St Michael’s Hospital in Hayle, imaging services were provided Monday to Friday between the hours of 9am and 5pm. Most of the imaging services commissioned by the community hospitals in Cornwall were available Monday to Friday between the hours of 9am and 5pm with a few exceptions where services were available seven days a week.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. We did not see any patients experiencing a mental health condition during our visit, but staff could give a good account of their understanding of how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. However, training compliance did not always meet the trust’s target.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that from May 2017 to April 2018, Mental Capacity Act (MCA) level 1 training had been completed by 100% of both medical staff and nursing staff within diagnostics at Royal Cornwall Hospital; and by 95.20% of the allied health professionals.

Deprivation of Liberty training data was not included within the RPIR.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Updated analysis for April to August 2018 found that Mental Capacity Act (MCA) level 1 training had been completed by 99.3% of staff within diagnostics at Royal Cornwall Hospital. All nursing and medical staff had completed the training.

(Source: Updated data provided by the trust)
Patients told us staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations. During the inspection we observed verbal consent was requested for all procedures, staff sought patient’s permission prior to initiating any imaging. Consent was documented on the patients’ electronic care record.

Discussions prior to interventional procedures included a description of the investigation, the possible side effects and the recovery period. Patients were given the opportunity to discuss any concerns or queries prior to giving written consent.

There was careful consideration to the MRI safety aspects of patients that lacked capacity for any reason. A separate safety questionnaire was available to referrers to complete on behalf of the patient using the case notes to ensure there are no contra-indications to MRI.

Is the service caring?

Compassionate care

We observed staff caring for patients with compassion and understanding. Staff demonstrated a good understanding of patient’s anxieties and approached them with a calm and reassuring manner. All staff introduced themselves to patients, gave details of their name and checked they had attended the department for the specific investigation they had expected.

Patients were treated with dignity and respect and as individuals. We saw staff take the time wherever possible, to interact with patients and their relatives. Screens were available when needed and staff always ensured patients were covered to protect their modesty during procedures.

Chaperoning was on offer to patients in the ultrasound department if they requested it. Male sonographers who carried out transvaginal scans always had a chaperone with them.

Patients gave consistently positive feedback about the care provided by staff, who they described as kind and caring. Patients told us staff were “all lovely” and another patient described their care as “excellent all the way through”. We saw multiple thank you cards in the CT control area from patients.

Staff members displayed understanding and a non-judgemental attitude when talking about patients who had mental health concerns or learning disability, autism or were living with dementia diagnoses.

One of the radiographers attended the monthly “Innovation and Inspiration Session” run monthly month by a consultant nurse and associate director of nursing. The sessions were designed to shape improvements in hospitals for people living with dementia and their carers. The session speaker believed that knowing the dementia patient, their life story and their goals was key to providing optimal care as it puts their everyday reality into a context. We were told the session was an “extremely good” the title for the session was “10-15 seconds” and was about how it takes this short time to make life more efficient and effective. These sessions were open to all staff who receive the invite via e mail.

There were changing cubicles available close to the imaging equipment which afforded patients adequate privacy. In the MRI scanning area lockers were provided for patient’s belongings.

Patients at reception were spoken to respectfully and dealt with efficiently; staff at reception greeted all patients and we observed staff informing patients if there was a delay in their appointment.
The governance and quality lead had recently developed a bespoke friends and family test to include more questions pertinent to visits to the imaging departments. At the time of our inspection one form had been completed and returned so we could not draw any conclusions.

In the nuclear medicine department caring was demonstrated through multiple examples of feedback including a therapy patient that had received multiple treatments. Staff clearly cared and discussed the time they took with patients to ensure they endured the scanning procedure providing reassurance throughout. This included wrapping patients in blankets to help them relax and feel ‘cosy’ during scanning.

**Emotional support**

We observed staff give reassurance throughout their examinations. Patients told us staff were professional and supported them well to minimise their distress. The staff in the MRI scanning unit explained how some patients found the experience claustrophobic and noisy, and staff had to reassure them constantly. Staff had good awareness of patients with complex needs and gave examples of how they would deal with individuals presenting as anxious.

