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 provides acute, emergency and planned care services to a population of approximately 430,000 residents within Cornwall and Isles of Scilly. The population significantly increases during busy holiday periods. The trust employs over 5,500 staff and 600 volunteers and has a budget of around £400 million.

The trust delivers care from five main sites:

- Royal Cornwall Hospital (Treliske)
- St Michael’s hospital
- West Cornwall Hospital
- Helston birth centre
- St Austell Hospital

The trust has seven care groups:

- Anaesthetics, critical care and theatres
- Clinical support
- General surgery and cancer
- Specialist medicine
- Specialist services and surgery
- Urgent, emergency and trauma
Women, children and sexual health

Royal Cornwall Hospitals NHS Trust is a teaching hospital 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.

Is this organisation well-led?

Leadership

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

The trust’s board was stable, and all members of the executive team had been asked by the Chief Executive to provide a minimum five-year commitment to the organisation so it remained stable and could deliver the improvements needed. Three executive posts and one non-executive post were joint roles with a neighbouring mental health and community provider. Joint board development sessions had been set up, and the two boards met regularly.

All board members had a clear set of objectives which were reviewed regularly during appraisals and performance reviews.

The Chief Executive had been substantively appointed since our last inspection, following a period as the interim Chief Executive. They were a confident individual with a good grasp of the challenges facing the organisation. They were capable of leading the organisation through its challenging improvement programme, with clear evidence of improvements having been made under their leadership.

The Medical Director had only been in post for four weeks, taking over from an interim who had been in the role for about six months. They were supported by a deputy and three associate medical directors. Despite only being in the trust a short time, they had a good understanding of the challenges and had built good relationships. This was their first executive role and the Chief Executive was ensuring adequate support and development was available.

The Director of Nursing, Midwifery and Allied Health Professionals was a strong and capable leader with a good understanding of 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. From 1 December 2019 for an interim six-month period they had also been appointed as the Chief Nurse for a neighbouring mental health and community trust. While we had concerns about the large portfolio and workload this would introduce, we were assured these had been considered and there were clear plans to support the Director of Nursing across both organisations. Plans being explored included having joint teams across both organisations, such as safeguarding and infection prevention and control. The deputy directors of nursing would retain their portfolios but hold these across both organisations to better support integrated working. The Chief Executive had been clear a joint clinical appointment would not have been possible any earlier because focus needed to be maintained on improvements at the acute trust, but now it was felt improvements had been made and sustained it was the right time to explore this way of working.

There was an experienced Director of Finance who joined the trust’s board in May 2017. This was a joint appointment with a neighbouring mental health and community trust, 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 several associate directors who took leads across different functions, for example chief accountant, outgoings and costs, and quality cost improvement planning.

The interim Director of Strategy and Performance was a competent individual with strong commitment to the trust. Their permanent position was as Director of Corporate Affairs. It was recognised some further development was required to help them excel in the role and build their career towards becoming a chief executive. They had a solid team who were performing well within the trust, particularly around quality improvement.

The Director of Operations had been in post since January 2018. They had been appointed to focus solely on the trust, rather than taking a wider responsibility across the system, although they were a key partner and leader in some system work. Their internal focus had enabled them to understand the operational challenges and give their attention to overcoming these without too much external distraction. They were proactive in the operational management of the trust, particularly in relation to flow.

The Director of Integrated Governance reported to the Director of Nursing, Midwifery and Allied Health Professionals. They had a large portfolio, including risk, compliance, patient safety, engagement, legal services, information governance, clinical effectiveness and patient experience. They were a strong leader with an increasingly capable team to support them across the portfolio and was about to complete the NHS Leadership Academy Aspirant Leader development programme.

The Director of Human Resources and Organisational Development had been in post since August 2018 and had a good understanding of the trust’s current position in relation to human resources issues. They had a good deputy and a complete HR function, with some development of the team needed to create a stronger HR department. While they appeared to have a good relationship with other board members, there was still some development needed for them to function as part of a unitary board.

A Chief Information Officer had been appointed in January 2019, and this was a joint role with a neighbouring mental health and community provider. Their role was focused on ensuring Cornwall IT Services was a shared service across the county. The chief information officer was new to the NHS and had been accepted on NHS Digital’s digital leadership programme which they believed would deepen their understanding of how the NHS works.

The Chairwoman had been substantively appointed since our last inspection, following a period as the interim Chairwoman. They were active across the sustainability and transformation partnership and had brought the chairmen from across the system together to ensure an aligned approach moving forwards. Their style complemented the Chief Executive’s style and they worked well together with appropriate respect, support and challenge.

There was a solid group of non-executive directors who were committed to driving improvements in the trust. They were all supportive of and challenging to their executive colleagues. They had varying levels of experience within the NHS but were skilled and able to undertake their roles and were fully engaged with the board development programme. There were two non-executive director vacancies and the Chairwoman told us they were looking to recruit someone with business and/or commercial background and someone with an equality background as these were areas that were not as strongly represented.
The chair of the finance and performance committee had taken on the responsibility about four months before the inspection but had been on the finance and performance committee for about three years. They had both clinical and commercial experience and were well-suited to the role.

Members of the board spoke of strong relationships and a cohesive approach. Board members clearly displayed the trust’s values and challenged behaviours which were not in line with the values.

Staff talked positively about the executive team and held them in high regard. We heard many positive comments about the board, but most notably about the Chief Executive and the Director of Nursing, Midwifery and Allied Health Professionals. 'Middle management' structures were largely spoken about more positively compared to our last inspection, with evidence the restructure from four division into seven care groups was having a positive impact to leadership across the trust. Staff told us the executive directors were visible and approachable and they felt supported to develop.

There was a clear policy to ensure directors were ‘fit and proper’, and this was being used well. We reviewed eight files for members of the board, including executive and non-executive directors. 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.

Leadership capability and capacity below the trust board had been strengthened since our last inspection as part of the care group restructure. Care group leadership positions had been advertised and appointments had only been made following competency-based assessments which ensured the right leaders were appointed. Staff felt the care group leaders were more visible than they had been in the old structure.

Leaders had strong relationships across the system, helped in part by the joint appointments with the neighbouring mental health and community provider. The joint appointments had been well thought through.

The chief pharmacist reported to the medical director who had board level responsibility for medicines optimisation. The chief pharmacist and the wider pharmacy team were visible across the trust and had good working relationships with the executive and board. They communicated openly to members of the pharmacy team and were supported by a senior leadership team.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust’s organisational development strategy was being rolled out, with the first 100 leaders having been trained and the next 1,000 leaders starting the training programme. The trust felt this strategy was key to continuing to improve quality and culture, and to invest in and value the staff.

A new digital strategy had been written with a focus on reducing the complexity and repetition of existing systems. Before the chief information officer had started in post (January 2019) the trust did not have a digital strategy. One of the first priorities was to create a strategy, working with the chief clinical information officer, that focused on two key areas: firstly, the clinical systems, and secondly the digital and service capabilities needed to deliver the clinical systems. The strategy
had seen funding agreed to introduce an electronic prescribing and medicines administration across the county and was informing the trust’s long-term plan which included replacing the patient administration system.

Actions from the hospital pharmacy transformation plan had been achieved. An integrated medicines optimisation strategy was in development for the county, to include acute, community and mental health services. Funding was approved for roll out of electronic prescribing and medicines administration (ePMA) in the local community and mental health trust, with implementation led by the Royal Cornwall Hospitals NHS Trust’s ePMA team. This meant moving forward there would be one set of medicines records across NHS trusts in Cornwall, which would improve medicines optimisation at discharge.

The trust’s equality strategy was being refreshed ready for 2020. The strategy currently stood alone and was not integrated into the trust’s human resources and organisational development strategies, or the trust’s overall strategy. The new strategy was being designed to thread through one of these strategies to give it a greater focus and impact.

Although the trust had a patient experience strategy, none of the existing patient experience team had been engaged with its development (they were all relatively new in post). The team were aware work was taking place to align all strategy documents with three strategic objectives under the overall trust strategy. The patient experience team were therefore working on a new draft strategy.

**Board Assurance Framework**

The trust’s Board Assurance Framework detailed three strategic objectives:

1. Brilliant Care - always providing safe, effective and compassionate care, where we listen and learn to provide an excellent patient experience
2. Brilliant People - working together in a supportive environment to attract, develop and retain brilliant people
3. Brilliant Improvement - instilling a culture of quality improvement where everyone feels empowered to make changes for the benefit of our patients

*(Source: Trust Board Assurance Framework – 2019/20)*

**Culture**

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust provided opportunities for career development. The trust had an open culture where patients, their families and staff could raise concerns without fear. More work was needed to promote equality and diversity in daily work.**

There was a positive culture among the board with historical tensions and a “bullying culture” no longer being evident. Communication appeared to be open and inclusive and board members felt supported to challenge each other. All board members spoke positively about and gave examples of the level of challenge at board and sub-committees, although this was rarely reflected in meeting minutes.

Staff were much more positive about working at the trust and spoke passionately about the changes they had seen over the last two years. There was a patient-centred culture across the trust and a palpable energy from staff to be ‘brilliant’. Staff felt supported by the board to do the right thing for patient care, including raising concerns and having confidence these would be addressed. Staff were proud to work for the trust. We were given an example of an end of life
patient who wanted to hear the trust’s choir sing. Within two hours of a message being sent out 20 members of the choir attended the patient’s bedside and sang to them.

The trust had invested in mental health training for staff. Over 300 staff had been trained in mental health awareness and a further 25 had recently been trained in mental health first aid. Further training was planned.

Positive relationships with partners across the local system had been sustained and there was an improved (and improving further) culture of joint working, particularly with exploring financial and quality sustainability across the health and social care economy.

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.

A new Freedom to Speak-up Guardian had been appointed and was three-months into the role. They did not have any other duties within the trust and were able to commit all their time to the role. They felt well supported by the Chief Executive and Director of Human Resources and Organisational Development and had a network of champions across the trust to help promote the role and support staff to speak up. Almost all staff we met felt there was a positive culture that allowed them to raise concerns safely, and they spoke positively of the Freedom to Speak-up Guardian role. However, there were some concerns the Freedom to Speak-up Guardian reported to the Director of Human Resources and Organisational Development, which some staff felt was inappropriate. The trust was aware of this and were looking to change the reporting line now the new guardian was in post. We were told there were 15 champions in the organisation who had received initial training but needed refresher training. There were also plans to increase the numbers of champions, with a focus on getting representation from currently underrepresented staff groups, for example those from a black and minority ethnic background or living with a disability. The guardian was part of the south west guardians’ network and was building good relationships within this group.

There was a positive approach from junior doctors to exception reporting, supported and encouraged by the trust’s guardian of safe working hours. There was a generally positive culture among junior doctors with no real ‘hot spot’ areas causing major concerns. Most exception reports were due to vacancies and rota gaps impacting on junior doctors, and this had been consistent for several years. However, the number of vacancies had reduced meaning from around 50 gaps in the rota there were now only 12. We were told the trust was “very good at engaging to solve problems”. Additionally, the trust had performed well in the General Medical Council’s annual national training survey.

The trust had allocated some money to invest in eight high impact actions to improve the working environment for junior doctors, as recommended by NHS England and NHS Improvement. Examples of actions taken included making rooms available for junior doctors to sleep before travelling home if needed and introducing hot food vending machines so hot meals could be available after the canteen had closed.

The trust had continued to strengthen its processes around duty of candour and were monitoring compliance against this legal duty on an ongoing basis. In October 2019 the trust was fined by CQC for 13 historical breaches of the duty of candour regulation. The trust had used the investigation and notices to educate staff, introduce duty of candour champions and strengthen oversight of the process. This had resulted in 100% compliance being achieved and sustained. 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’, give an apology and details of what happened and why, and provide reasonable support to that person.

Pharmacy staff reported an improved culture across the trust, with a greater focus on staff wellbeing, described as “getting a bit of heart into the place”. All staff were encouraged to report medicines incidents and we saw evidence of discussion at the medicines safety group. Incidents were investigated, and future risks mitigated. The pharmacy team held daily safety huddles and a weekly whole team meeting where learning from incidents was shared. A summary of medicines incidents per care group was reported at the medicines optimisation group in order for the incidents to be shared and for the directorate to take ownership of incidents within their services. Pharmacy staff had annual appraisals and regular 1:1s. Pharmacy staff were aware of the Freedom to Speak-up Guardian and their role but had limited awareness of how to speak up.

Human resource investigations were completed promptly, thoroughly and supportively. We reviewed six of the trust’s most recent human resources investigations, including grievance, capability and disciplinary. In each file we found comprehensive investigations and communications which followed trust policy and were supportive of the individuals involved. Relevant actions were taken to safeguard staff, for example occupational health referrals and phased returns to work. Letters were written clearly and gave staff any relevant information, including contact details and rights to appeal decisions. On average the whole process was completed within six-weeks.

There was little board ownership of and direction for equality and diversity in the trust, although there was an increasing focus in this area. There was an equality and diversity lead appointed, but there was a lack of resource to support them. The current lead had been in post for six years and since September 2019 was supported by one other person two-days a week to support black and minority ethnic staff. While they had a reasonable understanding of their role, some further development was needed to enable them to take the agenda forward with confidence and strength. Recruitment was underway for a disability lead, but there was nobody currently in this position. The board had undertaken equality and diversity training as part of their board development day in September 2019, but further board development was needed to improve understanding of equality and diversity issues and requirements and enable the board to actively drive these forwards.

The trust had a large number of staff from overseas who had joined the organisation following international recruitment campaigns. Support was in place for these staff to help them integrate into the trust, but further work was needed to help their cultural integration into local communities. We were told staff from black and minority ethnic groups often experienced discrimination from patients, and as a result the trust had introduced a zero-tolerance approach that encouraged staff to challenge and report discriminatory behaviour at the time.

The trust had a number of equality and diversity networks, although some groups usually seen did not exist. There were long-standing networks for black and minority ethnic staff and for staff carers. A newer network had been established for women (since January 2019) and was considered to be the most positive of the network groups. There was no LGBT network at the trust, which we were told was because the trust “haven’t got enough people to start a network”. We were told on inspection there was also no disability network, although after the inspection we were told a disability network had been in place since around 2014.

While culture had improved in the trust’s IT services, there was still further work to do to restore confidence in the teams that processes were managed fairly, and staff were able to speak up
confidently. The chief information officer was aware of the work needed, for example filling vacancies to rebalance workloads and build capacity within the teams to grow and develop. The Freedom to Speak-up Guardian was involved with some of the cultural work, and the chief information officer had a meeting planned with staff side representatives to talk openly and honestly about ongoing concerns and actions being taken to address these.

The trust’s sickness absence policy was not always popular with staff on long-term sickness. The policy did not allow for a flexible approach for staff on long-term sickness absence because of a serious or long-term condition, for example complex surgery or cancer. We were given examples of staff receiving standard letters at set intervals advising them of pay decreases because of the length of time they had been off sick. The letters were reportedly impersonal and seen as being punitive and unsupportive.

**Board diversity**

There were no black and minority ethnic (BME) directors on the board.

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

**Staff diversity**

As of March 2019, Royal Cornwall Hospitals NHS Trust employed 7,105 people, of which:

- 77.1% were women.
- 13.3% were aged 51 to 55 years old and 13% were aged 46 to 50 years old.
- 3.4% of staff were from black and minority ethnic communities, while 8.5% did not disclose their ethnicity.
- 3.6% of staff considered themselves to have a disability, 81.5% of staff said they did not consider themselves to have a disability with the rest either unknown or choosing not to disclose.
- 73.2% of staff identified as heterosexual and 0.01% as lesbian, gay or bisexual with the rest unknown or choosing not to disclose.
- 40.8% of staff considered themselves Christian, 16.3% as Atheists, 9.7% defined their religion as ‘Other’ and 32% chose not to disclose their religion or belief.

(Source: P102 Combination equality report 2018-19)

The trust provided the following breakdowns of staff pay scale by ethnic group.
### Ethnic origin by pay scale

<table>
<thead>
<tr>
<th></th>
<th>White Clinical</th>
<th>White Non-clinical</th>
<th>BME Clinical</th>
<th>BME Non-clinical</th>
<th>Unspecified Clinical</th>
<th>Unspecified Non-clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>2</td>
<td>16</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Band 2</td>
<td>992</td>
<td>471</td>
<td>36</td>
<td>13</td>
<td>51</td>
<td>11</td>
</tr>
<tr>
<td>Band 3</td>
<td>391</td>
<td>355</td>
<td>9</td>
<td>5</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Band 4</td>
<td>221</td>
<td>343</td>
<td>3</td>
<td>5</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>Band 5</td>
<td>1154</td>
<td>148</td>
<td>35</td>
<td>3</td>
<td>62</td>
<td>8</td>
</tr>
<tr>
<td>Band 6</td>
<td>836</td>
<td>93</td>
<td>18</td>
<td>3</td>
<td>28</td>
<td>3</td>
</tr>
<tr>
<td>Band 7</td>
<td>395</td>
<td>92</td>
<td>8</td>
<td>1</td>
<td>22</td>
<td>3</td>
</tr>
<tr>
<td>Band 8a</td>
<td>72</td>
<td>49</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Band 8b</td>
<td>21</td>
<td>22</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Band 8c</td>
<td>10</td>
<td>17</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Band 8d</td>
<td>5</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
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<td>Band 9</td>
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<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<tr>
<td>VSM</td>
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<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Medical &amp; dental</td>
<td>263</td>
<td>0</td>
<td>43</td>
<td>0</td>
<td>77</td>
<td>0</td>
</tr>
<tr>
<td>consultant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; dental</td>
<td>76</td>
<td>0</td>
<td>27</td>
<td>0</td>
<td>44</td>
<td>0</td>
</tr>
<tr>
<td>non-consultant career</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>grade</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; dental</td>
<td>117</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>210</td>
<td>0</td>
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<tr>
<td>trainee grades</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>New Junior doctors</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Non agenda for change</td>
<td>31</td>
<td>22</td>
<td>4</td>
<td>0</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4595</strong></td>
<td><strong>1646</strong></td>
<td><strong>208</strong></td>
<td><strong>33</strong></td>
<td><strong>544</strong></td>
<td><strong>62</strong></td>
</tr>
</tbody>
</table>

(Source: P102 Combination equality report 2018-19)

**NHS Staff Survey 2018 results – summary scores**

The following illustration shows how this provider compares with similar providers on 10 key themes from the survey. Possible scores range from one to 10. A higher score indicates a better result.
The trust’s 2018 scores for the following themes were significantly higher (better) when compared to the 2017 survey:

- Safe environment – violence
- Safety culture

The trust’s 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 survey:

- Safe Environment - Bullying & Harassment

(Source: NHS Staff Survey 2018)

**Workforce race equality standard**

The scores presented below are questions relating to bullying and harassment from the NHS staff survey. They are question 17b and key findings 21, 25 and 26, split between white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The difference between the experiences of BME and White staff was significant for two out of nine indicators at this trust.

When compared with other trusts in its peer group, for the four staff survey indicators, this trust had no positive findings and two negative findings.

The experiences of BME staff at this trust had significantly improved for one indicator.
Note: These scores are un-weighted, or not adjusted.

(Source: NHS Staff Survey 2018)

**NHS Friends and Family Test**

The NHS 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 October 2018 to September 2019 the trust scored above the England average for recommending the trust as a place to receive care.
The trust scored between 95.1% and 98.2% between September 2017 and August 2019. The data appeared to be stable with only random variation over the whole period.

(Source: Friends and Family Test)

Sickness absence rates

The trust’s sickness absence levels from July 2018 to June 2019 were similar to the England average.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

The trust performed about the same as expected for all indicators in the 2018 General Medical Council Survey.
Complaints

The trust had an open and compassionate approach to dealing with complaints. All complaints underwent an investigation by the appropriate care group, coordinated by the complaints team. Each complaint response was quality assured by the complaints team and a board director (usually the Director of Nursing, Midwifery and Allied Health Professionals or the Director of Integrated Governance) before being signed and returned to the complainant. We found complaint responses were compassionate and every effort was made to respond to each point of concern raised by the complainant. Where a complainant had further concerns or was unhappy with the response, the trust undertook further investigatory work and responded accordingly.

The trust’s complaints policy required all complaints to be responded to within 30 days (10 days for ‘informal’ complaints). There was no specific mention of reaching a personalised response timeline with the complainant, unless there was going to be a delay in which case the complainant should be informed.

Complaints process overview

The trust’s targets for responding to complaints and current performance against these targets for the last 12 months are below:

<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>3</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30</td>
<td>71%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>1,076 (August 2018 to July 2019)</td>
<td></td>
</tr>
</tbody>
</table>

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

Number of complaints made to the trust

From August 2018 to July 2019, the trust received a total of 485 complaints. The most complaints were for medicine, with 33.1% of total complaints, surgery (19.9%) and urgent and emergency care (17%).

<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>173</td>
<td>33%</td>
</tr>
<tr>
<td>Surgery</td>
<td>104</td>
<td>20%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>89</td>
<td>17%</td>
</tr>
<tr>
<td>(blank)</td>
<td>63</td>
<td>12%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>35</td>
<td>7%</td>
</tr>
<tr>
<td>Maternity</td>
<td>20</td>
<td>4%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>20</td>
<td>4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>10</td>
<td>2%</td>
</tr>
<tr>
<td>Critical care</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>2</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Note: percentages may not total 100% due to rounding.

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

From August 2018 to July 2019, the trust received a total of 7,504 compliments. The highest number of compliments were for medicine, with 36.9% of total compliments, surgery (22.4%) and services for children and young people (20.9%).

A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>2767</td>
<td>37%</td>
</tr>
<tr>
<td>Surgery</td>
<td>1682</td>
<td>22%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>1566</td>
<td>21%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1075</td>
<td>14%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>252</td>
<td>3%</td>
</tr>
<tr>
<td>Maternity</td>
<td>143</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>0.1%</td>
</tr>
<tr>
<td>Critical care</td>
<td>9</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

Note: percentages may not total 100% due to rounding.

The compliments were taken from the trust’s wonder walls (a space where people could leave comments), compliment letters and gifts/cards received into departments. Themes were not identified. Where compliments named specific members of staff, the learning from excellence team received these to identify learning opportunities and to give personal thanks to the staff member(s). The patient experience team shared positive feedback for service areas via social media and newsletters.

(Source: Routine Provider Information Request (RPIR) – Compliments)

Governance

Leaders operated effective governance processes throughout the trust and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet to discuss and learn from the performance of the trust.

The trust’s governance structures had been improved since our last inspection as part of a restructure from four divisions into seven care groups. As part of the restructure, governance managers were embedded within the care groups to bring a stronger focus on governance closer to and to improve relationships with the operational teams.

An external, predominantly desktop, governance review had been undertaken by NHS England and NHS Improvement in August 2019. The draft review identified several areas that were working well and several areas which could be improved and was undergoing factual accuracy checking at the time of our inspection. There were 60 recommendations in total, several of which overlapped or duplicated. Some were simple to resolve, including removing duplication, standardising meeting papers templates, increasing board member attendance at some meetings and improving timeliness of data. Other areas would take longer to address, including strengthening review processes for sub-committees and reviewing the sub-committee structures. All the recommendations had a named lead and progress was being reported at board.

Further work was being undertaken to explore joint governance arrangements with the neighbouring mental health and community trust. This was largely due to the number of meetings the three jointly appointed executive directors were required to attend, but also to increase oversight and joint working across the county for the benefit of the population. Previously the two
trusts had committees in common, but these had been stood down while Royal Cornwall Hospitals NHS Trust focused on their improvement journey. It was anticipated this would restart soon.

A company secretary was due to start shortly after our inspection. The role was being covered on an interim basis by the head of corporate secretariat, supported by the director of strategy and performance. The interim arrangement was working adequately, but it was recognised a qualified and experienced company secretary was needed to deliver continued improvements in the trust’s governance processes.

The trust’s Freedom to Speak-up Guardian produced a quarterly update to board and presented an annual report. This enabled the board to understand the nature of concerns coming through and oversee any actions needed to address the concerns.

Quarterly and annual reports were presented to the board by the medical director on behalf of the guardian of safe working hours. If there were any particularly complex issues, the guardian would attend to present them directly, but this had not been necessary as the reports over the last 12 months had been straightforward. The reports allowed the board to understand any themes from exception reporting and any actions being taken or needed to address concerns.

The medicines safety group reported to the executive board via the clinical effectiveness group. There were clear terms of reference in place to ensure medicines governance groups were multidisciplinary and had clear roles and responsibilities, although it was recognised junior doctors and nurses did not always have the capacity to attend. Pharmacy staff shared information at daily safety musters and weekly whole team meetings. Medicines safety information was shared across the trust in the ‘Pharmacy Matters’ newsletter.

The chair of the finance and performance committee had taken on the responsibility about four months before the inspection but had been on the finance and performance committee for about three years. The committee functioned well and was well-attended. We were told there were good levels of challenge and assurance, although minutes did not always reflect this.

The trust’s quality assurance committee and audit and risk committee had shared the same non-executive director chair for approximately 18 months, however this had changed just prior to our inspection. We were told the audit and risk committee now had a new chair, which would ensure the independence of each committee and allow challenge and oversight across the committees going forwards. Both committees had been chaired by the same person on an interim basis because of their experience and the need to fill a vacancy when a previous committee chair stepped down. Both committees functioned well and had undergone a lot of development work to ensure their effectiveness. Again, we were told there were good levels of challenge and assurance, but minutes did not always reflect this. The quality assurance committee was also attended by the clinical commissioning group and NHS England and NHS Improvement.

The audit and risk committee’s work plan was linked to the board assurance framework to ensure the trust’s strategic risks were understood and monitored. Audits were used to explore specific issues where needed, for example around understanding what does not work well for staff with existing mandatory training, making changes and then auditing the impact. There were also system-wide audits being undertaken, for example in end of life, and the outputs from audits were used to inform the quality assurance committee’s work.