Staff could deal with patients who could express complex behaviours. During the inspection staff identified an inpatient who was experiencing confusion which made them unable to co-operate with positioning prior to the treatment. We saw the staff take the time to persuade the patient to remain still by making them as comfortable as possible and kindly explaining the need for the investigation image.

We saw the quiet room available in the ultrasound waiting area to allow staff to discuss findings with patients in privacy.

**Understanding and involvement of patients and those close to them**

We saw staff continually interact with patients before, during and after their appointments to ensure they understood the investigation they were due to receive. Patients told us they were involved with decisions about their care and treatment. Staff informed patients how long it would be before they received the results of their investigations and advised patients when it would be appropriate to book a repeat appointment with their GP to review the results.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Diagnostic imaging services were provided over a seven-day working pattern, with an on-call service for emergency scanning, this enabled patients to be seen at times to suit their needs.

Services were provided in local community hospitals with evening and weekend sessions set up to manage demand in two of these hospitals. The imaging department in the main site was located very close to the emergency department and offered a 24-hour service for them.

Appointment letters explained the purpose of the diagnostic tests, what patients needed to bring, and how they needed to prepare. The patients we spoke with told us they received useful information to help them plan their visit.

The department had water fountains available for patients to access drinking water.

There were café facilities close by within the hospital which patients and relatives could access.

**Meeting people’s individual needs**

Staff told us they were usually aware if a patient attending for investigation had mental health needs or other additional needs such as a learning disability. Sometimes referrers omitted this
information so imaging staff would rely on a verbal handover and would add the relevant information to the CRIS to ensure this was available before future attendances by the patient. If this information was not known or documented however, staff knew the appropriate action to manage patient’s needs. Staff explained if a patient became anxious or restless during a procedure they used distraction and de-escalation techniques to calm patients, especially those living with dementia. Staff recorded in the electronic notes when patients displayed behaviours staff might find complex, to ensure other staff would be aware of these additional needs for future appointments.

The mammography department offered pre-appointment visits for patients with learning difficulties or dementia to familiarise them with the environment. Directorate meeting minutes showed there was a learning disability study session in June open to all staff.

The learning difficulties and dementia support team could be contacted in the hospital and provided support when needed. The nuclear medicine team had a quiet area for patients to reduce stress. They explained that they were usually successful in this and patients were not left alone.

Waiting areas were large enough to accommodate wheelchairs. We saw staff supporting patients with mobility aids to walk. There were patient toilets conveniently located and suitable for the use of patients who had reduced mobility and required aids or wheelchairs.

Moving and handling equipment to allow for the movement and investigation of patients weighing 127 kilograms plus was available. This included access to specialist wheelchairs, seating and tables to support patients to undergo imaging procedures.

In nuclear medicine there was a soft trolley and quiet room available for patients that wished to lie down or sleep during the uptake period. This is the waiting period following the injection of the radioactive isotope and before the scan can be carried out.

We saw good provision for children in the MRI scanning area with use of a play specialist and careful consideration of a child’s ability to cope with the scanner. There was a play scanner on the ward and the use of an electronic tablet, for music and to allow children to hear the noises the scanner makes before they arrive.

All young children were given a teddy bear provided by a charity before their scan which they could take into the scanner with them and then take home.

**Access and flow**

All patient appointments were managed from the main office except for nuclear medicine and ultrasound.

Radiologists justified and authorised all referrals that required an appointment at the main hospital site. The administration team and the lead clinician closely monitored radiologists’ leave, to ensure there were no gaps within the specialty teams.

The radiologists had a radiologist on duty (ROD) daily to be the point of contact for immediate advice. The day was divided into four sessions and the ROD was available on the phone for all queries relating to imaging needing immediate response. All the radiologists participated in the rota and they all agreed this model, introduced eleven months ago, was an improvement as it allowed those not on ROD to work undisturbed.

The service also sent out reminder letters and had recently procured an upgrade to the CRIS system with a consortium of four Devon trusts which enabled texts to be sent to patients. This meant a more imminent reminder would be able to be sent to patients soon.
We saw an excellent system for safe management of appointments for patients who did not attend for their appointments (DNAs) that ensured the referrer was made aware as quickly as possible. A daily check was made of the previous day’s work. All DNA referral forms were checked to ensure the correct address was used, if correct this was returned to the referrer with a letter. Staff called the patient’s practice for all patients referred by their GP to check the address. If this was correct the referral was returned to the GP. For patients on the suspected cancer pathway, a second appointment was offered. If there was a further DNA, the referral form was returned to the GP with a letter. For children that DNA, a second appointment was made, and at the same time this was logged by the radiology administrator onto a trust wide safeguarding database. If the patient DNAs a second time, the referral form went back to the referrer with a letter. Every week the list of DNA patients was checked to ensure that no patient was missed during the daily follow up procedure.

This DEXA service team were aware of the need to prevent fractures caused by osteoporosis in their patients. The radiology services manager was key in allowing the team to expand the service to accommodate as many patients as possible by increasing staffing and opening times to four days per week from June 2018. The DEXA unit at the Royal Cornwall hospital was the only one in the county at the time of our inspection. There was a very low DNA/cancel/abandon rate for the DEXA scanner appointments as all referrals were reviewed carefully by the radiographers to ensure that appointments were suitable (for those travelling from outlying areas) and that mobility and difficulty in patient positioning (for example those immediately post-operation etc) were considered before the patient was booked.

During the inspection the CT lead was seen to manage an equipment breakdown in an organised way so that although one scanner was taken out of commission for two days, arrangements were quickly made to re-arrange all appointments by ensuring radiographers and radiologists worked later shifts and by using all available scanning capacity. This ensured patients were not inconvenienced or delayed.

There was a good flow through the CT scanner with excellent utilisation that was monitored by the modality lead radiographer. It was staffed with two radiographers per scanner and one assistant. Cannulation and patient changing was undertaken outside of the scanning room to support good flow. This enabled 15-minute appointments and increased capacity.

Patients attending for colon scans were not delayed because the consultant radiographer in gastrointestinal imaging with reporting skills, and an advanced radiography practitioner in interventional radiography were able to refer for a chest scan where appropriate.

The sonographers told us the radiologists were extremely responsive and always took extra patients into their clinics when asked by the team.

There were multidisciplinary one-stop clinics, such as in the breast clinic, where patients could access consultations, diagnostics, results and clinical nurse specialists in one appointment.

**Diagnostic waiting times**

The imaging service provided a timely service within national performance standards for six-week waits.

For ultrasound appointments following GP referral the trust only provided approximations of their performance. These showed that for all types of ultrasound referrals, patients waited approximately six weeks for both urgent and routine appointments. For two-week waits, again patients waited approximately two weeks for both urgent and routine appointments.
Weeks waited by imaging specialty end of October 2018 (rounded):

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<th>2</th>
<th>3</th>
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<th>8</th>
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<td>25%</td>
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<td>10%</td>
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<td>3%</td>
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<td><strong>Mammography</strong> (3 patients)</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
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<td>17%</td>
<td>13%</td>
<td>13%</td>
<td>9%</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Fluoroscopy</strong> (148 patients)</td>
<td>26%</td>
<td>26%</td>
<td>18%</td>
<td>9%</td>
<td>12%</td>
<td>3%</td>
<td>3%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
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<td><strong>MRI</strong> (2,329 patients)</td>
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<td>21%</td>
<td>21%</td>
<td>17%</td>
<td>13%</td>
<td>6%</td>
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<td>0.2%</td>
<td>0.1%</td>
<td>0%</td>
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</tr>
<tr>
<td><strong>Nuclear medicine</strong> (321 patients)</td>
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<td>0%</td>
<td>0%</td>
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<td><strong>Radiology</strong> (2,010 patients)</td>
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<td>7%</td>
<td>6%</td>
<td>1%</td>
<td>4%</td>
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<td>0.2%</td>
<td>0%</td>
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<tr>
<td><strong>Ultrasound</strong> (1,683 patients)</td>
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<td>15%</td>
<td>9%</td>
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<td>0.3%</td>
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**GP X-ray appointment waiting times**