There was a quarterly patient experience report presented at the patient experience group, chaired by the director of integrated governance, which was then tabled at a trust board meeting. There was also a monthly incident review and learning group report into the quality assurance committee, again fed up to board. Additionally, every board meeting included a patient story.
There was a balance of positive and negative experiences to ensure the board had a broad recognition of how patients felt accessing services in the trust.

The trust’s research team produced an annual report and workplan for the board. This provided the board with information about research trials, including numbers recruited, income and results. However, we were told the board received little assurance about research in the trust outside of this annual report.

Minutes from the board sub-committees did not go to board. Instead, a summary report was produced. However, we were told this was going to change and that minutes would be included in board papers, so they could be scrutinised and used as part of an evaluation process of the functioning of the sub-committees. We were told evaluation of sub-committees currently was primarily through self-evaluation, although internal audit would attend on an ad-hoc basis if concerns had been raised.

Meeting minutes often lacked detail. We reviewed minutes from board meetings, sub-board committees and divisional meetings. In most cases we found there was little evidence of the discussions that took place, including any challenge. We were told the board had recognised this and there were plans to appoint professional minute-takers alongside a new trust secretary starting in early 2020.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust’s risk register was managed through the audit and risk assurance committee, which met six times a year. The risk register included risks to quality from the care groups, corporate risks and the board assurance framework (BAF). The risk register was also discussed at all board sub-committees. The BAF was reviewed at board every quarter.

Risks on the risk registers and BAF aligned with the risks staff and leaders told us about. Board members articulated the most significant risks to the trust and the actions being taken to reduce these risks, for example close management of the four-hour emergency department standard and flow through the hospital.

There were plans to change how the organisation managed and monitored its risks, with terms of reference for a new executive risk committee planned for sign off in January 2020. It was intended this new committee would take ownership for the corporate risk register, before the quality assurance committee and board subsequently received it. The audit and risk committee would have oversight of the full risk register within this new process, but other sub-committees would only see risks relevant to their areas rather than all risks, unless they asked otherwise. These changes were being planned to strengthen oversight and management. Although the trust felt confident the existing arrangements were working, it wanted to improve them.

Within the care groups, new ‘governance huddles’ had been introduced which were used to review risk registers and emerging risks on a regular basis. We were told these were working well and had enabled staff to feel more able to raise risks through the care group structures.

Patient acuity and staffing levels were assessed daily using a safer care tool. All areas completed the tool and staff were moved between areas or bank and agency staff were employed to manage patients as safely as possible.
Financial savings were not directly impacting on quality of care, and there was a clear focus on patient safety over financial savings. This was noticeable in increased spending on resources (for example bank and agency staff) against planned spending levels.

The board had oversight of patient harm reviews and ongoing risks in relation to delayed treatment, for example referral to treatment performance, through the sub-committee structures. They were assured risk of harm was being closely monitored and the right actions were being taken to prioritise patients where needed, and to report any instances of harm so investigations were undertaken.

Medicines safety risks across the trust were focussed on areas identified in the WHO global patient safety challenge: polypharmacy, high risk situations (anticoagulants, insulin, opiates) and transfer of care. The trust had a pharmacy risk register which was reviewed by the medicines optimisation group. Issues from local department risk registers fed through to the trust risk register.

Workforce capacity and recruitment of pharmacy professionals was on the risk register. With a significant shortage of pharmacists across Cornwall, the trust was working with other partners in the system to support integrated roles and to encourage staff to stay in the county. For example, increasing the number of pre-registration pharmacists from six to eight, with many of those posts shared with primary care networks, a neighbouring NHS trust or community pharmacies.

Fire risk assessments were not always escalated and responded to as expected. There were several areas within outpatients that had issues identified in consecutive fire risk assessments without action being taken. The trust’s fire safety officer was unaware of these fire risk assessments but told us they would follow-up our concerns immediately following the inspection. See the outpatients section of the inspection report for full details. Additional fire safety risks were well-known and understood, for example the fire doors in the tower block were not up to the required standard. Works to replace the doors had started and other actions had been taken to reduce the risk in the meantime. These included extra fire wardens and more fire patrols.

Following the inspection, we were told work to review all the fire risk assessments and actions outstanding had started. Work was expected to be completed by the end of March 2020.

The trust had not agreed a winter plan, despite our inspection taking place in December. We were told the winter plan had been delayed because the trust was waiting for system partners to input into the plan, but this had not been received as early as would have been hoped. The draft plan was ready and was being ratified at the next board meeting.

We were told the trust’s medical physics team were “on [their] knees” due to not having enough staff. Despite the staff shortages being on the risk register and a business case being put forward, the team had been told there was no money. It was felt there was a serious risk of sickness absence as a result of the significant work pressures and while there had been reasonable support given to the team, a solution had not been agreed and there was a lack of succession planning in the team.

Finances overview
The deficit reported in 2018/19 was greater than the previous year. Projections for this financial year indicated the trust would have an end of year position at £0.0 (breakeven) and that this would be the same for the next financial year.

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

The trust was timely in the submission of monthly and annual reporting to NHS England and NHS Improvement and provided responses to queries quickly.

The trust understood the risks and current weaknesses to its financial position and was taking pro-active actions to mitigate and/or address them. However, there were significant levels of risk in the 2019/20 plan that could make it difficult for the trust to deliver their agreed control total compliant plan. At the time of our inspection the trust was about £2.5 million short of their cost improvement plan, partly due to a decision not to close a ward to maintain patient safety, and there was an uncertainty the shortfall would be identified and met by the end of the financial year.

The finance and performance committee was considered an ‘assurance committee’ and we were told it operated well. Some recent changes had been made to how the committee papers were presented, which we were told allowed a greater focus on key points rather than lots of detail. As well as finance reports, the committee received performance reports from the care groups. The performance reports had been refined and standardised over the previous months to allow greater understanding and focus on the important details. We were told this had helped encourage greater challenge of the data and the reasons behind changes in performance.

Trust corporate risk register

The trust provided a document detailing their 20 highest profile risks. Each of these had a risk score of 12 or higher.
<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>Description</th>
<th>Risk score (current)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-13</td>
<td>high acuity patients will not be able to be treated in a high dependency area due to small resus area</td>
<td>20</td>
</tr>
<tr>
<td>Jun-12</td>
<td>Variability in ED performance</td>
<td>20</td>
</tr>
<tr>
<td>Dec-12</td>
<td>Terminal MR scanner failure - loss of inpatient MRI capacity</td>
<td>20</td>
</tr>
<tr>
<td>Jan-19</td>
<td>(*Risk under Review with Care Group) High acuity on Critical Care impacting capacity</td>
<td>20</td>
</tr>
<tr>
<td>Mar-15</td>
<td>Failure to comply with Duty of Candour regulations as a result of low staff awareness and performance management</td>
<td>16</td>
</tr>
<tr>
<td>Jun-15</td>
<td>Mandatory Training and PDR Compliance</td>
<td>16</td>
</tr>
<tr>
<td>Mar-18</td>
<td>Radiotherapy service delivery (staffing)</td>
<td>16</td>
</tr>
<tr>
<td>Nov-18</td>
<td>Corporate risk: Assurance regarding Medical Device Training</td>
<td>16</td>
</tr>
<tr>
<td>Dec-18</td>
<td>Lack of Security Incident and Event Management</td>
<td>16</td>
</tr>
<tr>
<td>Dec-18</td>
<td>Lack of Intrusion Detection or Prevention Solution</td>
<td>16</td>
</tr>
<tr>
<td>Dec-18</td>
<td>Cyber-Attack on Unpatched Software</td>
<td>16</td>
</tr>
<tr>
<td>Feb-17</td>
<td>Insufficient capacity to meet day case chemotherapy needs</td>
<td>15</td>
</tr>
<tr>
<td>May-17</td>
<td>Respiratory outpatient capacity</td>
<td>15</td>
</tr>
<tr>
<td>Jan-18</td>
<td>Patient Flow - Delayed discharges from Critical Care</td>
<td>15</td>
</tr>
<tr>
<td>Aug-17</td>
<td>Patient Monitoring in the ED</td>
<td>15</td>
</tr>
<tr>
<td>Nov-18</td>
<td>NICE Quality standard 158 - Critically ill patients may not receive adequate rehabilitation physiotherapy</td>
<td>15</td>
</tr>
<tr>
<td>Mar-18</td>
<td>Inability to assure whether prospectively booked follow-up patients are booked within their To Be Seen Date</td>
<td>15</td>
</tr>
<tr>
<td>Jul-18</td>
<td>(*Risk under Review with Care Group) Patients transferred from MAU to oncology assigned to oncologist without being seen</td>
<td>15</td>
</tr>
<tr>
<td>Aug-10</td>
<td>Improving communication and engagement with staff</td>
<td>12</td>
</tr>
</tbody>
</table>

*Risk under review with Care Group - these were new risks which the trust was reviewing at the time of the PIR submission.

(Source: Trust Corporate Risk Register)

Information management
The trust collected reliable data and analysed it. Staff could find the data they needed, in
easily accessible formats, to understand performance, make decisions and improvements.
The information systems were integrated and secure. Data or notifications were
consistently submitted to external organisations as required.

Live performance data was available across the trust and used regularly to review areas of risk
and tackle these as needed. Leaders felt performance data was accurate and gave the necessary
assurance and/or detail to respond to challenges.

The board and its sub-committees had recently started using statistical process control (SPC)
charts to present performance data over time. This method of performance reporting provides an
upper and lower limit (‘control’) and shows the variance over time, allowing significant variations to
be easily identified and targeted for investigation, as well as showing trends in performance. The
trust’s integrated performance report (IPR) used a mixture of SPC, red, amber and green (RAG)
ratings, simple line charts and written commentary. We were told further work was planned to
ensure the integrated performance report provided more assurance about the problems, actions
being taken and how this linked back into the data. Where RAG ratings were used at a high level,
it was possible to drill down into the data to see if any individual areas were underperforming and
in need of focus. A formal review of the IPR was due to take place in January 2020.

Pharmacy staff used the electronic prescribing system to prioritise high risk patients and missed
doses. Audits were prioritised in line with trust medicines risk themes and results were shared with
the director of nursing, matrons, ward leads and the medicines safety group. Safe and secure
handling of medicines was integral to achieving ward accreditation. Controlled drug (CD) audits
were in the process of being aligned with the CD local intelligence network. The CD accountable
officer (deputy medical director) submitted quarterly occurrence reports. Data of pharmacy

performance was available through a dashboard and reported monthly, through a performance
framework, to the operations board. The trust pharmacy team had worked with the South West
Academic Health Science Network to develop a framework to share medicines information with
patients’ community pharmacies at discharge. Data analysis found the 30-day readmission rate
dropped from 15% to 8% where people received a post discharge medicines use review by the
community pharmacist.

The trust reported monthly on its financial position and efficiency plans. Reports were shared with
NHS England and NHS Improvement either directly or via system oversight meeting papers.
Reporting included monthly revenue and capital performance as well as efficiency and specific
projects. It also included consideration of relevant workforce issues and approvals to recruit.

Finance, including risk, was included and considered at board meetings and at system oversight
meetings. A review of recent board minutes indicated finances were discussed and the agenda
covered the areas expected, including patient experience.

The trust’s 2019/20 plan submission had been signed off by the board and clearly articulated the
financial challenges and assumptions that had been made.

Cyber security had been reviewed by the chief information officer and several existing risks had
been downgraded, while others were upgraded. Work was progressing to strengthen the trust’s
cyber security, including the procurement of a managed solution (third party provided) in the short
term to deliver work at the speed needed, with longer-term plans to build the trust’s internal
capabilities to fully run cyber security functions themselves.

Engagement
Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. There was more work to do to engage with equality groups.

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. The Care Opinion website was publicly available, meaning anyone could access it to provide feedback and anyone could read the feedback and the trust’s responses. Every contact through the Care Opinion website received a response from the trust, including any action taken as a result of the feedback.

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.

The trust worked well with system partners across the county. They were actively engaged in the sustainability and transformation partnership and led some areas of this work. The system had worked well together in financial planning and there were programmes of work looking towards becoming an integrated care system.

With three joint executive director appointments and a joint non-executive director with the neighbouring mental health and community provider the trust had built stronger relationships across the county. Although the Director of Nursing, Midwifery and Allied Health Professionals had only recently started in the joint role, we were told there had been a noticeable difference in the community response to demand pressures across the system.

The patient experience team were developing how they engaged with patients to get more feedback on their experiences. For example, for a three-month trial from April 2020 they were planning to have several volunteers within each care group aligned to patient experience so there would be a more focused and consistent approach to gathering feedback.

Staff told us that over the last year engagement and messaging had improved. They felt they were being listened to and their ideas were being implemented where possible. Achievements were being recognised and celebrated and positive outcomes and experiences were being promoted.

The new medical director had started engaging with the medical workforce and planned several engagement activities. These included walk arounds, blogging, surveys and drop-in sessions for junior doctors.

The pharmacy team was linked to networks, including the south west chief pharmacist group and regional medicine safety officer group. The chief pharmacist worked with other pharmacy leaders and prescribers in the county to deliver integrated medicines optimisation.

The trust was one of the partners in the Patient Safety Kernow Quality Improvement Collaborative (PSKQI) group to reduce opiate use across the county. The pharmacy team worked with prescribers (secondary and primary care) and patient support groups to identify patients prescribed high doses or volumes of opiates and support a reduction. The trust pharmacy reviewed its prescribing of oral liquid morphine sulfate on discharge and implemented policies to ensure patients were not discharged routinely with more than 100ml. There was patient representation on the PSKQI and the incident reporting and learning group.
Quality and equality impact assessments were carried out for all financial improvement programmes. There was evidence of patient inclusion as part of the capital business case process to ensure patient needs were informing capital designs.

The quality assurance committee, one of the board sub-committees, were looking to introduce patient representation in 2020. They wanted this to be a meaningful input and were exploring how best this could be done, potentially working with Healthwatch.

Staff side (union) representatives told us there continued to be a poor relationship and engagement with the executive team. Although there was a monthly joint negotiation and consultation committee to which directors were invited, we were told these were poorly attended. It was suggested directors were not always able to attend because the meeting clashed with a board sub-committee. However, engagement between the head of midwifery and the Royal College of Midwives representative was reported to be constructive, open and supportive.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a quality improvement (QI) hub, which launched formerly in April 2019, and QI ambassadors were embedded throughout the trust. The QI hub was focused on supporting large projects, while QI ambassadors supported smaller projects. The trust was using a single QI methodology to ensure consistency and support across the organisation, and all QI activity was logged and tracked through the QI hub. There was a clear strategy and methodology to support QI, underpinned by strong governance arrangements and led by enthusiastic leaders.

The trust had introduced a ‘Dragons’ Den’ programme to enable staff to pitch their improvement ideas and ask for investment to support them. The second event took place during our inspection and two of the bids had involved patients.

Pharmacists were supported to become independent prescribers and many were using their prescribing skills in specialist clinics. Pharmacy staff described the trust as an “improved learning organisation” and could access learning and courses outside of their direct role. Members of the pharmacy team had received quality improvement (QI) training and had set up a QI pharmacy hub to manage projects. Three pharmacists and two pharmacy technicians had been recruited to work in the emergency department to “get admission right so ward based teams [could] focus on discharge”. The ePMA team were working with the software supplied to implement a barcode medicines administration system, to be piloted at West Cornwall Hospital.

There was an active research team in the trust, with several research trials being undertaken. Engagement from clinical areas varied. There were some really embedded and engaged teams (for example, haematology, oncology, stroke and diabetes), but some areas were less engaged largely due to capacity (for example, cardiovascular and respiratory). The research trials team were looking to change their model to introduce a peripatetic team who could go out to less engaged areas to support increased take-up of research trials. A large proportion of the research undertaken was commercial, which introduced cost benefits as well as clinical benefits. For example, in treatment trials medicines were provided free for patients, which saved the trust considerable money.

In the 2018/19 financial year, the trust recruited 3,720 patients into research trials, which was an increase of 1,000 from the previous year. The trust had agreed to recruit research specialty
doctors to support consultants, which we were told had made a positive impact on the trust’s ability to recruit patients into and participate in research trials. There were full time research doctors in oncology, medicine and surgery, and a further was being recruited for haematology.

Funding had been made available for a new smartphone application to be made available from January 2020. The new application would enable staff to view all the research projects ongoing across the trust and help them identify patients who could be eligible to take part.

Serious incident investigations were used to identify learning and make improvements to prevent recurrence. Investigation reports were generally thorough and identified recommendations and actions aligned to areas of improvement and learning. However, it was often unclear from the investigation reports how patients and families had been engaged with the investigation process, for example in agreeing the terms of reference in advance of the investigation starting. Learning from lower level incidents was not always evident within the electronic system and staff said learning was rarely shared within and across care groups unless the incident was investigated as a serious incident.

Learning from deaths
Not all deaths were being reviewed. The trust’s ‘Learning from Deaths Report’ dated 6 June 2019 and presented to the board reported only 195 of the 420 deaths (46%) during quarter three were reviewed. The trust’s policy required 100% of deaths to be reviewed, except for care of the elderly, but the board report did not break down the data to show performance against these targets. The board report stated the 100% target had been difficult to achieve, so there was a focus on ‘priority deaths’ as agreed by the mortality review oversight group. However, this was not in line with trust policy.

The trust had a structured process for learning from deaths which was in line with national guidance. It included a screening tool to identify any deaths where learning may be possible, structured judgement reviews and escalation to incident investigations if required. All deaths of patients in the following groups were required to have a structured judgement review completed as a minimum: children, stillbirths, learning disabilities, severe mental health and maternal deaths. Additionally, a structured judgement review was required for all deaths where significant concerns had been raised about the quality of care by families, carers and/or staff.

Minutes of the mortality review oversight group and of mortality and morbidity meetings were limited in detail but did evidence cases were discussed. However, there was limited evidence of how learning from cases was disseminated and shared across the trust.

Accreditations
NHS trusts can participate in accreditation schemes where services are reviewed and awarded accreditation if assessed to meet the relevant best practice criteria. An accreditation usually carries an end 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>Medical care (including older people’s care)</td>
</tr>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>Medical care (including older people’s care)</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>ISO 13485:2016 - Sterile Services department</td>
<td>Other</td>
</tr>
<tr>
<td>Individual GI JAG accreditation in order to be involved with the bowel screening programme - Gastroenterologists</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>Radiology - Compliance with ISO 9001:2015</td>
<td>Diagnostics</td>
</tr>
<tr>
<td>Audiology UKAS accreditation</td>
<td>Medical care (including older people’s care)</td>
</tr>
<tr>
<td>UNICEF Baby Friendly Initiative - NNU</td>
<td>Services for children and young people</td>
</tr>
<tr>
<td>BSUG Uro-Gynae accreditation application submitted and assessment completed 08/08/19 awaiting outcome</td>
<td>Gynaecology</td>
</tr>
</tbody>
</table>

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

Royal Cornwall Hospital

Royal Cornwall Hospital
Treliske
Truro
Cornwall
TR1 3LJ
Tel: 01872 250000
www.royalcornwall.nhs.uk

Urgent and emergency care

Facts and data about this service

Urgent and Emergency services are provided on two sites, the Royal Cornwall Hospital (accident and emergency) and West Cornwall Hospital (urgent care centre). Both sites operate 24 hours a day, seven days a week. We only inspected Royal Cornwall Hospital on this occasion.

The Royal Cornwall Hospital emergency department 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.

Royal Cornwall Hospital has a dedicated paediatric emergency department and an emergency service for adult patients. There are 22 cubicles for adult patients with major injuries, a treatment area for more minor injuries, and a three-bay resuscitation room. Within the department is an eight-bed clinical decision unit, where adult patients may be transferred from the emergency department for short-term care or investigations.

There is also a same day emergency care unit which operates seven days per week. This is where patients who have been referred by their GP are admitted as medically expected patients and where possible can be treated the same day without being admitted onto a medical ward. Where admission is necessary, all patients are assessed and a plan of care started prior to transfer to a ward. The unit is staffed by a multi-disciplinary team.

The Royal Cornwall Hospital emergency department is also part of the Peninsula Trauma Network. The network brings together all those responsible for treating patients who have undergone major trauma incidents across Devon and Cornwall, including the Isles of Scilly. Its purpose is to ensure 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 centre following on scene assessment, or may be taken to a trauma unit, such as that at The Royal Cornwall Hospital, for initial care and stabilisation. Because of the travel times involved within this region this is frequently the case.

A team of two inspectors and two specialist advisors spoke with 21 staff and 10 patients. We looked in multiple sets of patient notes at different times of the day throughout the inspection and
reviewed audit data, policies and processes. Our inspection was announced (staff knew we were coming) to ensure everyone we needed to talk to was available.

The service was last inspected in 2018.

**Details of emergency departments and other urgent and emergency care services**

- Royal Cornwall Hospital (24-hour emergency department)
- West Cornwall Hospital Urgent Care Centre

**Activity and patient throughput**

**Total number of urgent and emergency care attendances at Royal Cornwall Hospitals NHS Trust compared to all acute trusts in England, July 2018 to June 2019**

From July 2018 to June 2019, there were 217,070 attendances at the trust’s urgent and emergency care services. This represented a 5% increase in attendances compared with the previous 12 months.

(Source: Hospital Episode Statistics)
Urgent and emergency care attendances resulting in an admission

The percentage of accident and emergency attendances at this trust resulting in an admission decreased in 2018/19 compared to 2017/18 and the proportions were similar compared to the England average in 2017/18 but lower in 2018/19.

(Source: NHS England)

Outcome of urgent and emergency care attendances, from July 2018 to June 2019

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training
The service provided mandatory training in key skills including the highest level of life support training to all staff. However, there were some mandatory training courses where staff did not meet trust targets for updating these key skills and not all staff were up to date with highest levels of life support training.

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 practice guidance which would help to ensure patients and staff were kept safe. This was a concern as it was identified as an area the trust must improve on at the last inspection in 2018.

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

A breakdown of compliance for mandatory training courses up until July 2019 for registered nursing staff in the emergency department at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>April to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>82</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>76</td>
</tr>
<tr>
<td>Dementia awareness (including privacy and dignity standards)</td>
<td>80</td>
</tr>
<tr>
<td>Mental Capacity Act - level 1</td>
<td>80</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>77</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>72</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>71</td>
</tr>
<tr>
<td>Infection prevention - level 1</td>
<td>70</td>
</tr>
<tr>
<td>Fire safety (1 year)</td>
<td>69</td>
</tr>
<tr>
<td>Information governance</td>
<td>66</td>
</tr>
<tr>
<td>Resuscitation - level 2 - paediatric basic life support (1 year)</td>
<td>57</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>55</td>
</tr>
<tr>
<td>Infection prevention - level 2</td>
<td>51</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>46</td>
</tr>
</tbody>
</table>

Not all nursing and medical staff kept up to date with their mandatory training. The 95% target was met for four of the 14 mandatory training modules for which registered nursing staff were eligible and 10 of mandatory training modules had completion rates above 80%. This was a concern as
we identified that the trust must make sure medical and nursing staff had enough time to complete mandatory and safeguarding training at their last inspection in 2018. However, paediatric basic life support, equality and diversity and infection prevention (level 2) modules had a completion rate well below the trust target.

A breakdown of compliance for mandatory training courses from April to July 2019 for medical staff is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>April to July 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia awareness (including privacy and dignity standards)</td>
<td>42</td>
<td>42</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>42</td>
<td>42</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>39</td>
<td>42</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention - level 1</td>
<td>38</td>
<td>42</td>
<td>90.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>37</td>
<td>42</td>
<td>88.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>35</td>
<td>42</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>34</td>
<td>42</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>32</td>
<td>42</td>
<td>76.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety (1 year)</td>
<td>32</td>
<td>42</td>
<td>76.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>31</td>
<td>42</td>
<td>73.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>27</td>
<td>42</td>
<td>64.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention - level 2</td>
<td>17</td>
<td>42</td>
<td>40.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - level 2 - paediatric basic life support (1 year)</td>
<td>11</td>
<td>42</td>
<td>26.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 95% target was met for two of the 13 mandatory training modules for which medical staff were eligible. However, five of the mandatory training modules had completion rates of less than 80%. Paediatric basic life support, infection prevention (level 2) and conflict resolution modules had a completion rate well below the trust target.

For the previous financial year, (April 2018 to March 2019) at Royal Cornwall Hospital, medical staff achieved a 78% completion rate for mandatory training.

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

Managers monitored mandatory training and alerted staff when they needed to update their training. There was an online system for staff to monitor their training and they advised that they were alerted by email when their refresher training was due. However, there was no process for...
gathering all this information together to assess where the whole department stood in relation to its mandatory training. We requested data to show whether staff had completed, for example, advanced life support training for adults and children. Data provided showed significant gaps which did not provide assurance this training was being completed or revisited in accordance with intercollegiate statutory guidance.

The mandatory training courses were comprehensive and met the needs of patients and staff. Nurses completed three days’ mandatory training each year. This was arranged to ensure staff were able to attend. They were comprehensive and were developed to meet the needs of staff.

Clinical staff completed training on recognising and responding to patients living with certain mental health needs and dementia, but it was not provided for more specific mental health conditions or disorders. Staff received training in dementia awareness and mental health awareness at induction. This was described by staff as “basic” training and refresher training consisted of reading a leaflet. Staff told us they had not received training in recognising and responding to patients with autism or learning disabilities and were not sure if this training was available.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it. Most staff had completed safeguarding training.