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<th><strong>GP Plain Film Appointments</strong></th>
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<td>West Cornwall Hospital, Penzance</td>
<td>3 days</td>
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<tr>
<td>St Michaels Hospital, Hayle</td>
<td>6 days</td>
</tr>
<tr>
<td>Falmouth Hospital</td>
<td>8 days</td>
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<tr>
<td>Royal Cornwall Hospital, Truro</td>
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<tr>
<td>St Austell Hospital</td>
<td>12 days</td>
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<tr>
<td>Bodmin Hospital</td>
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<tr>
<td>Camborne &amp; Redruth Hospital</td>
<td>6 days</td>
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<tr>
<td>Newquay Hospital</td>
<td>same day</td>
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**Breast symptomatic target**

The target is 93% of patient to be seen within 2 weeks of referral and March performance was 95.6%. 7 breaches – 4 due to weather, 3 due to other patient reasons.

Data for the eight months prior to our inspection showed demand for all modalities was increasing month on month which explained the lack of capacity to reduce waiting times for access to the imaging service. The service manager said they felt the wait times at the time of our inspection
were manageable, but there were significant breaches for ultrasound scans. There was a DNA problem and the service was discussing with neighbouring services to see if improvements could be made. Some short notice appointments were sent to local people to fill any appointment slots made vacant by people who did not attend, and in-patient scans also filled any slots left vacant.

**Reporting turnaround times**

The diagnostic department had several methods of taking an image, termed modalities, which included X-rays, CT, MRI and ultrasound. There were two waiting periods involved with imaging investigations, the wait for the investigation (image) to be completed and the time for the image to be interpreted by a radiologist (termed reported). In some cases, an image was interpreted by a non-radiologist clinician, which was termed as "reviewing". Patient’s treatment often relied on the reporting of an image by the radiologist to the patient’s referring clinician. The trust provided data on the waiting times for radiologists’ reports to be completed. The service manager told us they “micro managed” the reporting and said an average of about 800 examinations was manageable; between 800-1,000 required intervention and over 1,200 rapidly became unmanageable. The service manager reviewed the reporting requirements weekly and enlisted insourcing and outsourcing services as required. All reporting members of the Cornwall Radiology Consultants (CRC) were current RCHT Consultant Radiologists. The CRC provided insourcing reporting capacity to the imaging directorate.” As much reporting as possible went to this group with minimal going to external providers. The trust never outsourced MRI prostate scans for example but did outsource simple neurology scans.

On-call reporting was undertaken by radiologists in training with 24-hour cover. Each covered a 1 in 30-night rota which also provided training opportunities. Peninsula Radiology On-call (PROC) covered the whole of Cornwall and Devon and was supported by the deanery.
Data for reporting timelines for each modality for the months of June to August 2018 are tabulated below. We noted these were within the numbers that the service found manageable.

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<th>Exam to Report Verified (days)</th>
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<th>CT</th>
<th>Ultrasound</th>
<th>MRI</th>
<th>Obstetrics</th>
<th>Fluoro</th>
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Learning from complaints and concerns

Summary of complaints

From January to August 2018 there were six complaints about diagnostic imaging. The trust provided data that showed the overall response to complaints where diagnostic imaging had been involved took an average of 48.9 working days to investigate and close. However, the diagnostic imaging service provided additional data which showed they responded promptly to investigate and close complaints and the delays reported in the trust’s data reflected delays in other areas of the hospital. The most prevalent types of complaints were those relating to appointments (five of six).