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

**Royal Cornwall Hospital emergency department**

Nursing and medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses up to July 2019 for registered nursing staff in the urgent and emergency care department at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>April to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></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>Safeguarding children - level 1</td>
<td>78</td>
<td>82</td>
<td>95.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 1</td>
<td>77</td>
<td>82</td>
<td>93.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children - level 2</td>
<td>75</td>
<td>82</td>
<td>91.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults - level 2</td>
<td>71</td>
<td>82</td>
<td>86.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children - level 3</td>
<td>32</td>
<td>38</td>
<td>84.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In the urgent and emergency care department at Royal Cornwall Hospital the 95% target was met for one of the five safeguarding training modules for which registered nursing staff were eligible.
For the previous financial year, (April 2018 to March 2019) at Royal Cornwall Hospital, registered nursing staff achieved a 93% completion rate for safeguarding training. Therefore, the updates for nursing staff had dropped slightly in compliance.

Medical staff safeguarding adults (level 2) training completion rates were much lower than the trust target and completion rates of other staffing groups.

A breakdown of compliance for safeguarding training courses from April to July 2019 for medical staff in the urgent and emergency care department is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>April to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></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>Safeguarding children - level 3</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults - level 1</td>
<td>41</td>
<td>42</td>
<td>97.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 1</td>
<td>41</td>
<td>42</td>
<td>97.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children - level 2</td>
<td>38</td>
<td>42</td>
<td>90.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults - level 2</td>
<td>25</td>
<td>42</td>
<td>59.5%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In the urgent and emergency care department at Royal Cornwall Hospital, the 95% target was met for three of the five safeguarding training modules for which medical staff were eligible.

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

Following our inspection, the trust submitted data which showed an improved picture, although trust targets were not quite met for safeguarding adults level 2 and safeguarding children level 3.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. Staff we spoke with in the paediatric emergency department, clinical decision unit, and major treatment areas were able to explain what protected characteristics were and give examples of why it was important staff were aware of them. A staff member in paediatrics advised us they had completed hate crime training through the local authority and explained staff could involve the police and security if they were concerned. They gave examples of people being abused and targeted by others due to age, race and disability.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with in all areas of the service told us about indicators on the booking-in system and patient notes that highlighted any additional needs or safeguarding concerns to staff. Staff knew who the safeguarding leads were in the department. They understood how the patient admission system enabled them to see previous safeguarding alerts or concerns and create new ones. Staff in the paediatric department had good links with community safeguarding teams and explained they worked in partnership to share information regularly. One staff member gave an example of an infant who attended the department with an unexplained injury causing some concern with the nursing staff. They explained how the senior nurse had contacted the duty social worker who was able to share additional information and
concerns with the hospital team. This led to a multidisciplinary approach to endeavour was to protect the infant and support the family.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and most aspects of the premises and equipment visibly clean.

Most areas we visited were visibly clean and had suitable furnishings to make cleaning them easier. Most furnishings we saw were clean and well-maintained. However, the fabric chairs in the relatives’ room were stained.

The service generally performed well for cleanliness. Cleaning audits we reviewed showed good compliance for cleaning and hand hygiene in the department.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. We saw cleaning take place regularly and appropriate records were kept. Staff followed infection control principles including hand hygiene and the use of personal protective equipment such as gloves and aprons. We observed staff were bare below the elbow (for effective hand-washing) and cleaned their hands regularly. Staff advised they expected high standards of each other and said senior nurses would challenge staff who did not conform to bare below the elbow guidance. There were plenty of well-placed handwash basins and hand gel dispensers for staff and visitors.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, there were times when larger cleaning tasks held up the department. We saw equipment with ‘I am clean’ stickers and observed staff cleaning equipment with appropriate sanitising products. There were domestic staff who also cleaned the department and who would attend when deeper cleaning was required. During our visit we were told about an episode of vomiting in the major treatment area and how the domestic team arrived within 15 minutes of being called. Staff told us this was not always the case and at times they had waited up to an hour for someone to come to deep clean the area, which affected patients being treated as efficiently as possible.

There were side rooms in the major treatment area, assessment area and the clinical decision unit, where infectious or patients with compromised immune systems could be cared for away from other patients.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe and patients visible to staff. However, the mental health assessment room did not meet recommended guidance for safety. Not all emergency equipment was checked every day as required.

The emergency department was well laid out and mostly allowed for easy access and circulation, safe working, and good lines of sight. However, the resuscitation room was small, only accommodating three patients, and working conditions were cramped. In the urgent, emergency and trauma care group performance review report (October 2019), it was reported the resuscitation room was “under significant pressure almost on a daily basis”. It was estimated, using historical data, with current activity and sickness of patients, approximately 250 patients requiring care in the resuscitation area would not be accommodated in a given year due to capacity issues. This was recorded as an extreme risk on the emergency department risk register and a bid had been developed for funding to expand this area to accommodate six patients.
Funding had been agreed in principle and a draft project plan showed work was due to start in April 2020, with a completion date of December 2020.

There was a designated ambulance entrance, which was a short distance from ambulance parking bays. This allowed easy access to the resuscitation room and major treatment areas.

The waiting area for self-presenting patients allowed one of the two receptionists to view most of the area. The triage assessment room also opened on to the waiting room, allowing triage nurses to maintain oversight of the patients waiting there. However, during our inspection, we identified a vulnerable patient by the entrance to the waiting room for over two hours. They were in a wheelchair, and as they were seated near the automatic doors, were shaking with cold. We drew this to the attention of a receptionist who was working on their own and sitting furthest away from the waiting area and therefore not able to see this patient. When prompted by us they established the patient had been discharged but had no means to get home. The patient was subsequently given the assistance they needed but the prolonged presence of this patient had not been identified by staff working in the area.

Staff working at the main reception desk told us they felt vulnerable at times, particularly at night when there was only one receptionist on duty. The reception desk was open, and staff told us patients had climbed over the reception desk in the past. They had a panic button, which they could use to summon the assistance of security staff but felt they did not always get a quick response.

In the major treatment area, 'red cubicles' had been introduced where staff would place patients who required close observation and frequent monitoring. These cubicles were located directly opposite the nurses’ station.

Patients who were accommodated in the major treatment areas of the emergency department were given call bells and they were placed where they could reach them. Patients accommodated in the emergency department corridor did not have call bells but during our inspection there were always members of staff nearby who patients could ask for help.

The design of some of the environment followed national guidance. There was a separate children’s waiting area within the department where children and their families would go after booking in with receptionists, and until they could be assessed. This area was entirely separate from the adult waiting area and was protected by a locked door controlled by staff within the department.

However, the mental health assessment room did not comply with all the Psychiatric Liaison Accreditation Network as recommendations. As recommended, there were no ligature points in the assessment room and the windows were made of toughened glass. However, the room was small and there was not seating for four people which is recommended. There were also two light-weight single chairs that could be easily picked up and used as a weapon or a barricade. There was a single alarm point in the room. However, the recommendation states there should be a strip alarm if staff did not carry personal alarms. There were two doors, one of which could open both ways. However, the second door was locked and could only open outwards. The lighting could not be dimmed, and the toilets located close to the room contained ligature points such as two coat hooks, a long alarm cord and grab rails secured securely to the wall. They were not appropriate for use for a person experiencing a mental health crisis.

This was of concern as we identified at the last inspection that the department must make sure the mental health assessment room met the quality standards described by the Psychiatric Liaison Accreditation Network 2007.
Records were kept showing when equipment was checked and maintained. Maintenance audits showed most equipment was maintained according to trust policy and maintenance schedules. All electrical equipment we saw was within review date for electrical checks.

However, records we reviewed in the clinical decision unit and paediatric emergency department showed emergency equipment had not been checked consistently in accordance with trust policy. There were 36 dates in the daily checks for the paediatric emergency equipment from 1 September 2019 to 12 November 2019 with missing signatures. There was also an unexplained entry in the paediatric crash trolley daily checks, found on 12 November, where the daily check for the 15 November had already been filled in.

On the clinical decisions unit, signatures were missing for 10 dates from 20 August to 5 November for the emergency equipment. Daily checks for oxygen, suction and hypoglycaemia were missing for 25 dates from 7 August to 7 November.

The nurse in charge of each shift completed a shift coordinator checklist to confirm daily checks of equipment had been completed. We checked this for three days and found records were mostly complete. However, entries were not timed and there was no commentary to indicate if anything was outstanding and why. Gaps were not explained.

The service mostly had suitable facilities to meet the needs of patients' families. There were changing facilities for babies and the department was easily accessible for pushchairs and those with mobility challenges.

The service mostly had enough suitable equipment to help them to safely care for patients. However, it was recorded on the emergency department risk register patient monitors within cubicles in the major treatment area were too small. The risk register entry stated, “There is a risk that patients who have been identified as needing continual monitoring will not receive it, or if they do, that abnormalities will not be noted and acted upon”.

The trust had taken action regarding this risk and cubicles were numbered with red or blue numbers, red for higher dependency patients and blue for low risk to further highlight patients who required frequent monitoring by staff. However, the trust’s risk register concluded this did not look like an effective solution and so new monitors were required. This was due to crowding in the department and difficulty moving patients out of bays to make room for others who required monitoring. Staff in majors advised the monitors had not yet been delivered.

Staff disposed of clinical waste safely. For example, we observed staff disposing safely of items using special containers (known as sharp bins), clinical waste bins and clinical waste bags in the major treatment area.

**Assessing and responding to patient risk**

There were systems to assess risk to patients and to keep patients safe.

**Ambulance Handover**

**Percentage of ambulance journeys with turnaround times over 30 minutes for this hospital**

**Royal Cornwall Hospital**

From August 2018 to July 2019, there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal Cornwall Hospital.

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Royal Cornwall Hospital**
It is recognised by NHS England that delays in handover from ambulance staff to emergency department can result in increased risks to patients. Some staff in the department said that ambulance staff were not always able to swiftly hand over care of patients to staff in the emergency department. They told us there were occasions when ambulances were not able to handover patients in the optimum time because the department was full.

We spoke with several ambulance crews and observed ambulance handovers which we found to be safe.

**Number of black breaches for this trust**

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.

From August 2018 to July 2019, the trust reported 56 black breaches, with an upward trend over the period. Fifty seven percent of all black breaches were reported in the most recent two months (June and July 2019). Though it is not clear, this may in part be due to increased seasonal demand on the department.

**Triage/initial assessment**

Patients were not always assessed promptly on arrival in the emergency department, although this was improving. Triage times were measured in accordance with the Royal College of Emergency Medicine (RCEM) standard, which required all patients receive an initial assessment within 15 minutes of arrival in the emergency department. This was to ensure staff were able to identify...
patients with serious or life-threatening conditions and prioritise them for treatment. This was identified as an action the trust must take to improve at the last inspection.

This RCEM standard was identified as an action the trust must take to improve at the last inspection. The data provided by the trust showed compliance with this standard ranged between 66% and 77% between August 2018 and July 2019. The data showed an improving trajectory though the department was still failing to meet the standard.

Staff used a national early warning score (NEWS) tool to identify deteriorating patients but did not always raise concerns appropriately. A nurse was allocated as handover nurse on each shift. They greeted patients and received a handover from ambulance staff. They were able to prioritise patients, who then received further assessment, including investigations, by the nurse-led rapid assessment and treatment (RAT) team, based just inside the ambulance entrance. There were laminated cards displaying ‘at a glance’ triggers and protocol for patients who presented with potentially life-threatening conditions, who would be categorised as high priority. These conditions included stroke, chest pain, sepsis and head injury. The RAT team consisted of five staff, including a designated sepsis nurse.

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The median time from arrival to initial assessment was about the same as the overall England median in all 12 months from July 2018 to June 2019.

**Ambulance – Time to initial assessment from July 2018 to June 2019 at Royal Cornwall Hospitals NHS Trust**

![Graph showing median time from arrival to initial assessment](https://example.com/graph.png)

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

**Self-presenting patients**

Self-presenting patients were booked-in by receptionists, who recorded demographic information and a brief outline of their reason for attending. However, reception staff told us they had received no training or guidance on ‘red flag’ presentations such as signs of collapse which required immediate assistance, as recommended by RCEM. They told us they used their judgement and alerted clinical staff in person, or through a loudspeaker system if they had concerns.

One or two triage nurses (depending on how busy the department was) were always on duty to perform initial assessment and prioritise patients accordingly. They were experienced nurses who had received in-house training to perform this task. They were able to request X-rays and Electrocardiograms (ECG) to help reduce waiting times for these tests. A nurse or healthcare assistant held the ‘ECG bleep’ and could be requested by the triage nurse to perform an ECG.

The service had 24-hour access to adult mental health liaison and specialist mental health support if staff were concerned about a patient’s mental health. There was access to a mental health liaison service which was available 24 hours a day, seven days a week for adults. Staff on the emergency department told us they mostly had a quick response from the adult service who would
aim to see a patient referred within one hour. However, the child and adolescent mental health service (CAMHS) was open from Monday to Friday from 9am to 5pm only. There was no overnight service for children and young people experiencing a mental health crisis.

The hospital security team had a target of a five-minute response time. Staff told us that they mostly met this response time. Staff working on the emergency department had annual training in conflict resolution. Security staff received de-escalation and restraint training every year. However, security staff did not feel they had enough training around mental health and dementia. Staff called the police if security staff were occupied with another patient or they needed more support.

Staff were required to complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff had access to a mental health risk assessment document which could be easily printed off from the hospital’s electronic database. However, we reviewed two mental health records in the department and found this document was not always included. When the records did have the document, it was not always completed fully.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Staff completed a handover sheet and relevant records were copied by administrative staff before a patient was transferred to a ward. Staff were confident with how information was shared at shift handover.

Frequent attenders were well known to staff across various groups of the hospital team. For example, a patient was admitted on the day of our inspection who had specific needs. We saw dedicated support from the safeguarding team, homelessness team, emergency department staff and the psychiatric liaison service. The hospital had a ‘radar’ system that tracked patients and highlighted concerns, if, for example, they were at risk of domestic violence.

**Ongoing monitoring of patient safety**

Clinical staff completed risk assessments for each patient on arrival using recognised tools (such as safety checklists), although ongoing monitoring was not as frequent as it should have been. Staff used a nationally recognised tool to identify deteriorating patients and escalate them appropriately. The emergency department used a patient safety checklist for all patients in the major treatment area. This was a time and sequence-based checklist of tasks, which was completed for all patients, from initial assessment through to discharge or transfer. Tasks included hourly observations of patients’ vital signs and the calculation of a national early warning score (NEWS) on arrival and hourly thereafter. A monthly audit of patient records showed the service performed well on measuring vital signs and recording a NEWS score on admission to the emergency department (compliance was between 95% and 100% from April to October 2019). However, performance was much worse for ongoing (hourly) observations. In the same time period, performance ranged from 48% to 66% for the hourly recording of vital signs, and between 46% and 66% for recording a NEWS score. This was of some concern as we identified at the last inspection that the department must ensure that risk assessments were completed to keep patients safe and this included the safety checklist.

Staff knew about and dealt with any specific risk issues. Staff were familiar with emergency pathways for the treatment of specific issues, for example, chest pain or sepsis. There were safety prompts within the patient safety checklist for time-critical investigations, such as imaging for patients with suspected stroke or broken hip. There was a clinical frailty scale for certain patients and requirements for staff to identify issues which might indicate the risk of deterioration.

**Sepsis**
Staff we spoke with were familiar with and alert to the signs of sepsis. Sepsis is a life-threatening condition caused by the body’s response to infection. There was a requirement within the patient safety checklist to ensure the time critical treatment pathway (sepsis six) was followed. Compliance was monitored monthly. In the six months from May to October 2019, audits had shown 100% compliance with following the pathway.

**Fractured neck of femur (broken hip)**

There was a requirement within the patient safety checklist to ensure patients with a suspected fractured neck of femur were X-rayed within one hour and the appropriate care and treatment plan commenced. The service reported 100% compliance with completion of the care and treatment plan.

**Chest pain**

Some patients in the emergency department were not always reviewed as quickly as required. The service had introduced a specific chest pain triage tool and had a healthcare assistant who was to complete ECG and observations on all patients who attended the department, whether they came by ambulance or walked in. There was a requirement in the patient safety checklist to ensure an ECG was performed on those patients presenting with cardiac chest pain, and this should be reviewed by a doctor within 10 minutes. The service audited and reported performance against this standard. Compliance ranged between 47% and 75% in the six months from May to October 2019.

**Stroke**

Staff we spoke with were aware and alert to the signs of stroke and were confident in the stroke specialist support available in the department. There was access to a stroke specialist nurse 24 hours a day, seven days a week. Staff advised of effective processes for fast-tracking access to computed tomography (CT) scans and thrombolysing (the breakdown of blood clots using medication) patients. The hospital’s reconfigured hyper acute stroke unit (HASU) beds were due to open to their full capacity of six beds the week after the inspection and staff were positive about the work to achieve the increase in HASU bed availability.

**Mental health**

The service had 24-hour access to mental health liaison and specialist mental health support for adults with a mental health concern. There was a mental health triage tool which enabled staff to identify the level of risk and make a referral to the mental health liaison team. However, we saw two examples where this had not been fully completed.

**Oversight of safety/management of crowding**

The nurse and the doctor in charge, were both responsible for safety oversight in the department. They worked together to complete regular board rounds. During these rounds they looked at who was in the department, how many were in the corridor and what the current time to assessment was. The nurse and doctor in charge were also supported by a co-ordinator who was an admin person who had oversight of the activity in the department and was able to use electronic systems to prompt staff to perform certain tasks. The co-ordinator keeping records of who was in the department and what they were waiting for. The escalation of the department was based on the triggers that were shown on the monitoring system.

The nurse in charge had a checklist of tasks which were completed during each shift. For example, this recorded staffing in the department and outcomes of spot check of records. These
checks happened to ensure that vital tasks were all completed even when the department was busy.

Patient safety checklists were used in the department. They outlined tasks that needed completing for each patient for the duration of their stay in the emergency department.

**Nurse staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix. However, although the situation was improving with new staff appointed, there had been a high level of vacancies and use of agency staff.

The service mostly met the national guidance for nurses with specialist children’s qualifications (Facing the future: Standards for children in emergency care settings, 2018). Standard 10 of the guidance recommended every emergency department treating children must be staffed with two registered children’s nurses. There were mostly two registered children’s nurses on shift in the department. Where there was not, there was mostly a registered children’s nurse and a registered adults’ nurse with appropriate children’s training.

We reviewed staffing rotas for the paediatric department from May to September 2019 and found staffing levels met national guidance over 80% of the time in this period.

The service had enough nursing and support staff to keep patients safe. Most of the nursing staff we spoke with raised concerns about the number of temporary staff employed because they felt these staff did not always have the necessary skills and experience. Managers acknowledged the high use of agency staff but told us many agency staff worked in the emergency department regularly. Some had completed in-house training, such as training to allow them to triage patients. There had been a high number of nurse vacancies, but this position was improving, and agency usage was decreasing.

**Royal Cornwall Hospital**

The table below shows a summary of the nursing staffing metrics within urgent and emergency care at Royal Cornwall Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Urgent and emergency care annual staffing metrics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>August 2018 – July 2019</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Staff group</strong></td>
<td><strong>Annual average establishment</strong></td>
</tr>
<tr>
<td>Target</td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>208</td>
</tr>
<tr>
<td>Registered</td>
<td>96.3</td>
</tr>
</tbody>
</table>
Nurses (7%) (20%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within urgent and emergency care at Royal Cornwall Hospital were analysed for the period between August 2018 and July 2019 and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness, bank use and agency use. The staff said that vacancies were common due to the trust having difficulties recruiting to the Cornwall area.

**Turnover rates**

The turnover rate for registered nursing staff (11%) was slightly higher than the trust target of 10%. It was also higher than the turnover rate for all staff in the hospital (7%).

**Sickness rates**

The sickness rate for registered nursing staff (4.7%) was higher (worse) than the trust target of 3.8% and higher (worse) than the sickness rate for all staff in the hospital (3.7%).

Please note the data for sickness rates was provided for a different time period (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

**Bank and locum staff usage**

Bank nursing staff filled 7% (or 14,418) of available hours in the service. Agency staff filled 20% (or 40,659) of available hours in the service.

The nurse in charge advised there was sometimes an increase in agency staff at night and other staff raised concerns they did not feel agency staff were as engaged in the department. No staff or patients said this had an impact on patient care or experience.

**Vacancy rates**

The annual vacancy rate for registered nurses was 24%, this was higher (worse) than the trust target of 10% and higher (worse) than the vacancy rate for all staff in the hospital (17%). However, evidence provided to us showed this number was to significantly improve with appointments made over the coming winter.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction. However, the service was still not fully meeting the guidance for consultant cover.

The service had enough medical staff to keep patients safe. There was consultant presence in the emergency department from 8am until 10pm, seven days a week. This was not accordance with Royal College of Emergency Medicine (RCEM) recommendations which stated 16 hours was optimal. Four consultants, employed on staggered shifts, provided cover during weekdays and two consultants were on duty during weekends. Two junior doctors provided medical cover at night.

The medical staffing establishment had been reviewed, using demand and capacity modelling, and recruitment was underway for additional consultants. In line with this recruitment were plans to then extend consultant cover until midnight and provide the 16 hours of cover recommended. A
paediatric lead consultant had just been appointed which staff were optimistic about as it provided additional oversight in the paediatric department.

Junior doctors told us they were well supported and supervised by their senior colleagues and were able to ask for help when they needed it. All junior doctors had a supervising consultant.

**Royal Cornwall Hospital**

The table below shows a summary of the medical staffing metrics within urgent and emergency care at Royal Cornwall Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate (Jul-18 to Jun-19)</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>10%</td>
<td>10%</td>
<td>3.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>208</td>
<td>17%</td>
<td>7%</td>
<td>3.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>47.7</td>
<td>13%</td>
<td>0%</td>
<td>0%</td>
<td>0 (0%)</td>
<td>5.007 (50%)</td>
<td>3,035 (30%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The data for sickness rates was provided for a different time period (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

From August 2018 to July 2019, medical staff had an annual unfilled hours rate of 30%.

Medical staffing rates within urgent and emergency care at Royal Cornwall Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for locum use. There was not enough variation in the turnover rates, sickness rates and bank hours over the last 12 months to comment on the performance of these metrics over time.

**Vacancy rates**

The service had a lower (better) vacancy rates for medical staff (13%) compared to the vacancy rate for all staff in the hospital (17%). However, the vacancy rate for medical staff was higher (worse) than the trust target of 10%.

Staff we spoke with advised there were ongoing difficulties recruiting at consultant level.
Monthly vacancy rates over the last 12 months for medical staff at Royal Cornwall Hospital shows a shift from February to July 2019.

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

Turnover rates

The service had a zero turnover rates for medical staff. This was below (better) than the trust target of 10% and lower than the turnover rate for all staff in the hospital (7%).

Staff we spoke with enjoyed working in the hospital and felt supported to develop and progress.

Sickness rates

Sickness rates for medical staff were zero. The department reported a 0% sickness rate for medical staff which was lower (better) than the trust target (3.8%) and lower (better) than the sickness rate for all staff in the hospital (3.7%).

Bank and locum staff usage

The service had a zero rate of bank medical staff use. Locums filled 50% (or 5.007) hours of available time in the service.

Managers limited their use of bank and locum medical staff and requested staff familiar with the service. Medical staff told us most bank and agency staff worked at the hospital frequently and worked there consistently for several months at a time.

Managers made sure all bank and agency staff had a full induction and understood the service. There were induction packs available within the department which included details of online training and how to access the intranet. Most staff we spoke with said agency and locum staff were well inducted and supervised.

Staffing skill mix

The skill mix of medical staff on each shift was reviewed regularly. In May 2019, the proportion of consultant staff reported to be working at the trust was similar compared to the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

There was a lower percentage of registrar group and middle career doctors in the trust compared to the England average. However, junior doctors told us they were well supported and encouraged to access opportunities to develop. They said they could access consultants for oversight and advice easily.

Staffing skill mix for the 29 whole time equivalent staff working in urgent and emergency care at Royal Cornwall Hospitals NHS Trust.
^ 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 kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care.

Most records were stored securely and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records. Administrative staff were employed on each shift and were responsible for copying records, which accompanied patients when they were transferred. Staff completed transfer forms.

In the major treatment area, patients' records were stored in locked cabinets by the nurses' station, where they were only accessible to staff. We noted paper nursing and observation records were kept in temporary folders, but paper records were not secured or ordered in these folders, so there was a risk some records could go missing or be difficult to locate.

There was a paper-based patient safety checklist completed for all patients in the major treatment area. This was a time and sequence-based checklist of prompts to ensure essential tasks were completed from time of assessment, and thereafter, hourly until patients were discharged or transferred. The department was awaiting the introduction of electronic observation records in 2020.

The nurse in charge of each shift was required to review two randomly selected patients records on each shift. They recorded this on a shift checklist although this simply provided evidence a check had taken place and did not identify what was found. However, monthly audits of safety checklists took place. These showed between April and October 2019 a checklist was completed most of the time. Compliance ranged from 84% to 94%.

Medicines

The service mostly used systems and processes to safely prescribe, administer, record and store medicines.
Staff mostly followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely, and doors were locked to treatment rooms where medicines were stored with access restricted to staff. Controlled drugs were stored securely and managed under legal requirements. However, not all controlled drug checks were completed in accordance with trust policy. The controlled drugs packaged for a major incident had expired in June 2019. One of our inspectors alerted staff to this and they were replaced the same day.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. We saw nursing staff introduce themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them. A medicines optimisation technician visited the emergency department daily to reconcile medicines for those patients being admitted and to advise medical staff when medicines needed to be reviewed.

Staff stored all medicines and prescribing documents in line with the provider’s policy. Medicines fridge and treatment room temperature records showed medicines were stored at the correct temperatures. The electronic prescribing and medicines administration system was password protected and secure.

Staff followed current national practice to check patients had the correct medicines. Policies and procedures were available and accessible to staff through the trust intranet. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines. Clinical guidance was also available on the trust intranet. Patient’s medicines were reconciled in line with current national guidance on admission and when transferring between locations.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff knew how to report incidents or near misses through the trust’s electronic reporting system. Staff we spoke with felt confident in raising an incident should they need to. They gave us examples of what they would report as an incident and how they would respond to the person involved.

Decision making processes ensured people’s behaviour was not controlled by excessive and inappropriate use of medicines. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses 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. Managers ensured actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us they were encouraged to report incidents and they knew how to do this. They were able to describe incidents they had reported, such as violence and aggression, and medicines’ errors. Staff told us incidents were discussed at meetings and most staff felt able to offer ideas and suggestions to prevent incidents happening again.

**Never Events**
The service had reported no never events in the last year. 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 October 2018 to September 2019, the trust did not report any never events for urgent and emergency care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy. In accordance with the NHS Serious Incident Framework 2015, the trust reported 16 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from October 2018 to September 2019. A breakdown of incidents by incident type are below.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>6</td>
<td>25%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>4</td>
<td>37.5%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of child patient by staff</td>
<td>1</td>
<td>6.3%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
<td>6.3%</td>
</tr>
<tr>
<td>Venous thromboembolism meeting SI criteria</td>
<td>1</td>
<td>6.3%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
<td>6.3%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>1</td>
<td>6.3%</td>
</tr>
<tr>
<td>Disruptive/ aggressive/ violent behaviour meeting SI criteria</td>
<td>1</td>
<td>6.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Records we reviewed showed that duty of candour was followed after serious incidents.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Serious incidents were reviewed at monthly safety meetings and learning was agreed and shared through governance newsletters and at handover meetings. In the July 2019 clinical governance newsletter, there was a brief overview of two serious incidents. One was a patient who spent four days in the emergency department due to a lack of child and adolescent mental health service (CAMHS) facilities. Learning points were around staff attending better to meet their basic needs (meals, washing facilities). The second incident related to an allegation of neglect of an elderly
patient, diagnosed with a fracture, who was discharged without pain relief. Learning points related to improving pain assessments and record keeping.

There was evidence to show changes had been made as a result of incidents. Cubicles had been designated as ‘red’ for high dependency patients who required close monitoring. This was following a serious incident where a patient did not receive adequate monitoring following a procedure.

Managers debriefed and supported staff after any serious incident. Staff told us they received feedback following any serious incident they were involved in. They told us this was done in a non-judgemental way and they were supported to learn from any mistakes. They saw it as a positive experience that helped them learn from mistakes and improve patient safety.

**Safety thermometer**

The service used monitoring results well to improve safety.

The safety thermometer is a national tool used to record the prevalence of patient harms. It is 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 on a set day each month.

Data from the patient safety thermometer showed that the trust reported no new pressure ulcers, six falls with harm and one new urinary tract infection in patient with a catheter from July 2018 to July 2019 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Royal Cornwall Hospitals NHS Trust**

![Graph of pressure ulcers](image)

- Total pressure ulcers: 0

![Graph of falls](image)

- Total falls: 6

![Graph of urinary tract infections](image)

- Total CUTIs: 1

The service used monitoring results well to improve safety.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. There was a search function on the staff intranet that made policies and guidance easily accessible to staff. There were additional documents (often known as care pathways) for staff to use with treatment for patients who had specific healthcare needs. These care pathways were used by staff as an addition to emergency department patient records. They provided guidance for who to contact and how to access additional tests and equipment if needed. We reviewed six associated documents which were all up to date. All were up to date and based on best practice.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. However, some specialist support was not as timely as it needed to be. Staff we spoke with were aware of the act and could describe different stages of support relating to the severity and risk associated with a patient’s condition. We were told about a patient who had arrived at the department late at night due to a mental health crisis. Staff had worked together to reassure the patient and make sure they were safe. Staff also explained they contacted the mental health liaison team to get specialist support for the patient as quickly as possible. Staff said the response times varied but mostly the team would arrive to provide support within the hour. However, while we were at the hospital, we observed two patients on the mental health pathway, one who had spent over 12 hours in the department awaiting specialist support.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, relatives and carers. Helpful information was available for patients, although we found it not routinely used. Staff knew how to get support from mental health teams in the hospital and had good links with community services for additional information and discharge support if appropriate. The safeguarding team showed us a pocket-sized document entitled ‘my mental health passport’. This included next of kin details for the patient, mental health diagnosis, effect of the person’s mental health on them and what can make them feel better or worse. It also contained information on how to contact the health and wellbeing service. However, this document was not present in the records we reviewed.

Nutrition and hydration

Staff mostly gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients’ religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw ward hosts and volunteers undertaking tea rounds, in consultation with nursing staff, to ensure they were alerted to any patients who had been designated ‘nil by mouth’ for medical reasons. Most of the patients we spoke with told us they had been offered refreshments while in the major treatment area of the emergency department. Patients we spoke with told us that options were available if they had a specific dietary requirement. One patient told
us that staff went out of their way to arrange some free from food for a relative who had been in the department for over 12 hours.

There were prompts within the safety checklist to remind staff to consider patients’ hydration and nutrition needs. However, audits of safety checklists showed compliance with this metric was poor.

**Urgent and Emergency Care Survey 2018**

The trust scored 6.19/10 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 other trusts.

*(Source: Urgent and Emergency Care Survey (October 2018 to March 2019; published October 2019)*

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. We reviewed 10 records and found each included an observation chart which had been complete and detailed patient’s full nutrition and hydration intake and any additional support needs.

**Pain relief**

**Staff did not always assess and monitor patients regularly to see if they were in pain.**

There were prompts within the safety checklist to ask patients about their pain and to repeatedly assess this. To support this, staff used a numerical pain assessment tool. For patients in the major treatment area, staff were prompted to assess patients’ pain on arrival in the emergency department and hourly thereafter. The service reported on performance against this standard and performed well in relation to pain assessment and administration at triage but performed poorly in relation to regular reassessment. In the six months from May to October 2019, compliance with the hourly pain reassessment standard ranged between 38% and 53%.

Staff prescribed, administered and recorded pain relief accurately and mostly gave pain relief in line with individual needs and best practice. When staff administered medicines, they signed the record with the correct date and time. Patients we spoke with said they were given pain relief quickly when they asked for it.

It was unclear how quickly patients with communication difficulties would be able to indicate they were in pain or receive pain relief. Most staff we spoke with were not aware of any communication tools and those that were did not feel confident using them.

In the paediatric department, staff used a tool as part of their triage process but advised they had good observation of children in the waiting area and could visibly monitor any physical responses to pain increasing.

**Urgent and Emergency Care Survey 2018**

The trust scored 7.6/10 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: Urgent and Emergency Care Survey (October 2018 to March 2019; published October 2019)*

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. However, the service was failing to meet fundamental standards or national averages for measures in many national audits.

The service participated in relevant national clinical audits. We discussed participation in national audits in line with Royal College of Emergency Medicine (RCEM) requirements with service leads.
There was a consultant who was the audit lead, but individual audits were delegated to other consultants to lead on. The service submitted data every year in line with national guidance.

Following the inspection, we looked at data submitted to the Royal College of Emergency Medicine (RCEM) in the 2017/18 audits. NHS trusts were asked to submit data in relation to three clinical standards: fractured neck of femur (broken hip), procedural sedation and pain in children. Fundamental standards for patients with a broken hip were not meeting RCEM targets, though results were better than the national median average.

- Fractured neck of femur audit (based on 48 patient records reviewed): Data showed 85% of patients had their pain assessed within 15 minutes of arrival to the department. This was a fundamental standard (standard one) which meant all patients with a fractured neck of femur should have their pain assessed within 15 minutes of arrival in the department. This was against a national median average of 29%. In the other fundamental standard (2c), patients in severe pain receiving analgesia within 60 minutes of arrival, the trust scored 38% against an expectation of 100%. The national median average was 30%.

Fundamental standards for patients needing procedural sedation were not meeting targets and most results were worse than the national average.

- Procedural sedation audit: This audit related to safety standards for patients undergoing procedures under sedation in the emergency department. The expectation was all audits should score 100%. The audit was based on 50 patient records and demonstrated compliance with all fundamental standards was low.
  - Standard 1: documented evidence of pre-procedural assessment scored 44% - national median average 34%. These results had improved since the previous audit in 2015/16.
  - Standard 3: procedural sedation taking place in a resuscitation room scored 66% - national median average 93%. These results had improved since the previous audit in 2015/16.
  - Standard 4: covering who is present at the procedure scored 38% - national median average 46%
  - Standard 5: monitoring during procedural sedation scored 4% - national median average 44%.
  - Standard 8: discharge arrangements scored between 21% and 42% for the four fundamental elements of this standard. All four were below (worse than) the national median average.

Fundamental standards for managing pain in children were not meeting targets and most results were worse than the national median average.

- Pain in children audit (based on 52 records): This audit had two fundamental standards. Standard one: pain score assessed within 15 minutes scored 65% - national median average 29%. The expectation was 100%. In the other fundamental standard (2c), patients in severe pain receiving analgesia within 60 minutes of arrival, the trust scored 40% against an expectation of 100%. The national median average was 69%.

In previous audits:

**Trauma Audit and Research Network (TARN)**

**Royal Cornwall Hospital**
The table below summarises Royal Cornwall Hospital’s performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a non-medical ward or transferred out to another hospital (for example, for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

The trust’s case ascertainment (or the proportion of eligible cases included in the audit) was rated ‘good’. A higher proportion of cases submitted may mean the results based on those cases are a more accurate reflection of the care provided by the service.

The service met the national standard for two of the three metrics for which there was a national standard. The trust’s performance was rated variably for the audit measures in TARN.

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Hospital performance</th>
<th>Audit Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Ascertainment</strong></td>
<td>100+%</td>
<td>Good</td>
<td>Met</td>
</tr>
<tr>
<td><em>(Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude median time from arrival to CT scan of the head for patients with traumatic brain injury</strong></td>
<td>35 mins</td>
<td>Takes longer than the TARN aggregate</td>
<td>Met</td>
</tr>
<tr>
<td><em>(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury</strong></td>
<td>66.7%</td>
<td>Lower than the TARN aggregate</td>
<td>N/A</td>
</tr>
<tr>
<td><em>(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care</strong></td>
<td>55.6%</td>
<td>Higher</td>
<td>Did not meet</td>
</tr>
<tr>
<td><em>(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk-adjusted in-hospital survival rate following injury</strong></td>
<td>1.5 additional deaths</td>
<td>Similar to expected</td>
<td></td>
</tr>
</tbody>
</table>

---
Managers used information from the audits to improve care and treatment. At staff meetings and handovers, managers shared learning from audits with staff. They also used the newsletter as an additional way of circulating the learning with staff. Outcomes were checked and monitored through ongoing auditing following any changes and completion of identified actions.

**Unplanned re-attendance rate within seven days**

The service had a higher than expected risk of re-attendance than the England average. From July 2018 to June 2019 the trust’s unplanned re-attendance rate to the emergency department within seven days was worse than the national standard of 5% and worse than the England average.

The gap between the trust’s re-attendance rate and the England average increased from January 2019 onwards with a gap of around 3% each month compared to a one to two percent gap from July to December 2018.

This was a concern as it may be an indicator that care on first presentation at the department was not good enough. It may also show that discharge pathways were not working effectively. The nurse in charge advised that the department were aware of this and were working with discharge teams and the department staff to improve discharge planning. The major treatment area administrator was working with the nurse in charge to make sure patients were receiving the care they needed.

**Unplanned re-attendance rate within seven days - Royal Cornwall Hospitals NHS Trust**

![Graph showing the comparison of re-attendance rates](source: NHS Digital – A&E quality indicators)

**Competent staff**

The service sought to ensure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development. However, the trust’s appraisal target rate was not met by all staffing groups in the service.
Staff were mostly experienced, qualified and had the right skills and knowledge to meet the needs of most patients. Some nursing and ancillary staff advised they did not have the skills to communicate with people who had any sensory loss or communication difficulty. This was mirrored by the security team who did not think they received enough training around mental health and dementia.

Managers gave all new staff a full induction tailored to their role before they started work. Most staff advised they had received a full and comprehensive induction and were supported by managers to progress.

There was a nurse practice educator based in the department who linked in with the matron. The role had started in January 2019 and was aimed at development and ensuring mandatory training, clinical skills and e-learning were kept up to date.

**Appraisal rates**

The trust’s appraisal target rate was not met by all staffing groups in the service. This was particularly low for nursing staff. Staff did not always have the opportunity to develop their skills and knowledge. There were mechanisms to provide staff with the development they needed, including appraisal and career development conversations. Staff told us they were encouraged to undertake training and to go on courses. However, one staff member told us it was hard to get the time to attend in busy periods.

**Royal Cornwall Hospital**

From August 2018 to July 2019, 82.6% of staff in urgent and emergency care at the Royal Cornwall Hospital received an appraisal compared to a trust target of 95%. Over 90% of medical staff and 65.2% of registered nursing staff had received an appraisal.

Two staff groups had an appraisal rate of 50% or less (additional clinical services, 48.8% and administrative and clerical, 50%). However, administrative and clerical staff were a small staffing group with only eight staff in the group eligible for appraisals. This was of some concern as we identified at the last inspection that the trust should allow more time for staff to complete their appraisals.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Additional professional scientific and technical</td>
<td>1</td>
</tr>
<tr>
<td>Medical</td>
<td>30</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>67</td>
</tr>
<tr>
<td>Registered nursing</td>
<td>43</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>4</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>41</td>
</tr>
</tbody>
</table>
Managers did not always support nursing staff to develop through regular, constructive clinical supervision of their work. Nursing staff did not receive regular or formal supervision of their work. Nurses had identified team leaders (band seven nurses) but did not routinely work alongside them. They were supervised on a shift by shift basis by the nurse in charge. They told us their team leader was their mentor, but they could approach any of the seven nurses or the practice education nurse for support.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us they were well supported and supervised by named consultants. In the General Medical Council training survey 2019, the trust achieved high levels of satisfaction with teaching, clinical and educational supervision, and a supportive environment.

The clinical educators supported the learning and development needs of staff. All trainees had a named supervisor and those we spoke with were positive about the support and supervision they received. Nursing staff we spoke with felt supported by the nurse practice educator.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff attendance at team meetings was good. Staff told us they could access the notes from meetings and would be sent updates and important information in emails and newsletters.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff told us there were allied healthcare professionals (such as physiotherapists and occupational therapists) based within the clinical decision unit who supported the department and were present for handover meetings and board rounds. They provided an input around therapy and ongoing care. There were also meetings with surgeons and physicians who provided additional input around treatment options of surgery and non-surgical treatment such as for soft tissue injuries. There were also meetings with the Psychiatric liaison team who provided additional support for patients who were experiencing mental health decline.

Staff said the hospital site management team normally attended the emergency department board rounds as well to give an additional level of information, planning and oversight.

Staff worked across healthcare disciplines when required to care for patients. There was a nurse-led frailty service in the emergency department, which operated Monday to Friday from 8am to 4pm. Clinical nurse specialists identified frail patients for whom they could provide additional support. This included support from occupational therapists, speech and language therapists and dietitians.

There was cooperative working with specialist stroke nurses, who were available 24 hours a day, seven days a week. We saw good working relationships with radiology. During our inspection, a radiographer personally attended the emergency department to discuss an X-ray request with the referring doctor.

Staff mostly reported good working relationships with specialty doctors. However, frustrations were expressed by staff about the speed with which doctors from orthopaedics, ear, nose and throat, and maxillofacial surgery reviewed expected patients. Staff said these patients all attended...
through the emergency department because there was no direct admission pathway for their speciality need. We did not see any occurrences of this during our visit.

Staff referred patients for mental health assessments when they showed signs of mental ill health. However, prompt support was not always available from mental health practitioners. Staff expressed concern that although they aimed to refer patients in a timely manner, the psychiatric liaison team could not always respond quickly due to being short of staff. Staff said they often felt uneasy about the risk this left with them but also the impact the delays may have on patient wellbeing.

**Seven-day services**

**Most key services were available seven days a week to support timely patient care.**

Staff could call for support from doctors and other disciplines and diagnostic services, including adult mental health services, 24 hours a day, seven days a week.

The emergency department had a range of services seven days a week at Royal Cornwall Hospital.

The emergency department was located next to the diagnostic imaging department and had rapid access to CT scanning facilities as required. The imaging services were available 24 hours a day, seven days a week.

Occupational therapy services were available seven days a week and were present in the clinical decision unit. They also provided an additional evening service available between Monday and Friday.

Physiotherapists were available six days a week and were also present in the clinical decision unit. There were also dietetic services and access to speech and language therapy five days a week.

The trust continued to have an agreement with a local community trust who provided mental health liaison service 24 hours a day, seven days a week for adults. However, the child and adolescent mental health services (CAMHS) service only operated Monday to Friday 9am to 5pm.

**Health promotion**

**Staff gave patients some practical support and advice to lead healthier lives.**

There was some relevant information promoting healthy lifestyles and available support in the emergency department. We saw some leaflets for community support services and healthy living prompts in the waiting area. These were available in Braille print and in an audio version. However, it was unclear if these were available in an easy read format and staff were not sure either.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff supported patients to keep mobile during their time in the department if this was safe. They also encouraged people to make and maintain contact with the family and friends whilst in the department. Staff advised they would discuss patients’ health and wellbeing with them at admission to develop a rapport. Staff explained they would offer information leaflets regarding healthy lifestyles and would discuss these further with patients if they were asked.

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

**Most consent was asked for and given freely by patients. However, staff did not always support some patients with cognitive impairment to make informed decisions about their**
care and treatment. They mostly followed national guidance to gain patients’ consent but did not always know how to support patients who lacked mental capacity or were experiencing mental ill health. Staff were not always clear when deprivation of liberty safeguards would be used in the department.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff taking time to discuss options with patients and to give them additional information to enable patients to give informed consent. We saw a member of staff revisit an older patient on four separate occasions to determine what the patient wanted to happen as the patient did not wish to talk to them. The staff member used a different approach each time to build a rapport with the patient.

On most occasions when patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions where known. However, we reviewed two patient records that did not clearly evidence a best interest process or include relatives, significant others or other professionals’ thoughts and opinions. Some medical staff were able to show us best interest paperwork and understood some aspects of best interest guidance. Other staff were unaware of requirements associated with best interest decisions.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients’ records. However, some staff were not fully confident in gaining consent from patients with difficulties in understanding. We observed staff discussing treatment options with patients and relatives. The staff revisited conversations in different ways if people did not understand what was being said to them. However, staff were unable to locate any communication aids that may support these conversations and some staff said they would not feel confident using them if they were there. One nurse told us there was a learning disabilities team who would be able to provide some support for patients with communication needs. However, they only worked daytime hours. Three other staff we spoke with were not aware of this team or how to get in touch with them. All documents we reviewed demonstrated evidence of consent being documented in patient notes.

Staff in the paediatric emergency department understood Gillick Competence and could describe how they would support children who wished to make decisions about their own treatment. Staff told us there were additional services available during working hours to support children to make their own decisions. However, it was unclear whether these services were based in the hospital or were community-based provisions and staff were unable to locate information to show us when asked.

Staff received training on the Mental Capacity Act and Deprivation of Liberty Safeguards and almost all staff had been recently updated in this area. A member of staff told us they felt the mental capacity training was good which was why it was well attended.

**Royal Cornwall Hospital**

The trust set a target of 95% for completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training courses from April to July 2019 at Royal Cornwall Hospital for registered nursing staff in urgent and emergency care is shown below:
Training module | April to July 2019
--- | ---
| Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No)
Mental Capacity Act - level 1 | 80 | 82 | 97.6% | 95% | Yes

In urgent and emergency care at Royal Cornwall Hospital, registered nursing staff met the 95% completion target for mental capacity act level 1 training.

A breakdown of compliance for MCA training courses from April to July 2019 at Royal Cornwall Hospital for medical staff in urgent and emergency care is shown below:

Training module | April to July 2019
--- | ---
| Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No)
Mental Capacity Act - level 1 | 42 | 42 | 100% | 95% | Yes

In urgent and emergency care at Royal Cornwall Hospital, medical staff met the 95% completion target for mental capacity act level 1 training.

Staff received and kept up to date with training in the mental capacity act and deprivation of liberty safeguards. There was a separate mental health and wellbeing team with a member of staff designated to supporting people with liberty protection. This staff member also provided education to teams on the changes in legislation and gave additional support regarding patient capacity as required. Patients were referred to the mental health and wellbeing team through an internal electronic system which most staff were aware of. However, some staff we spoke with were not clear of the difference between mental capacity act and mental health act and did not understand when deprivation of liberty safeguards would be authorised. This was of some concern as we identified at the last inspection that the trust should improve staff awareness of the Mental Capacity Act 2005 and relevant consent and decision-making requirements of this legislation.

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

Staff could describe and knew how to access policy on the Mental Capacity Act and deprivation of liberty safeguards. One staff member showed us how to access and search for the policy on the intranet. There was paperwork available prompting staff of the principles of the mental capacity act and giving staff prompts on completing both the diagnostic and functional tests.

Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff introducing themselves by name and role and talking with patients in a friendly way. We observed staff giving explanations to people who arrived in the department about what would happen next, information about any delays in the department and what the patient could expect.
Patients said staff treated them with kindness. All patients we spoke with said staff really seemed to care about them and staff were mostly friendly and approachable. A patient said staff were always thoughtful and often asked about home and family as well. Another patient was pleased staff asked what they would like to be called or how they would like to be addressed.

Staff understood and respected the individual needs of each patient. Staff showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Care records indicated staff knew how to support people in a mental health crisis. Records showed sensitivity and understanding of patients. A patient we spoke with said staff were kind and treated them like a person and not a number on a board.

In August 2019, a staff member in the emergency department was nominated for a Rainbow Day badge for “going above and beyond by obtaining a keepsake box for a lock of patients’ hair to give to the family of a deceased patient”. The nomination said: “M has consistently impressed her colleagues with her commitment to improving the experience of those dying in [the emergency department] and their loved ones.”

**Emotional support**

*Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.*

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients knew how to seek help and said they felt listened to. We observed patients approaching staff for support and staff responding courteously, even when the department was very busy.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed a patient in major treatment area who was distressed and had been waiting for additional support from the psychiatric liaison team. The department staff were kind and attentive. They provided reassurance every few minutes and gave guidance and updates to the patient and their relative at every opportunity. The staff we spoke with told us the patient needed to be in the line of sight of the nurses’ station. We observed staff getting down on their knees to talk with the patient and spoke calmly with a soft voice which seemed to help the patient to relax in the environment. We observed staff using curtains to protect patient dignity in the bays and mostly being conscious of patient dignity during any assessment completed in the corridor.

Staff understood the emotional and social impact a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff encouraged patients to maintain contact with their relatives and supported patients to get in touch with relatives when needed. We observed staff spending additional time talking with a patient who had recently lost a loved one. The staff showed genuine interest and the patient subsequently told us they felt safe and supported.

**Understanding and involvement of patients and those close to them**

*Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.*

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with said staff kept them updated and involved at every stage of their treatment. A patient told us staff took extra time to listen to and answer their relative’s concerns and questions. Most patients told us when they had received results from imaging and blood tests, staff had explained what results meant and what the next options were.
Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff we spoke with showed us leaflets and website links where patients could provide feedback. Patients told us they felt confident to feedback and had felt encouraged to do so by staff.

**Urgent and Emergency Care Survey 2018**

The feedback from the 2018 Emergency Care Survey was positive. The trust scored about the same as other trusts for all 24 survey questions relevant to the caring domain in the Urgent and Emergency Care Survey 2018.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2018</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.9</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 way you could understand?</td>
<td>7.9</td>
<td>About the same as other trusts</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>8.5</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</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</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td><strong>Question</strong></td>
<td><strong>Trust 2018</strong></td>
<td><strong>Comparison</strong></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
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<td>------------------------------</td>
</tr>
<tr>
<td>you in the emergency department?</td>
<td></td>
<td></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>8.6</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</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</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</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>5.4</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</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Question | Trust 2018 | Comparison
--- | --- | ---
home? | | other trusts

Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department? | 7.5 | About the same as other trusts

Q45. Overall | 7.9 | About the same as other trusts

(Source: Urgent and Emergency Care Survey (October 2018 to March 2019; published October 2019)

Friends and Family Test

The NHS patient friends and family test (FFT) asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The chart below shows the mean FFT scores (percentage which would recommend the service), with upper and lower control limits. The width of the control limits is based on the response rates, therefore the higher the response rates (shown by narrower control limits) the more confidence we have in the data. The trust scored between 82.9% and 97.7% from July 2017 to June 2019.

Response rates for Royal Cornwall Hospitals NHS Trust from July 2017 to June 2019 are shown below.

Royal Cornwall Hospitals NHS Trust – response rate July 2017 to June 2019
The response rate for the trust was higher on average during the first six months of 2019 compared with the preceding 18 months. However, this higher rate of response coincided with a deterioration in the trust’s FFT score.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served, although facilities could not always cope with patient demand.

Some parts of the facilities and premises were not always appropriate for the services being delivered. The emergency department was frequently crowded, and some patients experienced long delays before they were admitted to an inpatient bed if required. Patients who were delayed in this way were provided with a bed in the department but did not have access to some bathroom facilities or a hot meal. Patients arriving in the emergency department by ambulance were frequently held in the corridor, where they had little privacy. This was a regular occurrence and had become normal practice, in so far as it was planned for and staffed accordingly. Staff were sometimes able to move patients held in the corridor into a curtained cubicle, kept free for intimate examinations or providing treatment. We observed staff take histories from patients, and perform (non-intimate) examinations and procedures, such as taking blood, in the corridor. This was done sensitively and with the patient’s consent. We heard doctors and nurses apologise to patients and patients were given a crowding information sheet, which explained their treatment would not be delayed, while acknowledging their privacy and dignity may be compromised.