Complaints were managed by a member of the administration team working closely with the clinical team and the trust patient experience team to manage them effectively and within the agreed timeframe. This was not reflected in the data above. The quality and service improvement lead reviewed the complaints monthly and supported any investigations required.

Number of compliments made to the trust
From September 2017 to August 2018 there were 80 compliments made to the diagnostic imaging service.

**Is the service well-led?**

**Leadership**

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

The diagnostic imaging directorate formed part of the Clinical Support and Cancer Services Division (CSCS). The division was led by a clinical director, associate director and an associate director of nursing. The Imaging directorate was led and managed by a specialty director and an imaging lead, supported by a radiography service lead, a clinical governance lead, a clinical audit lead and a quality and service improvement lead radiographer. The imaging specialty director oversaw the management of the consultant radiologists and was responsible for delivery of clinical services and management of clinical risk. The imaging lead was responsible for the operational management, service delivery and performance, including management of demand and capacity, the environment, and the line management of staff. Each imaging modality had a team lead who reported directly to the radiography service lead.

The teams were well established, and staff told us that they found all the leaders approachable and supportive.

Staff in mammography told us they saw the service manager and were satisfied they received management information through their team leads.

Nursing staff in the interventional suite told us that the radiology manager was “exceptional in her management of the team and showed genuine care for her staff.”

The service quality and improvement lead regularly visited the other hospital sites to support the teams.

**Vision and strategy**

The trust had a common vision for nursing, midwifery and allied health professionals to ‘recognise and reduce the unwanted variations in care and treatment’ and ‘empowering the workforce to lead change’

There were two national strategic frameworks to support the vision “Leading change, adding value, for nursing, midwives and care staff and “Allied Health Professionals into Action – Using Allied Health Professionals to transform health care” which supported the trust strategy and engaged healthcare professional in the vision.

The vision and strategy were explained to all staff in a pocket-sized hand out, which all staff were given. Staff were encouraged at team meetings to suggest ideas that had the potential to improve through change.

The vision for the imaging service was evident, with robust plans to improve the environment and expand the service. The immediate goal was to achieve the ISAS accreditation and to realise the building plans to accommodate the replacement MRI scanners.

**Culture**

Throughout the inspection, staff told us they were happy with their work and enjoyed working for the trust. All the staff we spoke with said positive patient experiences drove their enthusiasm for
their role. Staff felt listened to and said they worked well as a team. There was a positive culture for delivering high-quality care.

The teams were positive about the capital investment plans and the whole team was very motivated.

All staff spoke proudly about their work in their individual modality and as a part of the diagnostic imaging service. Staff felt supported in their work and said there were opportunities to develop skills and competencies, which were encouraged by senior staff. Staff felt valued and were supported by colleagues and senior managers. For example, a senior administrator explained how supported she felt by her manager and the service manager, and how she valued the team working for her.

The lead consultant and the service manager agreed that their proudest achievement was “the positivity of the whole team and the collective responsibility of the radiologists; there was no silo working”.

The divisional manager agreed that this team were superb and good to work with. The last CQC report rated the outpatients and diagnostic imaging collectively as inadequate but the manager was clear that this was not down to this team. What we observed on this inspection supported that view.

Staff were aware of the duty of candour (DoC) regulation and showed this through discussion of the appropriate application when required. The service had a lead for applying the duty of candour. The DoC is a regulatory duty which relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

**Governance**

The service used a systematic approach to continually improve the quality of its services whilst maintaining standards of care. There was a governance structure which was effective and promoted staff confidence.

During our inspection we saw structures, processes and systems of accountability to support the delivery of high quality care.

The service meetings were inclusive and worked well. The quality and service improvement lead attended the clinical operations and the directorate governance meeting monthly, and team leads meetings each week. Each meeting included; capital plans; performance; governance; reporting; and another hot topic.

The service was assured that governance and performance at the other sites where imaging was provided were equivalent to the main site because:

- There were cross over meetings and feedback
- Rotation of staff through other sites resulted in sharing of practice and knowledge
- The lead for quality and improvement and the lead for trauma and general radiography regularly visited the other sites.