There were separate male and female toilets within the clinical decision unit, at either end of the ward, although one was out of order during our inspection. There were no further bathroom facilities. Although patients were not expected to have extended stays, these did occur. One patient had been accommodated on this unit for three days during our inspection. When long stays occurred, patients had to be escorted to bathroom facilities on the acute medical unit if required. This had an impact on the staffing levels in the department and was an inconvenience for patients. This issue was recorded on the emergency department risk register as a moderate risk. A request for new works had been submitted to provide wet room facilities but the status of this was not clear.

The resuscitation room was small, only accommodating three patients, and working conditions were cramped.

There was a small waiting area in the clinical decision unit where patients who had been assessed as ‘fit to sit’ could stay if they were, for example, waiting for test results or transport. This was a
very small space, with no natural light. A patient told us: “I feel like I have been put in a cupboard.” However, it had been provided in an attempt to release a bed to a patient in greater need.

The paediatric area was designed and equipped to meet the needs of children with child-friendly decoration and play equipment. However, the department was small, and sometimes cramped when several families were present sometimes with siblings and pushchairs.

The department was well lit and maintained and met most of the recommendations of the Royal College of Emergency Medicine guidance for emergency care departments (2017). There was adequate and clear signage leading to and throughout the department.

Staff knew about and understood the standards for mixed sex accommodation but were not always able to meet them in practice. The clinical decision unit was small and cramped and offered patients little privacy and dignity. Staff tried to ensure men and women were accommodated separately but this was a challenge, given the size and layout of the ward.

The waiting area for self-presenting patients was reasonably spacious. However, it was not always accessible for all patients. There was adequate seating for all visitors during our inspection, but we noted it was difficult for a patient in their wheelchair to navigate to a space, without others having to stand. The waiting area had recently been reconfigured, but the television remained in its original position which meant only reception staff could see it. Staff did not know when this was likely to be moved so visitors could view it.

There was some reading material available and there were vending machines where patients and visitors could purchase refreshments.

The service did not ensure patients could discuss their personal information with reception staff without being overheard or taken aside. A receptionist told us there used to be a line on the floor, which queuing visitors were asked to stand behind. They told us if the patient wished to discuss their condition in private, they would offer to take them into the corridor behind the reception desk, where they were less likely to be overheard.

The service did not always take account of patients’ individual needs and preferences. However, staff did coordinate care with other services and providers.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. Staff could access mental health records for adults to check whether patients had an existing mental health condition, including diagnosis of dementia.

The emergency department was not yet designed to meet the needs of patients living with dementia, although there were plans to develop a ‘dementia-friendly’ area. A room had been identified, which was to be refurbished, decorated and equipped to provide a calm space away from the busy department. A nurse, who had recently become the third dementia link nurse in the emergency department, had designed the space and had identified sources of funding from community sponsors.

There was an activity box stored in the clinical decision unit. This contained a range of resources, which could be used to occupy and distract patients, who may be anxious. Resources included jigsaw puzzles, books, magazines and tactile objects.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. ‘This is me’ is a document designed to support people with communication difficulties or cognitive impairments when they are in an unfamiliar place. It provides a ‘snapshot’ of their background, personal habits and likes or dislikes. These documents
were available in the emergency department and staff were familiar with them. They also used an initiative known as the red bag scheme. This was a national initiative aimed at improving communication and collaboration between hospitals and care homes. Staff did not use any visual signals or symbols to alert other staff a patient had cognitive or communication difficulties. The frailty specialty nurse told us there had been discussion about using the forget me not symbol on patients’ notes and purple wristbands to identify patients living with dementia to other visiting staff, but this had not been taken forward.

There was limited understanding or application of the policy on meeting the information and communication needs of patients with a disability or sensory loss. The department was not compliant with the Accessible Information Standard (a requirement that aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need). Staff did not receive training for or have access to communication aids/tools. Information leaflets were not available in easy read formats. However, there was a hearing loop in the department and there were personal communicators available around the hospital to support communication for patients with hearing loss.

Managers did not make sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. We spoke with a receptionist who was not aware of access to translation or interpreter services for patients whose first language was not English. Other staff told us they would call a translator service or could use a mobile phone application to aid communication or rely on English speaking friends/relatives. The service did not have information leaflets available in languages spoken by the patients and local community. There was a learning disabilities team and speech and language therapy team who were available to support communication during office hours.

Patients were given a choice of food and drink to meet their dietary preferences. Patients we spoke with said there was plenty of choice most of the time and staff would go out of their way to find alternatives if they or their relatives had dietary requirements.

Staff did not have access to communication aids to help patients become partners in their care and treatment. Most staff we spoke with were not aware of any provision though one nurse did advise us there used to be a communication folder, but they did not know where to find it and did not feel confident using it to support patient communication.

**Urgent and Emergency Department Survey 2018**

The trust scored about the same as other trusts for all three Urgent and Emergency Department Survey 2018 questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Urgent and Emergency Department Survey (October 2018 to March 2019; published October 2018)
Access and flow

People could not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards or England averages.

Managers monitored waiting times. However, patients could not always access emergency services or receive treatment within agreed timeframes and national targets. The Royal College of Emergency Medicine recommends the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet this standard for seven months over the 12-month period from July 2018 to June 2019. There were systems for managers to monitor this including the role of the administrative staff member in the major treatment area who monitored patients within the department and highlighted when tasks needed to be followed up.

Median time from arrival to treatment (all patients)

From July to October 2018 and from April to June 2019, performance was worse than the standard with median time to treatment above 90 minutes for every month in these periods. In winter months (November 2018 to March 2019) the median time to treatment was consistently low (between 35 and 45 minutes). This performance change may have been due to seasonal demand.

Median time from arrival to treatment from July 2018 to June 2019 at Royal Cornwall Hospitals NHS Trust

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

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

Managers and staff endeavoured to make sure patients did not stay longer than they needed to. However, the service consistently failed to meet national waiting time standards. The NHS England constitutional target for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From August 2018 to July 2019, the trust failed to meet the target every month but was better than the England average in 10 out of the 12 months.

There was a downward (deteriorating) trend in performance in this target with 93% of patients being admitted, transferred or discharged within four hours in August 2018 compared to 88% in June 2019. This was of concern as the four-hour target was also identified at the last inspection as an action the trust must take to improve.

Four-hour target performance - Royal Cornwall Hospitals NHS Trust
Percentage of patients waiting more than four hours from the decision to admit until being admitted

Patients also waited too long in the emergency department once a decision had been made to admit them to an inpatient bed.

From August 2018 to July 2019, the 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.

From August 2018 to February 2019, performance against this metric deteriorated with 34.7% of patients waiting more than four hours from the decision to admit until being admitted in February 2019. Performance remained over 28% over the next three months and reached a high of 38.2% in June 2019.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Royal Cornwall Hospitals NHS Trust

(Source: NHS England - A&E Waiting times)

Number of patients waiting more than 12 hours from the decision to admit until being
Over the 12 months from August 2018 to July 2019, 39 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in July 2019 (21) and June 2019 (16).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-18</td>
<td>399</td>
<td>0</td>
</tr>
<tr>
<td>Sep-18</td>
<td>379</td>
<td>0</td>
</tr>
<tr>
<td>Oct-18</td>
<td>437</td>
<td>0</td>
</tr>
<tr>
<td>Nov-18</td>
<td>507</td>
<td>0</td>
</tr>
<tr>
<td>Dec-18</td>
<td>502</td>
<td>1</td>
</tr>
<tr>
<td>Jan-19</td>
<td>648</td>
<td>0</td>
</tr>
<tr>
<td>Feb-19</td>
<td>826</td>
<td>1</td>
</tr>
<tr>
<td>Mar-19</td>
<td>790</td>
<td>0</td>
</tr>
<tr>
<td>Apr-19</td>
<td>824</td>
<td>0</td>
</tr>
<tr>
<td>May-19</td>
<td>922</td>
<td>0</td>
</tr>
<tr>
<td>Jun-19</td>
<td>970</td>
<td>16</td>
</tr>
<tr>
<td>Jul-19</td>
<td>606</td>
<td>21</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

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

The number of patients leaving the service before being seen for treatments had deteriorated. The monthly percentage of patients that left the department before being seen for treatment was better than the England average from July 2018 to February 2019. Performance then deteriorated to worse than the England average with 3-4% of patients leaving the department before being seen for treatment each month from March 2019 to June 2019.

Reception staff in the waiting area told us they used information to show waiting times at other minor injuries or urgent care services locally and this was provided to patients verbally or they could see this on a screen in the waiting room. It was considered as a safe alternative for the patient. The staff said that patients did not often choose to leave the department if the wait was less elsewhere but there were occasions where patients had. Staff told us they would look to give this information to patients when they first arrived in the department to help them make an informed decision.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - Royal Cornwall Hospitals NHS Trust
Managers and staff endeavoured to start discharge planning as early as possible. There was a team who worked to build a rapport with patients and identify any additional health and social care support or needs when they arrived. We observed this team approach a patient in a major treatment area bay who did not want to talk with them. The staff were understanding and professional, they tried several times to speak with the patient and gained some understanding about why they had not been coping well at home. Managers advised that they encouraged staff to engage this team as early as possible to reduce any delays to discharge.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. There were good links with the department and the wider hospital but also with community services such as adult social care and the local authority children and families teams. Staff told us about discharge planning alongside social care staff but also in conjunction with physiotherapists and dietitians where appropriate. There were policies to support staff in planning patient transfers between services. The administrator, who worked alongside the nurse in charge the major treatment area worked together to manage who had been in the department for how long and where they were meant to be going and when.

From August 2018 to July 2019, the trust’s monthly median total time in A&E for all patients was lower than the England average. The trust’s median performance was lower by an average of 50 minutes each month. This may be positive indicator that decisions regarding the next stages of care for patients in the department were made in a timely way. However, some data included the urgent treatment centre at West Cornwall Hospital and the county’s MIUs. This made it unclear whether the median total time in department was good for Royal Cornwall hospital or whether the urgent treatment centre/MIU data was making the figures look better than they were.
Learning from complaints and concerns

There were means for people to give feedback and raise concerns about care received. The service investigated concerns and complaints and shared lessons learned with all staff. However, most complaints were not investigated and closed within 30 days as stated in the trust's policy. The average was more than twice the timescale.

Patients, relatives and carers were able to complain or raise concerns. Patients we spoke with did not know how at the time how to make a complaint but told us they would raise concerns with staff and felt able to do so. The service clearly displayed information about how to raise a concern in patient areas. There were leaflets available, which explained how to raise concerns. This information was also available on the trust's website. Staff understood the policy on complaints and knew how to handle them. Staff told us if a patient, relative or career raised a concern while in the emergency department they would be invited to speak with a senior member of staff or directed to the trust’s complaints team. A patient we spoke with in major treatment area explained they had complained previously when they had been waiting in the corridor for a long time. Staff had come to apologise to them. The patient said they felt better one staff had explained that they were available and were still completing the same checks for patients who were in the corridor. The patient also found the information leaflet explaining why corridor care happened and what to expect helpful.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Senior staff in the emergency department investigated complaints. Complaints were discussed at monthly safety meetings and summarised, with learning points, in the clinical governance newsletter. In July 2019, the newsletter identified three main themes arising from complaints: clinical error, communication and attitude - and gave advice to staff on how these areas could be improved.

Staff could give examples of how they used patient feedback to improve daily practice. A staff member told us they were frequently reminded to keep patients and relatives informed, particularly when there were delays. Lack of communication was a frequent complaint.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. All formal complaints were acknowledged in writing and
complainants were kept informed if the investigation was delayed. Complainants received full written explanations following investigation and apologies were offered where appropriate.

**Summary of complaints**

**Trust level**

From August 2018 to July 2019, Royal Cornwall Hospital received 86 complaints in relation to urgent and emergency care (17% of total complaints received by the trust). The trust took an average of 64 days to investigate and close complaints. This was not in line with their complaints policy, which stated complaints should be closed within 30 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>32</td>
<td>37.2%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of a care package)</td>
<td>14</td>
<td>16.3%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>9</td>
<td>10.5%</td>
</tr>
<tr>
<td>Communications</td>
<td>8</td>
<td>9.3%</td>
</tr>
<tr>
<td>Patient care</td>
<td>7</td>
<td>8.1%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>5</td>
<td>5.8%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>3</td>
<td>3.5%</td>
</tr>
<tr>
<td>Restraint</td>
<td>2</td>
<td>2.3%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
<td>2.3%</td>
</tr>
<tr>
<td>Trust admin/policies/procedures including patient record management</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>Integrated care (Including delayed discharge due to absence of a Care package)</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>86</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Note due to the rounding of percentages the total may not add up to 100%.

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

**Number of compliments made to the trust**
From August 2018 to July 2019, there were 252 compliments about urgent and emergency care at the trust. This equated to 37% of all compliments received by the trust. A breakdown of compliments by site is below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical decisions unit</td>
<td>134</td>
<td>53%</td>
</tr>
<tr>
<td>Ambulatory emergency care</td>
<td>46</td>
<td>18%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>36</td>
<td>14%</td>
</tr>
<tr>
<td>ED Majors</td>
<td>31</td>
<td>12%</td>
</tr>
<tr>
<td>ED Minors</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>252</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Note due to the rounding of percentages the total may not add up to 100%.

More than half of all compliments received about urgent and emergency care were related to the clinical decision unit (134, 53%).

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

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The emergency department sat in the urgent, emergency and trauma care group and was managed, alongside acute medicine, by a speciality leadership team, which consisted of:

- Specialty lead (consultant), who had time allocated in their consultant job plan for this role. They provided strategic leadership for the medical workforce and the emergency department. They were also the governance lead for the emergency department. Other consultants had designated areas of special interest and responsibility, for example, education and audit.

- The matron provided strategic leadership for nursing staff. They worked part time and were supported by a newly appointed deputy, a senior (band seven) nurse, who was in a development role. There were also band seven team leaders, who led in different areas, such as education and safeguarding, and were responsible for staff development and pastoral care and performed the ‘nurse in charge’ role.

- Specialty manager. This manager provided operational and business support to the clinical managers. This was a recent appointment.

The speciality leaders had the right managerial skills, experience and support. However, they had no formal meeting structure, aside from weekly senior management meetings, but they appeared to work collaboratively and cooperatively. The specialty lead had worked in a similar capacity previously at another trust and in their current consultant role, had worked alongside the outgoing
speciality lead for several years. The matron was a long-standing appointment. They were supported by an experienced senior nurse who would develop into a deputy role, to ensure continuity and resilience.

The specialty leadership team reported to the care group leadership team, who they described as visible and supportive. This was also a relatively new leadership team, but this was described as a positive by many, who talked about new energy and focus.

Leaders fully understood the challenges faced by the service and clearly identified the actions needed to address them. They spoke confidently about workstreams and improvement plans which had been developed and were ongoing to improve performance.

Staff we spoke with told us that the local leadership team were liked and respected. They were visible on the ‘shop floor’ and were described as friendly, approachable and supportive.

**Vision and strategy**

**The service had a vision for what it wanted to achieve but no formal, overarching strategy for the department. The vision was focused on sustainability of services and aligned to local plans within the wider health economy.**

There was no formal, overarching vision or strategy for the emergency department. However, senior staff could clearly articulate their shared vision and the workstreams and project plans which supported this. Improvement plans were not focused solely on the emergency department but based on an integrated whole-system approach to unplanned care, to reduce pressure on the emergency department. External partners were involved in the development and delivery of improvement plans.

In line with the NHS long term plan (to reduce emergency department attendances through the provision of alternative assessment and treatment pathways), the trust had reviewed the pathway for expected (GP-referred) patients and had recently opened a same-day assessment unit. A second strand of this plan was the commissioning of a co-located urgent treatment centre, offering a GP-led service for patients who required urgent assessment and treatment but who did not need to attend an emergency department. This was about to open at the time of our inspection.

There was a four-hour standard recovery plan, which aimed to reduce demand in the department, improve patient flow outwards, prevent crowding and improving efficiency. Within this were a range of projects, focusing on, for example, escalation and site management, workforce, and input from specialised teams at the ‘front door’. A significant output from the four-hour standard recovery plan was the introduction of a medical assessment unit, which was designed to admit patients referred by their GPs and to bypass the emergency department. This was expected to reduce pressure on and crowding in the department. A winter plan was also a part of this work. There was appropriate trust, and care group-level governance systems to ensure oversight of the recovery plan. An improvement dashboard was maintained to allow monitoring of progress against key milestones.

There were capital plans to reconfigure the emergency department premises, including the expansion of the resuscitation area. This aligned to one of the highest risks on the emergency department’s risk register. A business case had been approved in principle and detailed planning was underway.

Staff we spoke with were familiar with plans and the overall direction of urgent and emergency care and some participated in workstreams.
Culture

Staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us morale in the emergency department was mostly positive. There was an evident culture of camaraderie, team work and peer support. Social events outside of work helped to build on this. We saw there were monthly runs organised, ‘bake off’ competitions and joint fund-raising for the department. Staff spoke about their ‘work family’ and said this helped them to be resilient in the face of work pressure they described.

Leaders were aware of the effect of operational pressure on staff resilience and wellbeing and were taking steps to support this. However, they recognised they needed to do more. For example, crowding in the emergency department caused pressure and anxiety for staff who told us they felt unable to provide the standard of care they aspired to. Staff advised there were healthy living initiatives and policies for staff around wellbeing. A staff member showed us the trust’s ‘smoke free policy’ and staff wellbeing posters and newsletters. Staff were encouraged at handovers to speak up about any situations which they had found challenging or distressing and a debrief was offered. We heard about staff being ‘fast tracked’ to counselling and occupational health services when needed.

It was recognised training and development were key to ensuring staff felt valued and supported. A nurse educator provided support to all nursing staff but had developed bespoke support to newly qualified staff. One staff member told us they had received “brilliant support” and had felt nurtured and welcomed. There were induction nights out for newly appointed doctors.

There were cooperative, supportive and appreciative relationships amongst staff. They jointly recognised and celebrated others’ successes. There was a ‘star of the month’ nominated by peers and their success was recognised in the staff newsletter. During our inspection, this was awarded to a healthcare assistant who had developed resources to improve the experience for patients (and their loved ones) at the end of their lives. The emergency department also participated in the trust-wide staff recognition and award scheme and had been the recipient of several awards.

Staff told us they were treated as equals; there was no hierarchy, aside from the necessary chain of command for safety and escalation. Staff felt supported and listened to. The matron in particular was described as a supportive manager, whose door was always open.

Nursing staff were employed in teams, led by a senior (band seven) nurse. Although they did not routinely work in teams, their training was organised and rostered by team, which fostered a sense of belonging and the allocation of a team leader provided a ‘go to’ person.

Staff told us they felt supported to raise concerns without fear of retribution. Some, although not all staff, were aware of the Freedom to Speak-up Guardian. All staff we spoke with felt there was culture in which it was safe to speak up.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance systems to provide assurance of quality and safety. The specialty lead was also the designated governance lead and chaired monthly safety meetings. These meetings were open to all staff. Medical staff had protected time to attend, and although
nurses did not, they were allocated three days’ annual refresher training, which was scheduled to coincide with this meeting, to facilitate their attendance at least once a year. Minutes were circulated to staff and key messages were summarised in a monthly newsletter.

Standard agendas were used to provide consistency and structure to meetings, although we noted not all items were always discussed. A tracker was used to record and monitor actions arising from meetings. The primary focus of meetings was patient safety, with the first hour devoted to this. There was a detailed review of serious incidents, audits and quality improvement projects and complaints learning, and safety messages for cascade were agreed here. This was also the forum responsible for ratification of clinical protocols, oversight of mortality reviews, risk register, key performance indicators, workforce and finance.

There was a weekly senior management team meeting for the management of business and operational matters, including immediate staffing arrangements.

Information was appropriately shared with senior leadership teams. The specialty lead attended care group governance meetings when able and provided monthly exception reports to this forum, which reported onwards and ultimately to the board.

There were regular meetings with partners, stakeholders and other healthcare providers, including the ambulance service and mental health organisations. Managers reported positive collaborative relationships with these partners.

**Management of risk, issues and performance**

Leaders and teams mostly used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, the departmental risk register was not clear around reviews and actions.

There were clear and effective processes for managing risks, issues and performance. Staff and managers were well informed about the risks and challenges in the emergency department and actions taken or planned to reduce and manage those risks.

There was much evidence of review of serious incidents, incident trends, mortality and performance and this was used to compile the emergency department risk register which was discussed at governance meetings. High and severe risks were escalated to care group or corporate level and there was a range of improvement projects to look at ways of managing known risks.

The risk register provided a comprehensive breakdown of risks and their severity, the controls and the further actions required to reduce or eliminate the risk. Risks aligned with what staff and managers told us was on their ‘worry list’, except for nurse staffing which was not identified as a risk. Although we saw evidence in the minutes of safety meetings that risks were regularly reviewed, this was not clear from the risk register document itself, as entries to update existing and planned controls were not dated. Top risks (extreme and high) were:

- Crowding in the emergency department, leading to queuing in corridors, ambulance crews unable to offload patients, and delayed assessment and treatment. The leadership team recognised this as their biggest challenge and where most focus was required. It was recognised crowding led to increased incidents, and a review of serious incidents had identified crowding as a contributing factor. Mitigating actions included review of the rapid assessment and treatment service, opening a same day assessment unit, ongoing close working with and escalation to site management to help with patient flow.
• The resuscitation room was too small to accommodate current demand and some seriously unwell patients had to be transferred and treated elsewhere. There was limited space to work effectively. There was business case to expand the resuscitation room from three to six beds.

• Delayed mental health reviews, due to short staffing within the psychiatric liaison team. Staffing had improved at the time of our inspection but ongoing dialogue with the mental health provider continued to find ways to improve the service.

• No out of hours provision of child and adolescent mental health services (CAMHS), leading to extended waits for some children in an unsuitable environment. There were ongoing discussions about how to improve this service with the mental health provider and commissioners.

• Patient monitors were too small to be read from outside patient cubicles, making it difficult to monitor changes in a patient’s condition. There was a business case pending for new monitors.

**Major incidents**

**The service had processes to deal with a major incident.** There was a command structure for major incident responses. This included designated commanders for each area of the hospital and a control room plan that aimed to redeploy staff to the areas of need. The trust declared a major incident in July 2019 and have used the learning from this to further develop understanding of and use of major incident process as a result. The major incident plan was available on the hospital’s intranet for all staff. It was reviewed annually to ensure it was current and up-to-date and additional training was provided to staff each year.

**The service had additional equipment to deal with the unexpected.** There was a major incident store that included additional equipment and a stock of controlled drugs. Staff received annual training refreshers which included surprise scenarios.

**Information management**

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

There were effective information systems, which provided real-time and retrospective reporting of performance, safety, risk and quality, including patient experience. Information was regularly reviewed and used to support continuous improvement. Attendance and performance data were used when looking at staffing levels and any restructures of the department.

There was real-time information recorded about activity and waiting times, which was constantly monitored by senior staff in the emergency department and the site management team. This provided data for a report around performance, which was monitored daily, weekly and monthly. This helped to identify the factors which contributed to waiting times and delays in care.

There were effective information governance processes and safeguards. Staff received information governance training and staff understood their responsibility to safeguard confidential data.

**Engagement**
Leaders encouraged staff to feedback their opinions and concerns. Staff supported and encouraged patients to feedback on their experiences of the service.

Staff we spoke with felt able to raise concerns to senior staff and managers when they had concerns. Three staff we spoke with told us that they were encouraged to speak up when things were not right in order that changes could be made. Staff told us that they had seen a lot of change happen following staff feedback in the past 18 months. For example, a senior band seven post was introduced which had helped with additional oversight for staff in the department. This said, one staff member did tell us that change could feel very slow to take effect at times although they were confident changes would happen. Most staff were aware of and could identify Freedom to Speak-up Guardian within the trust and department and spoke positively about the impact the freedom to speak up roles have had in the hospital.

Managers and senior staff told us that they valued the views of the staff. One senior staff member told us they knew the people who could identify risks and issues most quickly were the staff on the frontline working in the department. They told us they took feedback from staff seriously. They valued staff taking time to raise their concerns, so patients could be kept safe and the department could function efficiently.

Patients were able to feedback verbally, through written feedback forms, and through a link to a survey on the trust website. Patients we spoke with told us they were listened to and encouraged to give feedback. One patient said a staff member had helped them to access the feedback section on the hospital website as they were struggling to find it for themselves.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

There was a strong emphasis on education, audit research and quality improvement, and a proactive culture which encouraged and supported learning and innovative practice. There was a lead consultant for quality improvement and audit and they invited staff to lead projects and audits. Findings and achievements were regularly presented at safety meetings. Involved staff were asked to create a poster, detailing achievements and projects were judged by a panel, with a prize given to the winner. Examples included a sepsis improvement plan, a review of ‘five tier trauma response’ calls, a self-assessment against royal college of emergency medicine (RCEM) best practice guidance (the department scored well for QI and audit).

The emergency department had won two trust-wide Clinical Research and Audit awards in 2019. These recognised the emergency department’s patient safety checklist project and sepsis improvement team.

There were opportunities for staff to pursue interests and we saw many examples where staff ideas had been put into practice to provide meaningful improvements to patients’ care and safety. For example, a nurse had researched how the environment could be improved for people living with dementia and had approached the local bus company to supply a bus stop, which was to become the focus of a new adapted ‘dementia-friendly’ area in the emergency department.