The larger sites such as West Cornwall, had their own governance meetings and linked directly with the lead for quality and improvement. The service shared an example of a security concern at West Cornwall hospital, which led to a review of the safety strategy and the introduction of self-locking doors and increased reception hours.
There were champions in each modality for infection prevention and control; health and safety; the electronic quality management system; and audit. We learned that there were two staff in the mammography team with specialist skills and knowledge in dementia and people with learning disabilities. The champions were supported to attend meetings and training which were available monthly.

The operational team leads had a daily huddle at 9am each morning to engage all staff and update them on the activities during the night which may need further input, attention, or follow up.

Trust board meeting minutes showed divisional boards and speciality governance meetings occurred monthly and shared learning from recent incidents were included. The format varied on the level of meeting and the audience. For example, “Divisions will hold high level shared learning events specifically to invite debate about themes and trends either across the division or the trust. The imaging service were able to contribute to the division to share learning.

The radiation protection advisor attended the health and safety committee every six months which was chaired by the chief operating officer. This ensured that issues relating to imaging were always on the agenda at high level.

Other formal meetings included the Ionising Radiation (Medical Exposure) Regulations 2017 update meetings and the radiation protection committee. These meetings brought together representatives from all services that used ionising and nonionizing radiation to share and discuss issues. The committee was attended by the trust health and safety lead, and the radiation protection adviser, who were both able to escalate any concerns that needed to be addressed by trust executives.

Management of risk, issues and performance

The service acted to proactively identify risks to the service which could impact on the quality for the care required. All staff took responsibility to ensure risks were minimised wherever possible without compromising the quality of care.

The service manager maintained a local risk register, and the key risks were discussed at directorate and team meetings whenever there was any change in status. The scores or seriousness of the local risks ranged from ‘red 16’ e.g. the end of life notices on the MRI scanners, to the risk of contaminating scopes within the drying cabinet when electricity failed, or staff did not follow local procedure when removing scopes; this scored at green level 2. The items on the register and the levels and impact of these were reviewed at the clinical imaging clinical governance monthly meeting (CICG). Performance reports were presented and monitored at the CICG.

All meetings included governance and safety issues and were opportunities to cascade learning. The quality and service improvement lead has plans to make an MRI safety video for inclusion in trust wide mandatory training because of a serious incident.

Staff told us that any issue arising with the radiology management system were reported to the service manager who always acted as soon as possible to resolve them. For example, the availability of comparative scans for a patient when a clinical decision was necessary to plan treatment.

Information management

Staff had access to policies, standard operating procedures and patient information leaflets electronically through the electronic quality management system. Staff confirmed that this ensured information was easily accessible and up to date. The service regularly reviewed quality
performance which was discussed at meetings across all modalities. This information was shared electronically with staff through meeting minutes to ensure their awareness of where improvements in performance could be made.

The service used several IT systems to collect and share information such as x-ray and scan results; staff could access patient information using these electronic systems.

The service had information governance policies and procedures to ensure information was stored securely and protected patients’ privacy and security. Staff were aware of their responsibilities in relation to data protection and making sure information was accurate and managed securely. We saw data protection principles followed throughout the department.

We reviewed minutes of several the directorate meetings including:

- Ultrasound team meetings
- CICG meetings
- Monthly directorate meetings
- Team leaders’ meetings