A healthcare assistant had used charitable funds to provide relatives of patients at the end of their lives with blankets and toiletries, so they could stay overnight with their loved ones. Raffia bags were provided for deceased patients’ belongings to remove the often-felt indignity of using plastic bags.
Simulation training was provided for doctors every week, and this had now been established for nursing staff. The nurse who had introduced weekly simulation training for nurses had shared the initiative as an example of good practice with colleagues nationally and internationally.

The service had looked at innovative ways to improve staff recruitment. There had been successful international nurse recruitment. Healthcare assistants had been supported to train and become registered nurses and there was the conversion of temporary staff to substantive trust-employed staff to help reduce agency usage. Eight advanced care practitioners were currently in training.

There was an ‘innovation breakfast’ meeting where staff could bring ideas and discuss them with colleagues. There were plans to formally establish this so staff could be enabled to attend.

The service was working with the national improvement team at NHS England and NHS Improvement, called ‘Getting it Right First Time’. The team were awaiting their next visit shortly after this inspection where they were anticipating a rerun of data regarding the aggregated time patients spent in the department to be considered.

Schwarz rounds were planned for the week after our inspection. These are an evidence-based forum where hospital staff from all backgrounds can come together to talk about the emotional and social challenges of caring for patients. The aim was to offer a safe environment where staff can share their stories and offer support to each other. Staff we spoke with felt positively about this time and told us they were looking forward to the next opportunity to meet.

The department were also working with an independent consultancy firm to design admission avoidance pathways. This was alongside work to open the urgent treatment centre (UTC) (planned to be attached to the walk-in area of the current emergency department) in the first week of December 2019. The opening of the UTC was in line with the deadline set by NHS England in the guidance document Urgent treatment centres – principles and standards, 2017.

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

**Facts and data about this service**

The medical care service provides care and treatment for a range of acute and specialist services including general medicine, respiratory medicine, cardiology, renal services, neurology, hepatology, gastroenterology, haematology, elderly care, stroke services and specialist cancer services. There are 354 medical inpatient beds located across 37 wards.

Medical services provide both inpatient facilities and outpatient clinics, with clinics at the main hospital sites and peripheral clinics.

(Source: Routine Provider Information Request AC1 - Acute context)

During this inspection we only visited medical services at the Royal Cornwall Hospital.

Inpatient services include cardiology and a coronary care unit, with an elective and inpatient ward shared with respiratory medicine. The service provides primary percutaneous coronary intervention (PCI) four hours a day, seven days a week and there are two catheterisation laboratories. Patients requiring cardiac surgery are referred to two other trusts in the south west.
There are two acute medical assessment wards which contain 12 frailty pathway beds for elderly care. There is also a same-day emergency care unit which receives patients through GP referral and patients from the emergency department.

There are two care of the elderly wards, one of which is shared with neurology. There is a dedicated stroke ward with two “hyper acute stroke” beds.

There is one respiratory ward, including six higher care beds, providing non-invasive ventilation (NIV) to these patients.

Endocrinology and nephrology patients are accommodated jointly in two wards, providing 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.

Medical care is provided for oncology patients on Lowen Ward.

The endoscopy department provides day-case endoscopy treatment each weekday.

Day-case activity includes endoscopy, renal dialysis, cardiac procedures and diagnostics. There is a medical day unit providing infusions and pre/post recovery for patients undergoing interventional radiology.

There is a discharge area which operates Monday to Friday 7.30am 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.

During our announced inspection between 12 and 14 November 2019, we visited:

The acute assessment unit, the same day emergency care unit/medical assessment unit, the medical day unit, the discharge ward, Kynance ward, the coronary care unit, cardiac catheter laboratories, cardiac investigations unit, Wellington ward and higher dependency bay (respiratory), Roskear ward (cardiac and respiratory), Phoenix (stroke ward), Grenville ward (endocrine and renal), Kerensa ward and Tintagel ward (older peoples care), Lowen ward (oncology), gastroenterology and liver unit and the endoscopy department. We also visited two surgical wards (Eden ward and Wheal Coates ward), where outlier medical patients were accommodated.

Our inspection team comprised of two inspectors, a CQC pharmacist and a mental health inspector, and three specialist advisors. We spoke with 112 members of staff, including nurses, doctors, therapists, pharmacists, administration staff and housekeeping staff. We spoke with 26 patients and relatives. We looked at 30 sets of patients’ records, which included medical, nursing and observation records.

There were 63,840 medical admissions from March 2018 to February 2019. Emergency admissions accounted for 21,736 (34%), 1,565 (2.4%) were elective, and the remaining 40,539 (63.5%) were day-case.

The highest number of admissions were seen in:

- General medicine: 20,988
- Gastroenterology: 17,273
- Clinical oncology: 10,168

(Source: Hospital Episode Statistics)
Mandatory training

The service provided mandatory training in key skills to all staff but not all staff completed it.

The trust set a target of 95% for completion of mandatory training. At our last inspection in 2018 we found statutory and mandatory staff training compliance did not meet the trust’s 95% completion target. At this inspection of the Royal Cornwall Hospital we found some improvement.

Trust level

A breakdown of compliance for mandatory training courses from April to July 2019 at trust level for registered nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module 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>360</td>
<td>360</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS CSTF resuscitation - level 2 - newborn basic life support - 1 year</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (inc privacy &amp; dignity standards)</td>
<td>433</td>
<td>435</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>418</td>
<td>435</td>
<td>96.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>418</td>
<td>435</td>
<td>96.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>409</td>
<td>435</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>407</td>
<td>435</td>
<td>93.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>406</td>
<td>435</td>
<td>93.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>387</td>
<td>435</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>379</td>
<td>435</td>
<td>87.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>370</td>
<td>435</td>
<td>85.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>368</td>
<td>435</td>
<td>84.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>336</td>
<td>435</td>
<td>77.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS CSTF resuscitation - level 2 - paediatric basic life support - 1 year</td>
<td>14</td>
<td>19</td>
<td>73.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Within the medical care the 95% target was met for five out of 14 mandatory training modules for which registered nursing staff were eligible.

For the previous financial year; April 2018 to March 2019 at trust level, registered nursing staff achieved a 94% completion rate for mandatory training.

A breakdown of compliance for mandatory training courses from April to July 2019 at trust level for medical staff in medicine is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Dementia awareness (inc privacy &amp; dignity standards)</td>
<td>239</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>234</td>
</tr>
<tr>
<td>Information governance</td>
<td>230</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>219</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>219</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>205</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>199</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>187</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>186</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>185</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>185</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>134</td>
</tr>
<tr>
<td>NHS CSTF resuscitation - level 2 - paediatric basic life support - 1 year</td>
<td>0</td>
</tr>
</tbody>
</table>

Within medical care the 95% target was met for two out of 13 mandatory training modules for which medical staff were eligible.

For the previous financial year; April 2018 to March 2019 at trust level, medical staff achieved an 80% completion rate for mandatory training.

**Royal Cornwall Hospital**

Nursing staff received mandatory training, but this was not kept up to date in all areas.

At this inspection we found some areas had improved training levels, whilst in other areas compliance rated had deteriorated. Within medical care the 95% target was met for four out of 14 mandatory training modules for which registered nursing staff were eligible.

There were shortfalls in infection prevention, health and safety and adult basic life support. There had been improvements in conflict resolution and information governance but compliance for fire awareness had remained the same and the target had not been met. Staff told us that when the hospital was busy training was often cancelled.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

At our last inspection in 2018 staff told us the mandatory training in mental health needs, learning disabilities, autism and dementia was not enough to provide them with the knowledge and skills required to care for these patients. At this inspection we found that there had been improvements in the training completed for dementia and a new role had been implemented to support staff manage patients with dementia and delirium. Most staff told us they had already found the support and learning provided had increased their knowledge and improved patient support. However, we saw some aspects of mental health care where learning could be improved to support patients’ needs. This is identified later in the report.

A breakdown of compliance for mandatory training courses from April 2019 to July 2019 for registered nursing staff in medical care at Royal Cornwall Hospital is shown below:
Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was recorded and monitored through an electronic staff record. Staff confirmed that they were alerted by email when training was due.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us the quality and content of the training was appropriate and relevant to their needs. Staff were trained to be aware of the signs of sepsis and knew what their actions should be. Staff said they had received training at induction about sepsis and further ongoing training to support their practice.

Medical staff mandatory training was not completed in all areas. A breakdown of compliance for mandatory training courses from April 2019 to July 2019 for medical staff is shown below:

<table>
<thead>
<tr>
<th>Training module 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>307</td>
<td>307</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS CSTF resuscitation - level 2 - newborn basic life support - 1 year</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (inc privacy &amp; dignity standards)</td>
<td>380</td>
<td>382</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>366</td>
<td>382</td>
<td>95.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>366</td>
<td>382</td>
<td>95.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>357</td>
<td>382</td>
<td>93.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>357</td>
<td>382</td>
<td>93.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>355</td>
<td>382</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>336</td>
<td>382</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>335</td>
<td>382</td>
<td>87.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>326</td>
<td>382</td>
<td>85.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slip, trips and falls)</td>
<td>324</td>
<td>382</td>
<td>84.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>291</td>
<td>382</td>
<td>76.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS CSTF resuscitation - level 2 - paediatric basic life support - 1 year</td>
<td>14</td>
<td>19</td>
<td>73.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Within medical care the 95% target was met for two out of 13 mandatory training modules for which medical staff were eligible.
For the previous financial year; April 2018 to March 2019 at trust level, medical staff achieved an 80% completion rate for mandatory training.

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

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.

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

Trust level

A breakdown of compliance for safeguarding training courses from April to July 2019 at trust level for registered nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>426</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>424</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>413</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>12</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>397</td>
</tr>
</tbody>
</table>

Within the medicine department the 95% target was met for three out of five safeguarding training modules for which registered nursing staff were eligible.

For the previous financial year; April 2018 to March 2019 at trust level, registered nursing staff achieved a 90% completion rate for mandatory training.

A breakdown of compliance for safeguarding training courses from April to July 2019 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>235</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>232</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>197</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>184</td>
</tr>
</tbody>
</table>

Within the medicine department the 95% target was met for one out of five safeguarding training modules for which medical staff were eligible.

For the previous financial year; April 2018 to March 2019 at trust level, medical staff achieved a 79% completion rate for mandatory training.

Royal Cornwall Hospital

Nursing staff received training specific for their role on how to recognise and report abuse. Some staff told us they had could complete level three training for adults and children, this included the Acute medical Assessment Unit which accommodated young people aged 16 and above on the ward at the time of our inspection. Medical staff had access to level three safeguarding training for children.
Staff we asked spoke positively about the trust’s safeguarding training. Staff explained the training, alongside the trust’s thorough admissions process, enabled them to identify potential safeguarding issues.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff demonstrated an understanding of anti-discrimination and provided person-centred care. If a patient had mental health problems staff would consider if enhanced care was needed, would seek advice from the safeguarding team and would aim to provide extra support for the patient.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff understood their responsibilities to raise concerns and report abuse. 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 trust’s safeguarding team, who provided further support tor staff when needed. Staff training included recognising domestic abuse and female genital mutilation (FGM).

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff used electronic systems to alert safeguarding risks to the safeguarding team and the local authority. Staff could give us examples of when safeguarding concerns and alerts had been raised and the actions they had taken. The feedback of outcomes to staff was variable with some having received detailed updates and some staff saying they had received no feedback.

Staff were able to refer patients with no fixed abode to a homeless officer working for a charity based at the hospital. Staff we spoke with explained the hospital's policy was not to discharge patients without a fixed abode until accommodation had been arranged.

A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 for registered nursing staff in medical care department at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>373</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>371</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>361</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>12</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>346</td>
</tr>
</tbody>
</table>

Within medical care the 95% target was met for two of the five safeguarding training modules for which registered nursing staff were eligible. This was consistent with our previous inspection findings.

For the previous financial year; April 2018 to March 2019 at Royal Cornwall Hospital, registered nursing staff achieved a 93% completion rate for mandatory training, this was slightly below the trust target.

A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 for medical staff in the medicine department at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>225</td>
</tr>
</tbody>
</table>
Safeguarding children (level 1) | 222 | 236 | 94.1% | 95% | No
Safeguarding children (level 3) | 10 | 11 | 90.9% | 95% | No
Safeguarding children (level 2) | 187 | 236 | 79.2% | 95% | No
Safeguarding adults (level 2) | 176 | 236 | 74.6% | 95% | No

Within medical care the 95% target was met for one out of five safeguarding training modules for which medical staff were eligible.

For the previous financial year; April 2018 to March 2019 at Royal Cornwall Hospital, medical staff achieved a 79% completion rate for mandatory training.

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

**Cleanliness, infection control and hygiene**

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. An outside cleaning contract service was used on all units and wards we visited, and we saw good levels of cleanliness and hygiene.

At the time of our inspection, Tintagel ward had been put under quarantine due to a recent outbreak of norovirus. We reviewed the daily/weekly cleaning schedule on the ward for the clinical environment and patient contact items we identified several gaps in the recording of cleaning undertaken. Senior ward staff we spoke with explained they were assured cleaning was taking place, and that the issue was about a failure to document this activity.

The service generally performed well for cleanliness.

Each ward completed cleaning audits and displayed scores at the ward entrance. All wards we visited scored between 95 and 100%. Hand hygiene audits were displayed on all the wards and departments we visited and results for most areas were good, with most being 100% compliant.

Staff followed infection control principles, including the use of personal protective equipment (PPE). All staff were bare below the elbow in line with trust policy. Patients and visitors were reminded of the importance of hand washing. Staff used personal protective equipment, such as gloves and aprons, as required, and disposed of these correctly in clinical waste bags. We observed doctors and nursing staff washing their hands and using anti-bacterial gel in line with trust guidelines.

All wards and departments had single rooms to ensure they could treat and care for patients with confirmed or suspected infectious diseases. These rooms were clearly signed with appropriate equipment available before entering. Lowen ward, which accommodated haematology and oncology patients and who were at increased risk of neutropenic sepsis, had a general policy of not accepting patients suspected of being infectious to reduce the risk to patients on the ward. The ward also had two side rooms for patients for infection control purposes.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw equipment had been cleaned and labelled with ‘I am clean’ stickers to indicate items were ready for use.

The endoscopy unit minimised the risk of spread of infection while ensuring treatment procedures were carried out safely. Staff planned for patients with possible or confirmed communicable infections to be treated at the end of the list and they were managed in a separate area.
Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

At our last inspection in 2018 we found that some ward and unit areas were not fully equipped with oxygen and suction for each bed space used. At this inspection we found that the use of those areas had been reconfigured and were used in controlled and limited circumstances for patients.

Patients could reach call bells and staff responded quickly when called. We observed that staff responded promptly to call bells.

The design of the environment followed national guidance. However, we saw on the Acute Assessment Unit there were ligature risks in bathrooms and toilets, which were not risk assessed to promote patient safety. This would require extra monitoring by staff to ensure patients at risk of self-harm were safe.

Staff carried out daily safety checks of specialist equipment.

Emergency equipment was mostly checked daily in accordance with trust policy. Equipment for urgent and emergency situations was kept in tamper-evident trolleys and was checked daily by staff. Records of these checks were signed and dated daily, we saw one trolley which was not signed as checked and was not secured. We alerted staff to this and they immediately completed the check process and secured the trolley. A further trolley was seen to have some gaps in checks which meant there was no assurance checks were completed.

On the medical assessment unit had occasional gaps in daily and weekly checks and there were significant gaps in the recording of checks of the oxygen, suction and emergency box. On Tintagel ward, daily and weekly checks of oxygen, suction and emergency equipment were regularly not recorded, meaning it was not possible for staff to be assured these checks were being carried out and that equipment was fit for purpose.

The service had enough suitable equipment to help them to safely care for patients.

However, escalation areas used at times of high operational pressure were not always suitable and safe for patients and staff. We observed that when six-bed bays were used for seven patients, there was no oxygen, suction, call bell or curtains available for the extra person. Staff told us this was risk managed on a day to day basis to ensure only low risk patients were placed as extra in bays and this was for a limited time only. Staff confirmed they had access to equipment at short notice and maintenance arrangements were efficient.

Staff disposed of clinical waste safely. Disposable items of equipment were disposed of appropriately, either in clinical waste bins or sharps instrument containers. We saw disposal bins were closed when possible and clinical waste bins were clearly identified.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. This is except for venous thromboembolism (VTE) assessments which were not consistently completed.
At our last inspection in 2018 we saw staff used a modified early warning score as part of an electronic observation system to identify patients who had deteriorated. The system had connectivity problems in some areas of the hospital and had to be supported by paper systems. This was problematic for some staff and risked patients’ observations not being recorded in a timely manner, or the correct staff not being alerted if a patient was deteriorating. At this inspection we found, whilst connectivity varied between areas, staff found that this had improved. Systems were now in place to ensure that when connectivity was an issue a clear and consistent process of recording on paper was maintained.

Staff completed risk assessments for each patient as part of the admission process. Staff used a modified early warning scoring (EWS) as part of an electronic observation system to identify patients who had deteriorated. This is a numeric scoring system, using observation of patients’ vital signs to identify deteriorating patients and prompt 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, regardless of the scoring system. Staff we spoke with commented positively on this method of recording, especially about their ability to promptly escalate concerns to senior colleagues. Most of the staff we spoke with said connectivity issues that had previously existed with mobile electronic observations had improved, though staff on Lowen ward and MAU said they still experiencing some problems.

Patients with suspected sepsis were identified using the electronic observation sepsis bundle and the training and experience of the staff. 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 is time-critical and requires prompt action. Staff audited the treatment of patients with sepsis every two months. The audit randomly selected 20 patient records for review. In June 2019 the audit showed that 86% of patients identified as having sepsis had the required antibiotics within an hour of diagnosis.

We saw sepsis boxes on wards and units. These included the equipment needed for taking blood and blood cultures.

Risk management plans were developed to meet any identified area of risk. We saw risk assessments were completed, evaluated and updated as the patients’ needs changed. These included pressure ulcer risk assessments, falls risk assessments and a malnutrition risk assessment. Staff updated information about patient risks and any changes at staff handovers and safety briefings.

Patients were assessed within 24 hours of admission as to their risk of falls. Those patients who were identified as high risk were allocated to beds in staff’s line of sight. On Lowen ward, we found staff were not consistently completing and recording required assessments for patients who experienced a fall on the ward. Staff on the ward explained this was due to confusion among some staff following recent introduction of additional assessments to be completed when patients experienced a fall on the ward.

Pressure ulcers were an area of focus for staff because of the risk profile of patients typically cared for on the wards. Processes required pressure ulcers to be assessed and graded by a nurse and to be promptly reported as an incident. Specialist equipment, including air mattresses were available for patients when required. Debriefs were carried out following the identification of every pressure ulcer categorised two or above. The purpose of these debriefs was to identify any learning from each incident quickly. Staff told us of plans to introduce a similar process for falls.
Risk assessments for venous thromboembolism (VTE) (formation of blood clots) were not completed 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. The trust’s policy was that VTE assessments were carried out within 24 hours of a patient's admission, although staff told us that in practice these assessments were done more quickly. Not all patients had a VTE assessment, we reviewed 17 patients records and found the initial risk assessment was consistently completed but the VTE assessment was not completed on four occasions. However, the trust’s electronic prescribing and medicines administration system required completion of a venous thromboembolism (VTE) assessment before medicines could be prescribed.

The October 2019 trust governance minutes noted that risk assessments for VTE had been assessed as 96% completed.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

There were no specific mental health risk assessments for patients. If mental health, learning disability or dementia needs were identified there was not a corresponding care plan.

There was access to mental health liaison (covering the age range of the ward/ clinic) if staff were concerned about risks associated with a patient’s mental health.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe.

A safety huddle took place each day on all wards and units. This was a meeting used to review patients and followed a set process and proforma to ensure all areas of safety risk were covered.

There was no specific medical high dependency unit in the hospital. This meant patients with higher dependency needs, except for respiratory higher dependency and the coronary care unit, were cared for in critical care or in the medical ward bed base. The ward medical and nursing teams were supported by the outreach team for specialist advice (an on-call team of nurses with enhanced skills to look after the acutely unwell patient). The team assisted with escalation of treatment, such as managing sepsis, starting non-invasive ventilation and pain relief.

Staff had completed mandatory conflict resolution training and could call two security staff who had completed restraint training and would support staff to ensure patient and staff safety. We observed an incident when a patient was challenging, and ward staff and security staff deescalated the incident calmly.

Nurse staffing

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Trust level

The table below shows a summary of the nursing staffing metrics in medicine at trust level compared to the trust’s targets, where applicable:

| Medicine annual staffing metrics |

20190416 900885 Post-inspection Evidence appendix template v4
August 2018 to July 2019

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate (Jul-18 to Jun-19)</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>1,592.6</td>
<td>10%</td>
<td>10%</td>
<td>3.5%</td>
<td>106,949 (12%)</td>
<td>43,848 (5%)</td>
<td>30,363 (3%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>487.2</td>
<td>21%</td>
<td>4%</td>
<td>5.1%</td>
<td>106,949 (12%)</td>
<td>43,848 (5%)</td>
<td>30,363 (3%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

The data for sickness rates was provided for a different time period (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

The annual vacancy rates for registered trained nurses was 21%, this was higher than the trusts target rate of 10%.

Nurse staffing rates within medicine at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for agency usage.

Vacancy rates

Monthly vacancy rates over the last 12 months for registered nurses and health visitors showed a shift from February 2019 to July 2019. The trust advised that recruitment remains ongoing.

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

Turnover rates
Monthly turnover rates over the last 12 months for registered nurses and health visitors showed an upward trend from December 2018 to April 2019.

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

**Sickness rates**

Monthly sickness rates over the last 12 months for registered nurses and health visitors showed an upward trend from January 2018 to June 2019.

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

**Bank and agency staff usage**

Monthly bank hours over the last 12 months for registered nurses and health visitors showed a shift from February 2019 to July 2019. The trust advised that recruitment remains ongoing to ensure enough staff.
**Royal Cornwall Hospital**

The service had enough nursing and support staff to keep patient in most areas safe, albeit with a heavy reliance on temporary staff.

At our last inspection 2018 we found there was a chronic staffing shortage which resulted in delays for patients and poor staff morale. There were high vacancy rates on the wards and gaps in the rota were covered by agency and bank staff. At this inspection staff frequently told us they were short of staff. However, the trust had made determined efforts to recruit more staff, including overseas recruitment drives and we saw that a combination of factors had improved morale, despite the ongoing staffing pressures.

Data provided by the trust demonstrated that some wards, such as Kynance ward, had high vacancy rates, with eight registered nurses and two health care assistant vacancies. Staff told us about the pressures, for example there was regular use of agency staff and some wards had agency staff on most shifts, with particularly high use at night. The trust risk register noted that nurse vacancies in elderly care may result in a compromise of patient care and safety.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance.

A safer staffing system had been implemented to review levels of patient need and associated staffing requirements.

Safer care meetings took place twice a day, which matrons and other senior nursing staff and site coordinators attended, to discuss staffing resource and patient acuity.

The trust used an electronic system to measure patients’ dependency and associated staffing levels and skill mix needed to ensure those needs were met. This required staff to input the patient’s level of need three times a day. This information fed into the safer staffing meetings so that staff could be redeployed to areas with a higher need. The safer staffing meetings were held twice a day and used to plan for the evening and following day. Staff we spoke with explained these meetings were an effective forum to request further staffing support if this was necessary.

The numbers of planned and actual staff on duty was displayed at the entrance to each ward. Most wards we visited during our inspection did not have the right number staff on duty, as planned for. This meant that the nursing levels were not as they needed to be, and staff were spread wider across the wards.

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

Tintagel ward accommodated both neurology and elderly patients. There were no defined numbers of how many patients in each speciality were accommodated and therefore there was no way to identify if the staffing levels were accurate in relation to patient dependency.

The endoscopy unit was staffed with enough nurses to ensure all endoscopy procedure lists could be carried out safely.

Staff told us about high levels of vacancies for occupational therapists, with some difficulties in recruitment.
On Tintagel ward, a specialist ward for elderly patients receiving general medical care and for patients with acute neurological conditions, there were two dedicated physiotherapists, two physiotherapy technicians and an occupational therapist for patients on the ward with a neurological condition. Staff explained they had access to speech and language therapists and dietitians, and that the therapy team were responsive to the needs of the patients on the ward. The therapy staffing for Tintagel was also shared with the stroke ward so delays in discharge could occur due to the share of therapy staff.

The ward manager could adjust staffing levels daily according to the needs of patients.

Staff were moved between wards to cover shifts. The decision to move staff was made at a daily trust-wide staffing meeting. Redeployment of staff to other wards and areas was considered normal by staff.

On Tintagel ward, staff explained that, often, the actual number of nursing and health care assistants on the ward were below the planned numbers. Staff on the ward explained they regularly used agency and bank staff to fill in gaps in the rota, although staff we spoke with told us, that despite staffing challenges the ward was always safe.

The table below shows a summary of the nursing staffing metrics in medicine at Royal Cornwall Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate (Jul-18 to Jun-19)</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>3.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>1,464.0</td>
<td>16%</td>
<td>6%</td>
<td>4.3%</td>
<td>94,833 (12%)</td>
<td>36,968 (5%)</td>
<td>27,801 (3%)</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>432.5</td>
<td>22%</td>
<td>4%</td>
<td>5.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The data for sickness rates was provided for a different time (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

Nurse staffing rates within medicine at Royal Cornwall Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness use.

Vacancy rates
Monthly vacancy rates over the last 12 months for registered nurses and health visitors showed a shift from February 2019 to July 2019.

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

**Bank and agency staff usage**

Monthly bank hours over the last 12 months for registered nurses showed a shift from February 2019 to July 2019.