We found the minutes to be of a good standard and included actions to take forward and the responsible person. Some examples included:

| DNA and cancellation of appointments policy for children and young people. RM offered to print the relevant section of this and display in all areas, however KR and the team have a process in place for paediatric DNAs so will liaise with her first. | Update for 18 04 18 - RM discussed with KR and this fulfils everything required, currently system robust and no requirement for change of processes at the present time. |
| Get clarification on use of new defibrillators. | 16/7/18 – Ongoing. Can only do chest compressions at present. 6/8/18 – JK awaiting clarification. 13/8/18 - Ongoing |
| JK suggested putting an alert on CRIS by the radiographer who x-rays patient at the time of pacemaker fit. To be discussed at CISUG. – JK to speak to EA and IR Team It was suggested that we find out who has had pacemakers fitted retrospectively and put an alert on CRIS. To be audited in six months. | 06 12 17 – There has been a lot of discussion between AS and Dr H regarding what is done nationally. NH is in close discussion with MH in Bristol. IR radiographers put alerts on CRIS that patient has a pacemaker and the type. 07 02 18 – Admin task to get alerts uploaded to CRIS, plan in place – Ongoing 28 02 18 – Ongoing 21 03 18 – Ongoing – KR dealing. JK to do a plan and feedback at the next CICG 18 04 18 – Ongoing – IR Radiographers put on CRIS – JK to speak to KR 23 05 18 – JK to ask KR the current situation with this. |

**Engagement**
The service engaged with patients to get feedback to improve the quality of the services. The service participated in trust-wide patient surveys, but responses rarely directly related to care within the imaging service. The quality and improvement lead was working closely with the patient experience team to design a more bespoke survey to capture some direct feedback.

We saw evidence of a staff member working together with the trust volunteer team and the patient experience team to improve patient feedback on the diagnostic imaging service. Volunteers went to the wards to interview patients who had been to the imaging department; there was a bespoke questionnaire designed for the purpose. Volunteers also provided this service in the other hospital imaging sites.

Several events were started to engage staff and focus on their well-being. For example, the Clinical Support and Cancer Services Division (CSCS) held a health and well-being day for their staff in July 2018 which included some physical exercise, a walk, a Nordic walking taster session and sessions focussed on mental health, such as laughter therapy and mindfulness.

The trust-wide 2017 staff survey which showed that 25% of staff had experienced harassment, bullying or abuse from staff in the previous 12 months. This resulted in a CSCS campaign to stop bullying. The division had produced a leaflet for staff with a variety of contact numbers, and signposted support services and sources of help.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training and innovation.

We saw an innovative solid waste management and recording system in nuclear medicine department ‘decay store wizard’, designed by one of the medical physics experts, and the same physicist had designed a bespoke system to check for radioactive contamination of staff hands. This was automated and ran reports for each individual.

The trust’s use of the ‘Scan4safety’ initiative run by the department of health in the catheter laboratory and interventional suite ensured that stringent checks were made of all implants and audit of each one was made possible.

The radiologists’ daily huddle attended by all the consultant radiologists, including radiologists in training, would not be unusual on wards or in operating theatres but within radiology it was very unusual. The radiologists considered it an important part of their working day, which did not occur in other imaging departments they had worked in.

The monthly clinical audit meeting was well run and inclusive with progress and actions emerging from audits minuted and shared. Again, whilst this practice was not necessarily unusual in other areas of healthcare; however, the multidisciplinary nature of the meeting and the learning and service improvement that arose from the audits was commendable.

The development of the CT coordinator role made an improvement to the working environment, and to the benefit of patients. The role enabled the staff to be able to afford the time to properly assess patients’ needs whilst giving them privacy and dignity during discussions about their imaging procedure and the cannulation procedure. This also improved the work flow through the scanner, allowing for increased capacity, optimising time, space and staff skills.

Following the major incident in the MRI scanner the team made considerable improvements to access to the area and training for any staff who entered the area. When staff were appropriately trained to understand the safety issues in an MRI environment they were issued with a green lanyard, making staff who understood MRI safety quickly identifiable.
Provision for children in the MRI scanning area with use of a play specialist, a play scanner on the ward, and the use of an electronic tablet, for music and to allow children to hear the noises the scanner makes before they arrive.

The local induction packs for each clinical area and for the administrative team were superbly put together providing structure and detailed training in all areas with competence assessments.

The service used Peninsula Radiology On-call (PROC), which meant that radiologists in training gained on call experience without a negative impact on their training schedule. This was supported by the deanery, and the model has been presented nationally.