(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 keep patients safe from avoidable harm and to provide the right care and
Manager regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Trust level
The table below shows a summary of the medical staffing metrics in medicine at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
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</thead>
<tbody>
<tr>
<td>Target</td>
<td>1,592.6</td>
<td>16%</td>
<td>6%</td>
<td>4.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>247.0</td>
<td>10%</td>
<td>5%</td>
<td>0.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The data for sickness rates was provided for a different time (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

Medical staffing rates within medicine were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, bank use and agency use.

**Vacancy rates**

Monthly vacancy rates over the last 12 months for medical staff showed a shift from February 2019 to July 2019.

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

**Sickness rates**
Monthly sickness rates over the last 12 months for medical staff showed a shift from January 2018 to June 2019.

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

Royal Cornwall Hospital

At our last inspection in 2018 we found 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. At this inspection consultants told us the shortage of consultants continued but the trust’s efforts to recruit were acknowledged. They told us the culture had changed so that leads were involved in the assessment and management of risk, while recruitment continued.

The service had variable vacancy rates, depending on speciality but there were high vacancies in some areas.

There were consultant vacancies in different specialities throughout the medical care group. The vacancies were due to difficulty in recruiting medical staff despite continued efforts by the trust to do so. The risks related to the vacancies were reported on the trust risk register and monitored.

Neurological consultants had 3.86 consultant vacancies and junior doctors covered Tintagel ward with the medical registrar providing overnight cover and elderly care consultant providing weekend cover. The lack of a seven-day neurology service had the effect of increasing the length of stay for those patients. From the week of our inspection the shortage meant that neurologists were not undertaking their own ward rounds, and these were being covered by the elderly care consultants.

The elderly care consultants covered the elderly care wards in the main body of the hospital and the 12 frailty beds allocated on the Acute Medical assessment Unit. The elderly care consultants provided some cover for the stroke ward and the neurology ward rounds. They had vacancies for 2.57 consultants and this meant increased weekend rotas and fewer consultants to cover the workplan. An action plan and recruitment process were underway.

The cardiology consultant team was now complete and with the increase in consultants some improvements were seen in waiting list times to complex medical devices, improvements were seen in referral to treatment times. However, nationally set targets were still not being met.

For cardiology, the trust’s risk register identified there were 10 consultants and capacity and demand work showed a need for 11 to 12 consultants. There was a risk that routine, urgent and elective cardiology patients did not get timely access to appointments and treatment, relevant to their clinical needs. The trust was committed to recruiting to the remaining two positions. The trust monitored and recorded the effects of delays and the resulting emergency admissions. The
management of young stroke patients was also affected by the reduced number of cardiologists as lack of capacity meant some testing could not be undertaken.

Gastroenterology consultants had 2.33 whole time equivalent vacancies. The gastroenterology team had a responsibility to cover the GI (gastrointestinal) bleed rota and contributed to the general medical rota. To reduce waiting times some outsourcing of capacity and development of practitioner roles were being used in endoscopy.

The respiratory consultants had 0.8 consultant vacancies. Endocrine consultants had one consultant vacancy and covered complex respiratory patients for 56 hours unbroken in four out of five weekends. The Endocrine consultants were all trained in general medicine but not for the management of complex and specialist respiratory problems seen on respiratory higher care.

There were three consultant vacancies in acute medicine, this was impacting on providing front door cover. The lack of consultant cover amounted to a risk in delivery of medical care.

Hepatology had a vacancy for one consultant and during inspection recruitment was underway.

The service always had a consultant on call during evenings and weekends.

The general medical rota used a consultant of the day system. This was done for a week at a time and the same consultant was on call evenings and weekends. This meant that the one consultant saw all patient specialties and could mean that a patient may not see the consultant for their specific need.

Medical staff confirmed there were learning opportunities within the hospital and all junior doctors said that while some felt under pressure, they felt supported in their day-to-day work and their ongoing professional development including teaching sessions.

The table below shows a summary of the medical staffing metrics in medicine at Royal Cornwall Hospital compared to the trust’s targets, where applicable:

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<td>4.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>236.4</td>
<td>10%</td>
<td>5%</td>
<td>0.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The data for sickness rates was provided for a different time (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

Medical staffing rates within medicine at Royal Cornwall Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, bank use and agency use.

Vacancy rates
Monthly vacancy rates over the last 12 months for medical staff showed a shift from February 2019 to July 2019.

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

Sickness rates

Monthly sickness rates over the last 12 months for medical staff showed a shift from January 2018 to June 2019.

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

Staffing skill mix

In May 2019, the proportion of consultant staff reported to be working at the trust and the proportion of junior (foundation year 1-2) staff were lower than the England average.

Staffing skill mix for the 195 whole time equivalent staff working in medicine 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>42%</td>
<td>45%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>22%</td>
<td>20%</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 - Medical (01/05/2019 - 31/05/2019)

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Some care planning was limited in its content.

Patient notes were comprehensive, and all staff could access them easily.

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 a series of paper observational records stored with the patient to enable a continuous record to be available.

On all wards we found that there were integrated medical, nursing and therapies paper records. Staff referred to a system called Nerve Centre and had received appropriate training for its use. This was an electronic system. Staff told us that there were rarely any periods of time without computer access and so the systems worked well enough.

The electronic system was a telephone sized piece of equipment kept in each nurse’s pocket. This 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. When the calculated score reached three, a red flag appeared which indicted to staff that a trained nurse needed to be informed. When the score got to five then a doctor should be informed by the nursing staff. Patient records reflected when this had taken place.

The trust had undertaken a piece of work to improve the quality and legibility of patient records. As part of this work, staff were provided with customised stamps with their names to use when making entries on records. However, we found that records were not always fully completed. For example, on Lowen ward, we found failures to record assessments of capacity and details of discussions concerning resuscitation of patients.

When patients transferred to a new team, there were no delays in staff accessing their records.

Paper booklets had been developed for the patient’s initial assessments and for their inpatient stay. These included a space for a care plan. These documents were generic with little space for detail of patient’s specific care needs. This meant not every patient had a detailed individualised care plan to guide and direct staff on the patients care and treatment needs.
We looked at 30 sets of records and found that nursing and allied health professional notes were well completed and legible.

We found that all medical records were clear, accurate, legible, and almost all were completed quickly in line with the General Medical Council guidance on keeping records. Some nursing records were not fully completed for patients under mental health safeguards. Concerns about a patient’s mental health were flagged up in their patient records and handed over during shifts.

Medical staff completed discharge summaries for patients who were discharged from hospital. A copy was provided to the patient and another sent to their GP to ensure important information about ongoing care was shared effectively.

Records were stored securely.

Paper records were stored securely in locked cabinets. Staff we observed were mostly careful to ensure records were not left accessible and confidentiality was not compromised. However, on the medical assessment unit, we found a cabinet containing patient records left unlocked and unattended. We spoke to senior staff who explained staff were regularly reminded to keep these cabinets locked. They said they had to reiterate this message to ensure new staff including new doctors starting at the service were aware of the importance of locking the cabinets.

On the Gastroenterology and Liver Unit, nursing notes were kept in folders outside patient rooms or at the end of their beds for those patients in bays. Patient records were sometimes accidentally left in these folders. Staff explained new folders had been ordered with instructions to staff on what should and should not be kept in these folders to protect patient confidentiality.

Records were audited to ensure accurate completion. Endoscopy audited ten sets of patients records each month and audited the endoscopy room activity ten per month. This enabled a clear overview of the actions and records. Audits of record security were maintained monthly to protect patient’s confidentiality.

**Medicines**

_The service used systems and processes to safely prescribe, administer, record and store medicines._

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Medicines were mostly stored securely in locked trolleys and doors were locked to treatment rooms with access restricted to appropriate staff. Controlled drugs were stored securely and managed appropriately. Regular balance checks were performed in line with trust policy. However, during our inspection, the lock to the treatment room on the gastroenterology and liver unit was not working. Staff told us the issue had been reported to estates and staff were being reminded in the interim to manually lock the door. However, we were able to access the room unsupervised on multiple occasions.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines.

We saw that nursing staff introduced themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them. A pharmacist visited daily to review prescriptions and advise medical staff when doses needed to be revised.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy.
Medicines fridge and treatment room temperature records showed medicines were stored at the correct temperatures.

The electronic prescribing and medicines administration (EPMA) system was password protected and secure. Other prescription stationary was stored securely.

Staff followed current national practice to check patients had the correct medicines.

Policies and procedures were available and accessible to staff via the trust intranet. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines. Clinical guidance was also available on the trust intranet.

Patient's medicines were reconciled in line with current national guidance on admission and when transferring between locations.

Patient Group Directions (PGDs) were in use and there was a procedure in place to review them. PGDs are written instructions which allow specified healthcare professionals to supply or administer some medicines in the absence of a written prescription.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff knew how to report incidents or near misses via the trust's electronic reporting system. Staff we spoke with felt confident in raising an incident should they need to. They gave us examples of what they would report as an incident and how they would respond to the person involved.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

The Serious Incident Framework 2015 states that an incident should be considered as a serious incident if a patient's death was unexpected or avoidable which was contributed to or caused by weakness in care or service delivery. Staff were encouraged to report incidents and other concerns. Staff were confident that learning was shared across the trust when significant issues arose through hot topic emails, safety briefs and newsletters. Tool box talks had been implemented to discuss relevant issues as they occurred.

Staff reported all incidents they should report. Senior staff felt there was a good reporting culture and staff understood their responsibility to report concerns.

There was evidence that changes had been made because of feedback.
We saw that on the Same Day emergency care Unit, learning had been recognised following an incident. Staff showed us that extra signage had been implemented to alert and remind staff about patient checks. This learning had been shared with the wider trust.

The specialist medicine care group had plans to hold monthly care group wide shared learning forums. Senior leaders explained these multi-disciplinary meetings would be a new and additional mechanism to disseminate learning from, among other things, serious incidents.

**Never Events**

The service had no never events on any wards. From October 2018 to September 2019, the trust reported zero never events for medicine.

Managers shared learning with their staff about never events that happened elsewhere. 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.

Alerts and learning from incidents including never events were shared with staff through emails, newsletters and other communications. Summaries of serious incidents and learning were placed on staff boards on wards and departments.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

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 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. The incident reporting system had a section for duty of candour which enabled staff to prompt action needed. All staff had a good understanding of the duty of candour and could describe when it would be used.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

We reviewed incident data which showed that incidents were assessed and graded, and appropriate action taken. Staff told us that department and wider trust learning was cascaded through safety briefs each day.

Managers debriefed and supported staff after any serious incident.

A learning from deaths report June 2019 reviewed mortality and created a policy. Mortality meeting took place quarterly for each speciality when 30% of deaths needed to be reviewed. A monthly report went to all consultants to share any learning identified.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy.

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported 39 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from October 2018 to September 2019.

A breakdown of the incident types reported is in the table below:
<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>16</td>
<td>41.0%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>6</td>
<td>15.4%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>5</td>
<td>12.8%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>4</td>
<td>10.3%</td>
</tr>
<tr>
<td>VTE meeting SI criteria</td>
<td>2</td>
<td>5.1%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>2</td>
<td>5.1%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by third party</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see.

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.

The safety thermometer data showed the service achieved harm free care within the reporting period.

All wards and departments displayed monthly safety thermometer audits at the ward entrance for all to see, this was updated monthly.

Staff used the safety thermometer data to further improve services.

Data from the Patient Safety Thermometer showed that the trust reported 33 new pressure ulcers, 12 falls with harm and five new urinary tract infections in patients with a catheter from July 2018 to July 2019 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Royal Cornwall Hospitals NHS Trust**

![Graph showing prevalence rate of pressure ulcers](chart.png)
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Policies and guidelines had been developed in line with national policy. These included the National Institute for Health and Care Excellence (NICE) guidelines. There was good access to the trust intranet to look at clinical guidelines policies and procedures.

At the time of our inspection, the central clinical effectiveness team were carrying out a retrospective review of guidance. Leaders told us this information had since been provided to the central clinical effectiveness team, and that they were up to date on the implementation of national guidance and evidence-based practice.

The trust’s central clinical effectiveness team informed care groups regarding updates about national guidance and best practice. Care group leaders disseminated this information as appropriate to their relevant specialities and fed back to the central clinical effectiveness team on their progress on implementation of national guidance and best practice.

Implementation of best practice was discussed locally at governance meetings with areas of concern discussed with trust management at monthly performance review meetings.

Staff did not fully understand their responsibilities to patients subject to the Mental Health Act 1983 and Code of Practice.

Not all staff were fully aware of the scope of the mental health act and there was some confusion by staff between the mental health act and the mental capacity act. There were two patients who were legally detained under a section of the mental health act, this meant that the patients could not leave, but staff did not understand the scope of the section. There are different types of

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 - Safety Thermometer)
sections each with different rules to keep you in hospital. Staff on Roskear told us they did not use and were not aware of any specialist or evidence-based tools for assessing a patient’s mental health and wellbeing despite caring for patients under a mental health section on the ward. This is detailed further in the report.

A dementia care strategy was used and was planned to be updated to reflect new NICE guidelines.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Care plans informed staff about nutritional care and fluid needs and how they were to be met. We saw clear instructions for patients with identified nutritional needs and staff could tell us which patients needed what help. We observed support being provided to eat and drink.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. Nursing staff supported patients who needed assistance to eat and drink and food and fluid charts, we saw were kept up to date.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

The trust used a national tool malnutrition universal screening tool (MUST) to identify patients at risk of being malnourished or at risk of malnutrition. This screening tool was designed to identify adults at risk of malnutrition and to categorise them as being at low, medium or high risk.

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 enough nutrition.

Specialist support from staff such as dieticians and speech and language therapists were available for patients who needed it.

Therapist were available including speech and language therapist and dietitians to support those patients who needed it.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff used a nationally recognised pain assessment tool to identify the severity of patients’ pain. We saw pain relief was given when needed. The trust had a pain specialist nurse who could provide advice or review referred patients to ensure the pain relief they received was appropriate.

Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.
Medication charts reflected when medicine had been administered and the rationale for any omissions or delays.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

The service participated in relevant national clinical audits.

A stroke pathway meant that patients could be treated quickly in the emergency department and transferred to a higher care bed on the stroke unit by a specialist stroke nurse. These nurses were available 24 hours a day and were not counted in the ward staffing number which enabled them to move with the patient when needed.

The Sentinel Stroke National Audit (SNAPP) audit had improved from D to B which meant that services had improved for patients.

The trust submitted data to the National Diabetes Inpatient Audit (NaDIA). 2018 was a Quality Improvement Collaborative (QIC) year and as a result only the Hospital Characteristics survey was undertaken. In September 2019 there will be another Bedside Audit and Patient Experience survey alongside the Hospital Characteristics element.

The Getting it Right First Time (GIRFT) Diabetes review highlighted that the specialty does well for 7 day working, which was reflected in the NaDIA results, where RCHT is one of only 23.1% of Trusts that provide Diabetes Physician cover 7 days a week. Priority actions arising from the GIRFT visit are currently being agreed and taken forward.

The trust was working hard at falls reduction. Falls sustained by patients were discussed at the staff huddle meeting and how they could have been avoided were discussed. A nursing role had been implemented and was developing immediate actions to review falls and identify prevention. Initial review indicated an improvement in falls, but further review was planned.

The endoscopy unit had previously gained Joint Advisory Group (JAG) accreditation. To gain this accreditation, the unit was assessed against several national standards and continued to monitor its own service provision to ensure compliance. Reaccreditation was due in 2020 and the data required for this had been submitted.

The endoscopy unit used the world health organisation (WHO) checklist for invasive procedures. The (World Health Organisation (WHO), 2008) underpinned the process of theatre checks for safety with a standard operating procedure to ensure all staff were aware of their responsibilities in line with national guidance. The Checklists were audited to ensure completion.

Outcomes for patients were not all positive, consistent and did not all meet expectations.

Some areas of medicine showed shortfalls in the complete and incomplete pathways they used to monitor activity. These showed that cardiology and respiratory medicine had breaches for both pathways with hepatology and gastroenterology showing breaches in incomplete pathways.

Some areas had high waiting times. For example, data provided as of October 2019 showed cardiology had 228 patients waiting more than the 18-week waiting target and gastroenterology had 417 patients exceeding the 18-week target.

**Relative risk of readmission**

**Trust level**
From February 2018 to January 2019, patients at the trust had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in clinical oncology and 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
- Patients in general medicine and cardiology as well as geriatric medicine had a lower than expected risk of readmission for non-elective admissions

**Elective Admissions – Trust Level**

![Bar chart showing elective admissions by specialty]

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 represents the opposite. Top three specialties for specific trust based on count of activity.

**Non-Elective Admissions – Trust Level**

![Bar chart showing non-elective admissions by specialty]

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 represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (01/02/2018 - 31/01/2019))

**Royal Cornwall Hospital**

From February 2018 to January 2019, patients at Royal Cornwall Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in clinical oncology and 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
- Patients in general medicine and cardiology as well as geriatric medicine had a lower than expected risk of readmission for non-elective admissions

**Elective Admissions - Royal Cornwall Hospital**
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 represents the opposite. Top three specialties for specific site based on count of activity.

Non-Elective Admissions - Royal Cornwall Hospital

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 represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (01/02/2018 - 31/01/2019))

Lung Cancer Audit

The table below summarises Royal Cornwall Hospital’s performance in the 2017 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist</td>
<td>80.4%</td>
<td>Does not meet the audit aspirational standard</td>
<td>Did not meet</td>
</tr>
<tr>
<td><em>(Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted one-year survival rate</td>
<td>37.1%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td><em>(Adjusted scores take into account the differences in the case-mix of patients treated)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery</td>
<td>13.3%</td>
<td>Worse than expected</td>
<td>Did not meet</td>
</tr>
<tr>
<td><em>(Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment</td>
<td>66%</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td><em>(For fitter patients with incurable NSCLC anti-cancer treatment is</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)

Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen) 80.5% Within expected range Met

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls

Royal Cornwall Hospital

The table below summarises Royal Cornwall Hospital’s performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national aspirational standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Crude proportion of patients who had a vision assessment (if applicable) (Having a vision assessment is indicative of good practice in falls prevention)</td>
<td>100%</td>
<td>Green</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) (Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention)</td>
<td>26.9%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients assessed for the presence or absence of delirium (if applicable) (Having an assessment for delirium is indicative of good practice in falls prevention)</td>
<td>27.6%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients with a call bell in reach (if applicable) (Having a call bell in reach is an important environmental factor that may impact on the risk of falls)</td>
<td>100%</td>
<td>Green</td>
<td>Met</td>
</tr>
</tbody>
</table>

(Source: National Audit of Inpatient Falls)

Managers used information from the audits to improve care and treatment.
Each ward recorded as part of a safety thermometer check how many falls had occurred. For patients identified as at risk, assessments and action plans were completed. We saw coloured socks were provided which had some grip on them to avoid slipping but also to identify the risk to staff.

Managers and staff implemented local changes to improve care and monitored the improvement over time.

There had been a role implemented around falls management. Staff told us they had found the extra support valuable and records showed a consistency in approach in falls prevention and action taken when a patient had fallen. Link nurses for falls were seen on the wards and falls behaviour charts used to identify risks and ensure enhanced care was provided when needed. Audits were planned to measure any improvement following this role development.

**National Audit of Dementia**

**Royal Cornwall Hospital**

The table below summarises Royal Cornwall’s performance in the 2017 National Audit of Dementia.
<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit's Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good (A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</td>
<td>65%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of staff responding “always” or “most of the time” to the question “Is your ward/service able to respond to the needs of people with dementia as they arise?” (This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)</td>
<td>80%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium (Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</td>
<td>18.5%</td>
<td>Worse</td>
<td>No current standard</td>
</tr>
<tr>
<td>Multi-disciplinary team involvement in discussion of discharge (Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)</td>
<td>89.3%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Audit of Dementia)

Managers and staff implemented local changes to improve care and monitored the improvement over time.

A dementia care strategy was used. Staff had been recruited to specialise in dementia and delirium and while relatively new to the role, ward staff told us they found this extra support helpful. Training sessions were planned and delivered by the specialist nurses to staff when requested.

**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 development.
Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work.

Staff had the right skills and knowledge to provide safe care and treatment for patients. Staff received a staged induction and a checklist was used to ensure that this was complete. New staff we spoke to on one ward said they were well supported, and that ‘staff look out for each other’.

Monthly simulation training took place to allow staff to practise real life scenarios within the safety of a simulated environment, with a strong emphasis on multi-disciplinary training.

Some staff had obtained additional qualifications within their speciality and ongoing training was being provided on the wards.

Training was sometimes delayed by the staffing difficulties in the hospital. Staff explained that training was not a priority when busy and the training sessions were delayed.

On Lowen ward, staff explained one of the challenges they faced was getting all relevant staff to undergo chemotherapy nurse training. Staffing pressures meant it was a challenge to release staff for this training. However, senior staff on the ward explained half the nurses on the ward were now trained and that practice educators now in post were working to ensure all nurses were trained.

At our previous inspection in 2018 staff told us they received mandatory training on patients with mental health needs, learning disabilities, autism and dementia. Staff did not feel this training was enough to provide them with the knowledge and skills required to care for these patients. At this inspection, staff still lacked some specialist knowledge around patients detailed under the mental health act.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work.

Trust staff did not all receive an appraisal within the trusts target. From August 2018 to July 2019, 78.3% of staff within medicine department at the trust received an appraisal compared to a trust target of 95%.

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Eligible staff</th>
<th>Staff who received appraisal</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and Ancillary</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>48</td>
<td>47</td>
<td>97.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>197</td>
<td>166</td>
<td>84.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>12</td>
<td>10</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>41</td>
<td>33</td>
<td>80.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>389</td>
<td>299</td>
<td>76.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>418</td>
<td>311</td>
<td>74.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>19</td>
<td>14</td>
<td>73.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine, two staff groups out of eight exceeded the trusts 95% completion rate for appraisals. Administrative and clerical had the lowest completion rate with 73.3%.

**Royal Cornwall Hospital**

From August 2018 to July 2019, 80.5% of staff within medicine department at the Royal Cornwall Hospital received an appraisal compared to a trust target of 95%.
<table>
<thead>
<tr>
<th>Eligible staff</th>
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<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and Ancillary</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>48</td>
<td>47</td>
<td>97.9%</td>
<td>95%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>189</td>
<td>159</td>
<td>84.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>12</td>
<td>10</td>
<td>83.3%</td>
<td>95%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>41</td>
<td>33</td>
<td>80.5%</td>
<td>95%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>340</td>
<td>269</td>
<td>79.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>370</td>
<td>288</td>
<td>77.8%</td>
<td>95%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>19</td>
<td>14</td>
<td>73.7%</td>
<td>95%</td>
</tr>
</tbody>
</table>

In medicine, two staff groups out of eight exceeded the trusts 95% completion rate for appraisals. Administrative and clerical had the lowest completion rate with 73.7%. Some wards were particularly low in completion, these included Kerensa, Kynance and Tintagel wards.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Some wards told us that team meetings did not take place regularly, often due to pressures on the service and staffing levels. Staff confirmed they received updates through safety briefs and emails.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role.

Specialist nurses provided training and guidance to staff when needed. For specialist nursing competencies training was provided and records of competency assessments maintained. For the stroke service, staff worked towards an acute stroke competency framework. Some stroke staff were working towards becoming advanced nurse practitioners.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked collaboratively to ensure continuity of care to patients and ensure the appropriate professionals were involved in care and treatment. The complex care and dementia team, learning disability team, alcohol liaison team employed by the trust were available throughout the medicine specialities. We spoke with the alcohol liaison staff who attended the wards and supported patients and staff with specialist advice.

Therapy staff worked on wards and units to facilitate care and treatment and assist patients to improve enough to go home.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Multidisciplinary team meetings took place on the wards to ensure a full medical overview was maintained and action plans completed. We attended a meeting where multiple agencies worked together to support the patients.
Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

At handover meeting, staff referred to the psychological and emotional needs of patients, their relatives and carers. The service included round the clock access to mental health liaison and/or other specialist mental health support if staff were concerned about risks associated with a patient's mental health.

Patients had their care pathway reviewed by relevant consultants

Discharge was variably organised depending on which ward the patient was on. Some wards organised their own simple discharges and some wards had discharge coordinators. This was a historic decision without any current rationale. A discharge lounge was available but was limited in its scope for use as it was used as an escalation area. On the discharge lounge, senior staff explained that when patients unexpectedly deteriorated, they often found themselves persistently having to escalate the matter to colleagues. Senior staff we spoke with said barriers to timely discharges of patients included issues with completion of discharge summaries and take-home medication. They explained these issues had been raised in the service but remained unresolved.

Complex discharges 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.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway.

The provision of seven-day services is to ensure that patients receive consistent high-quality safe care every day of the week. Patients located on the acute medical admissions unit were seen by consultants each day. Each patient was reviewed within 14 hours of admission by a consultant and then referred to a speciality medicine consultant. There were sometimes delays in speciality consultants attending AMU as they had ward rounds on their own wards to do first. The AMU had junior medical staff who assessed and reviewed speciality medicine patients to ensure the speciality care identified was completed. Each day there was a daily board round which was attended by a multi-disciplinary team, which reviewed the patients care and treatment. All medical specialities except neurology held ward rounds daily, even at weekends and on bank holidays.

A seven-day steering group reviewed the development of a seven-day strategy as part of an ongoing process.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

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 consultancy 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.
Neurology was not providing a seven-day consultancy led service which put patients at higher risk during weekends as there was no specialist cover.

Patients had access to x-ray services 24 hours a day seven day a week, including diagnostic scanning services, 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. Rehabilitation therapy support was available for emergency medicine areas such as AMU over the weekends to support discharge. This was a seven-day rota with staff having days off midweek.

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.

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. Stock top-up service was provided by pharmacy. Each ward, except for the discharge lounge and the Kynance ward were visited daily by a clinical pharmacist, Monday to Friday.

The pharmacy has extended opening hours Monday to Friday (7.00 to 19.00) and 8.30 to 17.00 at weekends. On-call pharmacist was available out of hours and emergency cupboard was available for urgent access by ward staff.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support on wards/units.

Information for patients was available to patients on all wards. The leaflets were of good 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 to use to translate the information verbally and easy read formats.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

The service promoted healthy lifestyles and signposted patients to sources of support, for example, alcohol abuse and smoking. During the inspection the trust ran an alcohol awareness week together with a local alcohol related service. This was a pilot scheme and if successful would potentially be rolled out in a wider area. The trusts alcohol specialist nurses support patients through the emergency department and on to further treatment. The trusts electronic system flagged frequent attending patients and engaged specialist nurses to identify admission avoidance strategies.

We saw posters and information on wards about ‘Mouth Care Matters’. This was promoting for patients and staff the importance of good mouth care.

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

**Trust level**
The trust set a target of 95% for completion of Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA training courses from April 2019 to July 2019 at trust level for registered nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>434</td>
</tr>
</tbody>
</table>

Within the medicine department the target was met for the MCA training module for which registered nursing staff were eligible.

For the previous financial year; April 2018 to March 2019 at trust level, registered nursing staff achieved a 100% completion rate for MCA training.

A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to July 2019</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>238</td>
</tr>
</tbody>
</table>

Within the medicine department the target was met for the MCA training module for which medical staff were eligible.

For the previous financial year; April 2018 to March 2019 at trust level, medical staff achieved a 96% completion rate for MCA training.

**Royal Cornwall Hospital**

The trust set a target of 95% for completion of mental capacity act (MCA) training.

A breakdown of compliance for MCA training courses from April 2019 to July 2019 at Royal Cornwall Hospital for registered nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to July 2019</th>
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<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>381</td>
</tr>
</tbody>
</table>

Within the medicine department the target was met for the MCA training module for which registered nursing staff were eligible.

For the previous financial year; April 2018 to March 2019 at Royal Cornwall Hospital, registered nursing staff achieved a 100% completion rate for MCA training.

A breakdown of compliance for MCA training courses from April 2019 to July 2019 at Royal Cornwall Hospital for medical staff in medicine is shown below:

<table>
<thead>
<tr>
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<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>228</td>
</tr>
</tbody>
</table>

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.
Within the medicine department the target was met for the MCA training module for which medical staff were eligible. For the previous financial year; April 2018 to March 2019 at Royal Cornwall Hospital, medical staff achieved a 96% completion rate for MCA training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff did not always clearly record consent in the patients’ records.

Not all care plans included a record of requested and received consent to provide care and treatment, this included for invasive treatment such as cannulation. Staff told us that while they ensured they would gain verbal consent they would not routinely record consent but would always record refusal to consent. Therapists consistently recorded consent in patients notes.

Staff made sure patients consented to treatment based on all the information available. When patients could not give consent, staff made decisions in their best interest, considering patients’ wishes, culture and traditions.

Staff were aware of all policies regarding consent, mental capacity act and deprivation of liberty safeguards and had access to them through the intranet.

If staff were concerned about a patient’s capacity to consent, they would arrange for an assessment of their mental capacity, and if they lacked capacity to consent to be on the ward would request a DoLS authorisation. Staff sought the assistance of the trust’s learning disability team when needed. Staff explained the team were responsive to their requests for assistance. Staff explained they involved the trusts safeguarding officers when making a Deprivation of Liberty Safeguards application.

Staff were not all clear about the implementation of Deprivation of Liberty Safeguards in line with approved documentation.

We saw that in some cases the documentation for the mental capacity act was incomplete or missing and not all staff were confident in their understanding of the mental capacity act.

We saw that 442 Deprivation of Liberty Safeguards had been completed in the medicine and emergency departments between November 2018 and October 2019.

On Roskear ward nurses would assess a patient’s capacity if there were any concerns but would pass this onto the consultant for action. Health care assistants felt consideration of mental capacity act was outside of their remit.

Kerensa ward had frequent DoLS authorisations in place on the ward. Staff were confident they knew their responsibilities under Mental Capacity Act 2005. However, they only requested authorisations for patients who were objecting to the care or actively trying to leave. On querying their understanding staff did not think it was appropriate to make referrals for all patients who met the acid test as this meant almost all patients would need a DoLS authorisation.

In patient records on Kerensa ward for patients under a DoLS authorisation, there was no evidence of a mental capacity assessment relating to the DoLS authorisation request. One record did refer to a best interest meeting taking place but no evidence of following the checklist as part of this best interest’s decision-making process.

On Roskear ward someone had recorded a patient was detained under section 2 of the Mental Capacity Act 2005, this is a confusion with the Mental Health Act 1983. The patient was recorded as lacking capacity, but there was no evidence of assessment or decision around capacity. Further records indicated that intravenous fluids could be administered in the patients’ best interests, but no evidence of the mental capacity assessment or best interest decision making process were
available. Concerns were raised with the ward staff at the time of inspection who sought further assistance and clarity.

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act.

On acute medical unit (AMU) many patients come onto the ward with mental health problems, staff said they were not equipped as a ward to manage this, they told us they were generally nurses “fire-fighting” and couldn’t give the appropriate care needed to patients. Psychiatric liaison was available to support but were a small team covering a large hospital. Staff on AMU were confident with the use of holding powers and attributed this to their experience of patients often admitted to the ward from a nearby psychiatric hospital.

Staff had concerns AMU was an inappropriate place for younger patients (under 18 year old) on the ward following, for example, an overdose. However, there were limited alternatives and staff were reliant on the child and adolescent mental health service assessing and finding an alternative, more appropriate bed.

Not all staff were aware that a person detailed under the mental health act was in their direct care. Some risk assessments for mental health were seen but were not fully completed or known to staff. On Grenville ward staff had not seen a mental health risk assessment and had no awareness of this being in place for a detained patient on the ward. Staff were unaware of the detained patient’s details and this meant they were unaware they required enhanced observations.

Staff were not all aware that treatment for mental health only was covered under the Mental Health Act 1983. Staff were of the understanding that they could “force” a patient to be washed under the Mental Health Act. Staff said they had contacted security for help with this and had written up sedation medicines “just in case”. Staff were not considering whether the patient had mental capacity, under the Mental Capacity Act 2005, to make decisions about his care and whether they could wash the patient in his best interests if not.

On Roskear ward staff understanding of their powers under the mental health act (for the patient detained under section 2), were unclear. There was a risk assessment for the patient which included reference to mental health, but no other risks (other than of absconding), despite staff also having evidence of aggression. The patient also had a care plan stating that they should be read their section 132 rights, but the sheet for signing to confirm they had been given these was not completed.

Is the service caring?

Compassionate care

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

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

We saw patients on all wards and in all departments being treated with dignity, respect and kindness. We saw patients and relatives were spoken to quietly and with consideration. Patients we spoke with reiterated this was always the experience of care they had received in the service.

We observed on the Same Day Emergency Care unit staff greeting patients warmly with “Hello, welcome, my name is…. how are you, let’s make you more comfortable” and staff took time to
interact with patients and their relatives in a respectful and considerate manner. A patient told us staff had apologised when a delay had occurred, and that respect had meant a great deal to them.

Staff maintained patients’ privacy and dignity when attending to patients’ needs. Staff introduced themselves and curtains were drawn around patients’ bed spaces when care was provided.

Patients gave positive feedback about the service.

Patient’s we spoke with were positive about the care they had received. Comments from patients included, “All the nurses have been fantastic. I can’t sing their praises enough” and “The consultants have been outstanding”.

The trust encouraged patients to complete the friends and family test, to help them evaluate their services. A current drive was underway for staff to request the questionnaires be completed.

Patients told us about their experiences which included a patient who had been accompanied by a member of staff to see a relative also in hospital. The patient said this was integral to their recovery and had appreciated this opportunity. Patients told us there were no limitations with visiting hours and that visitors were encouraged to stay with the patients during mealtimes to help them.

Staff followed policy to keep patient care and treatment confidential.

Staff ensured that within the bounds of the environment patients were treated confidentially. On the Medical Day Unit, the chairs in the treatment lounge were very close together and so all conversations could be heard by the rest of the room. Staff explained they sought to manage this risk by using their discretion to offer patients the option of having conversations in private where the subject of a discussion was especially sensitive.

Daily multidisciplinary board rounds were held in staff rooms away from patients to protect patient dignity and confidentiality.

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

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.

**Emotional support**

*Staff provided emotional support to patients, families and carers to minimise their distress.*

*They understood patients’ personal, cultural and religious needs.*

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff provided support for patients’ relatives as well as to the patients. At handover meetings, staff referred to the psychological and emotional needs of patients, their relatives and carers.

Staff showed a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia. Learning disability passports were seen to be used, to inform staff of patients’ individual needs.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.
The endoscopy unit offered patients with high anxiety, phobias or learning difficulties the opportunity to visit the unit out of hours, to look around and talk to staff before their procedure. This was available to any patient who felt this would relieve anxiety.

On Lowen ward, a patient told us of how staff “went out of their way” to accommodate their partner who stayed with them over night for emotional support, including arranging a bed for them.

**Understanding and involvement of patients and those close to them**

_Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment._

Staff made sure patients and those close to them understood their care and treatment

All patients we spoke with felt involved in decision-making processes and were able to tell us what the next plan was for them. We spoke with relatives who felt included and updated on the patients care pathway. Patients and relatives told us they felt more at ease as a result.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

All patients identified on admission as having learning disability needs were flagged on the computer system to alert the learning disability team. Staff had access to communication aids via the learning disabilities team to help patients become partners in their care and treatment and to enable all physical and emotional support to be available. This service was not available out of daytime hours and so could be delayed.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

_The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care._

Managers planned and organised services, so they met the changing needs of the local population.

The trust had a provisional winter plan for 2019 currently under review. The plan was not fully agreed and confirmed but the plans were underway. Considerable work was being done to improve capacity and flow through the hospital. We saw a new enthusiasm from staff to ensure patient pathways met the needs of patients. Overall bed capacity had been assessed and identified a shortfall of 99 beds for January and February 2020. A plan was underway to reconfigure services to account for 43 beds leaving a shortfall of 99 beds. Further plans were underway to reduce the bed shortage further. The management of patient pathways included a wider health community. We saw that other organisations were involved in teleconferences through the week to ensure patients were discharged when possible and that community facilities were utilised to their full potential.

The stroke unit had planned, equipped and had nursing and therapy staff to reconfigure the unit from 27 acute stroke unit beds, to six hyper-acute stroke unit and 21 acute stroke unit beds. The opening date for this increased service was having to be delayed as there were not enough medical staff recruited to support the increase. This was disappointing for staff who had worked hard to prepare for the increased service. The development of the stroke service included a new
therapy gym, a new occupational therapy kitchen and an increase in therapists to included six
days a week physiotherapy and seven days a week occupational therapy.

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.

Younger patients who had strokes were supported to go home with an early support package of
care.

Staff knew about and understood the standards for mixed sex accommodation and knew when to
report a potential breach.

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.

Facilities and premises were appropriate for the services being delivered.

At our last inspection in 2018 we found when the hospital was under pressure with surges in
demand for inpatient beds, the trust used a system where patients were placed in the centre of
ward bays pending an admission bed. They did not have access to equipment or privacy and
dignity. At this inspection we found that while the same system was used, control measures had
been implemented to ensure it was a safer practice. There were now limitations on who could
agree for the extra patient, the risks involved, and the timescale agreed.

The trust had a discharge lounge being used as a ward where patients who were clinically stable
and ready for discharge could be transferred to while they waited for ongoing care. However,
patients were staying in this area for a long-time awaiting discharge due to delayed transfers of
care.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients
with mental health problems, learning disabilities and dementia.

The service had arrangements, known to all staff on duty, to meet patients’ urgent or emergency
mental health care needs at all times, including outside office hours and in an emergency.

The service had systems to help care for patients in need of additional support or specialist
intervention.

A seven day a week activity coordinator role had been implemented across three wards. The
wards included the elder care wards and the discharge ward. This was a work, rest, play model
providing meaningful activity for patients. There were three staff employed and they provided
activity including taking patients who were well enough off the ward and into a garden area. Staff
told us that the engagement of patients was showing a reduction in some levels of care and
observation needed. Auditing had not taken place, but staff were confident this would demonstrate
any notable improvement.

The service relieved pressure on other departments when they could treat patients in a day.

The same day emergency care area was open from 8am to 10pm Sunday to Saturday and had
been operational since July 2019. The same day emergency care area was used whenever safely
possible to treat patients and return them home. The area was staffed by medical and nursing
staff. This area was 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 back to the emergency department. Occasionally patients remained in the Same day Emergency Care Area overnight, but every effort was made to prevent this so that the morning shift could immediately start to process patients through the emergency department.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

At our last inspection 2018 we found delays were seen in the response time to answering patient call bells. At this inspection we saw this was much improved with very little delay in bells being answered. A patient told us “They are here on the spot, as soon as you press the buzzer.”

Wards were designed to meet the needs of 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, these took place bi-monthly. Fast track pathways and policies were used to promote a quick and direct patient transfer from the emergency department to the ward.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. The trust had a psychiatric liaison team to support patients with identified learning disabilities. This is 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. The learning disability team was not available out of daytime hours and so may mean a delay in advice and support.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

On Grenville ward psychiatric liaison notes recommended ‘line of sight’ observations but this was not happening on the ward. Recommendations stated that any less observations should be documented as to why. There was no evidence of this documentation and staff were not aware of the patient having to be in line of sight. Staff demonstrated a lack of knowledge around the trust’s enhanced observations policy and did not know what ‘line of sight’ entailed when spoken to.

The service had information leaflets available in languages spoken by the patients and local community.

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.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were aware of how to support patients with additional communication needs. There were systems to meet patients’ additional communication needs accessible during day time hours.

Staff had access to communication aids to help patients become partners in their care and treatment.

Staff understood the process to ensure a safe discharge of patients who were homeless. They were able to describe who to contact to access the support services available.

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

At our last inspection in 2018 we saw that the systems used to promote flow were not all effective and the increasing demand outweighed the capacity available within the trust. The hospital had problems maintaining flow from admission to timely discharge because of both the increased demand for admission but also because patients were delayed in being discharged.

At this inspection we found that while the existing issues and causes of difficulty with patient flow through the hospital remained, there was a new approach and enthusiasm to address the trust and wider capacity issues. This work was ongoing but had a clear plan and staff were driving the changes forward.

Staff told us the most pressing issue was the additional bed capacity needed. The winter plan was split into four core elements;

The existing four-hour standards recovery programme which is focused on developing and delivering business as usual sustainable change to reduce demand in the ED and improve flow out of the ED into beds. To create additional bed capacity. To introduce additional capacity for winter specific issues for example Flu and Norovirus and severe weather and implementation of the sub-acute model of care.

In addition, there is a system wide winter planning process which planned to bring together the organisations across the Cornwall health economy to provide a joined-up response to winter pressures.

Average length of stay

Trust Level

From March 2018 to February 2019 the average length of stay for medical elective patients at the trust was 7.4 days, which was higher than the England average of 5.9 days. For medical care non-elective patients, the average length of stay was 5.6 days, which was lower than the England average of 6.1 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology and clinical oncology was lower than the England average.
- Average length of stay for elective patients in general medicine was higher than the England average.

Elective Average Length of Stay – Trust Level

![Chart showing average length of stay for elective specialties](chart)

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for non-elective specialties:
• Average length of stay for non-elective patients in general medicine was lower than the England average.

• Average length of stay for non-elective patients in cardiology and geriatric medicine was higher than the England average.

**Non-Elective Average Length of Stay – Trust Level**

![Chart showing comparison between Trust Level and England Average for different specialties]

*Note: Top three specialties for specific trust based on count of activity.*

**Royal Cornwall Hospital**

Managers and staff worked to make sure patients did not stay longer than they needed to and monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them.

While considerable work was undertaken to reduce length of stay we saw that some patients stayed longer than needed. This was due in some part to lack of beds in the hospital, so patients stayed longer on the assessment units, or they were placed as outliers and so had some delayed care. During July 2019, the trust had on average 82 patients with a length of stay greater than 21 days which is defined nationally as super stranded.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

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 included medical beds. Each day bed meetings took place at 8am, 12pm, 3pm and 4.30pm to review the flow of patients through the hospital. Those meetings were attended by bed managers, ward senior staff, transport staff and any other interested and affected partners.

From November 2018 to October 2019 the OPEL framework had reached level three for 267 days and the highest level, OPEL 4, on 21 days. This indicated the high level of pressure the trust had been under.

A system of bronze, silver and gold command meetings were used to escalate any developing issues around bed management and flow of patients. The 11.30am call each day was a bronze command meeting, we attended and saw that a wider system approach was used to review bed capacity and promote patient flow.

A flow hub meeting took place three times a week. This meeting reviewed all patients assessed as medically fit to be transferred or discharged. Actions were agreed to promote discharge and each action was allocated to a staff member to ensure its completion or a reason why not. We attended one meeting when a lot of discussion focussed on patient expectation and discussions with patients about what the reason for delayed discharge was. Patients with a delayed transfer of care (DTOC) were seen mostly in the discharge lounge, Phoenix ward, Kynance ward, Kerensa ward,
Tintagel ward and Wellington ward. Between November 2018 and October 2019 there had been 2,631 patients with a delayed transfer out of the hospital to another area of care.

Patients transferred to Kynance ward were at risk because they were without medical support and did not have the staff providing the speciality care they needed. The trust risk register said that patients were not within the parameters of the unit's clinical capabilities. There was a risk of suboptimal care as there was no access to a consultant and patients risked an extended length of stay.

There were currently 32 escalation beds available to use when there was extra capacity needed. When these beds were full, patients were placed on other wards which did not provide the medicine speciality the patient needed. These patients were referred to as outliers. On the second day of our inspection there were 57 medical outlier patients throughout the hospital.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards, however these did not all meet the patient's needs.

The policy for staff to follow for outliers was part of the trust flow policy. This means there was no specific criteria to define outliers and the safety considerations needed. This meant that while the plan to place outliers looked at acuity and safety, and included identifying the patient's diagnosis and discharge plan, on Eden ward records showed patients without this information were placed as outliers.

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, Kynance ward and Wheal Coates ward, which meant that the ward staff with surgical skills were looking after medical patients. The trust risk register noted that medical outliers on a vascular ward increased the risk of cross infection.

The wards were receiving patients with high levels of medical need, needing to be placed in the most visible place on the ward to ensure enhanced observation and so displacing the surgical patients.

Between November 2018 and October 2019 there had been between 33 and 47 per day. The majority were on Eden ward, the surgical admissions lounge and Wheal Coates ward. Lesser numbers were seen on the trauma units.

On Eden ward the outlier patients were cared for medically by the Eden junior medical staff and seen on a ward round by the renal medical consultant. Of the surgical ward base, eight beds were funded as medical beds, the patients were not under the consultant care for their medical speciality although the renal consultant could discuss with the other medical consultants. The outliers would be seen by the renal consultant mid-week but at weekends the medical teams would only see new or sick patients.

The divisional risk register noted that the acuity of patients on Eden ward was rising, with medical patients on this ward regularly breaching the agreed limit making managing these patients difficult.

The therapist on these outlier wards were surgical therapist and no consideration was given to the skills needed to treat the extra medical outlier patients.

The outcome for the outlier patients on these wards were delays in their care. For example, on Eden ward, patients would have received the specialist care they needed much quicker if they had been on the appropriate ward. One patient waited two weeks on Eden ward without treatment, when transferred to the appropriate ward received treatment that day and started recovery. The trust risk register noted that on Eden ward there was a risk that when medical outlier patients were
admitted, if they were not allocated to a renal consultant, despite being medical patients, they may be missed on the ward round or risk not being escalated to the right consultant.

Eden ward had on some occasions had to use the treatment room as a side room to increase capacity. If the patient could not be discharged, the treatment room became an extra room. This is not a safe or suitable place for patients.

A further impact on flow through the hospital was the lack of seven day working in the hospital. This meant that each week the hospital treatment and discharge facility slowed down at the weekends because there were fewer decision-making staff and less therapy staff available. So, each Monday to Wednesday there was a backlog of patients waiting to be discharged.

Records showed when the patient had been assessed, admitted and when they had been reviewed by a consultant within 14 hours of their admission.

Staff on the stroke ward explained that because of the lack of medical staff, is a patient arrived around 5pm, the wards junior doctor cover finished at 5pm and the hospital wide medical team covered from then on. This meant patients may exceed the 14 hours to be seen because they would have to wait until the next morning.

From November 2018 to October 2019 the average length of stay for medical elective patients at Royal Cornwall Hospital was 5.6 days which was an improvement of the previous period when the length of stay was 6.5 days. The England average is 5.9 days.

On Eden ward we looked at patients with extended length of stay, for six patients seen the length of stay was between 14 and 22 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology and clinical oncology is lower than the England average.
- Average length of stay for elective patients in general medicine is higher than the England average.

**Elective Average Length of Stay - Royal Cornwall Hospital**

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine and respiratory medicine is lower than the England average.
- Average length of stay for non-elective patients in cardiology is higher than the England average.

**Non-Elective Average Length of Stay - Royal Cornwall Hospital**
Referral to treatment (percentage within 18 weeks) - admitted performance

From July 2018 to June 2019 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was generally lower than the England average. In the latest period the trust’s referral to treatment time was 86.8% compared to the England average of 87.5%.

The trust risk register noted that there was a risk of a delay in treatment for patients requiring some procedures due to a lack of available beds on the coronary care unit. A plan was underway to mitigate that risk.

Referral to treatment (percentage within 18 weeks) – by specialty

Four specialities were above 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>Geriatric medicine</td>
<td>100.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100.0%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>82.4%</td>
<td>80.9%</td>
</tr>
</tbody>
</table>

Four specialities 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>90.0%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>87.2%</td>
<td>92.5%</td>
</tr>
<tr>
<td>General medicine</td>
<td>69.6%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>65.6%</td>
<td>80.8%</td>
</tr>
</tbody>
</table>

Patient moving wards per admission

Managers monitored that patient moves between wards/services were kept to a minimum. The service moved patients only when there was a clear medical reason or in their best interest.

On admission, all patients had an estimated date of discharge. There was a focus on discharge and overcoming any barriers to this, early in the patients’ stay. Processes to identify possible...
discharges and actual discharges were overseen by the site management staff and were consistent and effective.

At our last inspection 2018 we saw that bed moves and discharges were taking place both during the day and night, despite the trust trying to avoid this. These moves and discharges included patients with dementia or who lived alone. At this inspection we found patients were still moved but consideration of patient risk and how many previous moves were considered. A system was used which noted how many times a patient had been moved. If they had been moved three times their name changed to purple on the swift board, indicating to staff not to move them again.

Bed moves were avoided whenever possible but were taking place both day and night time. Staff told us that bed moves at night varied but was minimised when possible. Staff confirmed told us, and the trust risk register confirmed that when patients were moved from one outlier ward to another there was a lack in continuity of care.

From August 2018 to July 2019, 84% of 13,191 of individuals moved wards once during their admission within two medical wards at the trust. 23% of patients were classified as vulnerable and 4% were considered as being at the end of life.

**Patient moving wards at night**

Staff did not move patients between wards at night without consideration for necessity and patient safety.

Discharging patients out of hours was undertaken in both day and evening time. Consideration was given to discharges in the evening and were screened to ensure they were safe and appropriate. These discharges included patients with dementia or who lived alone. 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.

From August 2018 to July 2019, there were 1,479 patient moving wards at night within medicine. The three wards with the highest number of ward moves at night were:

- Coronary care unit: 186
- Grenville ward: 184
- Gastro and liver unit: 154

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

**Summary of complaints**

**Trust level**

A breakdown of complaints by type is shown below:
Royal Cornwall Hospital

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

There was information displayed for patients and their relatives about how to make a complaint. Patients knew how to make a complaint and felt they could raise concerns with staff. Patients, carers and relatives were able to 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 Advice and Liaison Service.

Staff understood the policy on complaints and knew how to handle them.

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. Learning from complaints were shared on wards through staff safety briefs and an overview of complaints was reviewed through the medical care services governance board.

Managers investigated complaints and identified themes.

At our last inspection, we found complaints were not consistently managed in a timely manner. On this inspection we saw the trust still did not meet their own policy timeframes. From August 2018 to July 2019, the trust received 169 complaints concerning medical care (32.3% of total complaints received by the trust). The trust took an average of 45 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be dealt with within 30 working days.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

Staff told us that learning was provided from across the trust to ensure a wider hospital learning. They gave us examples of when learning about infection control had been shared to develop a wider improved practice.

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>35</td>
<td>20.7%</td>
</tr>
<tr>
<td>Patient care</td>
<td>30</td>
<td>17.8%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of a care package)</td>
<td>24</td>
<td>14.2%</td>
</tr>
<tr>
<td>Communications</td>
<td>24</td>
<td>14.2%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>16</td>
<td>9.5%</td>
</tr>
<tr>
<td>Trust admin/policies/procedures including patient record management</td>
<td>7</td>
<td>4.1%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>6</td>
<td>3.6%</td>
</tr>
<tr>
<td>Appointments</td>
<td>5</td>
<td>3.0%</td>
</tr>
<tr>
<td>End of life care</td>
<td>4</td>
<td>2.4%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>4</td>
<td>2.4%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>3</td>
<td>1.8%</td>
</tr>
<tr>
<td>Consent</td>
<td>3</td>
<td>1.8%</td>
</tr>
<tr>
<td>Staff numbers</td>
<td>3</td>
<td>1.8%</td>
</tr>
<tr>
<td>Privacy, dignity and wellbeing</td>
<td>3</td>
<td>1.8%</td>
</tr>
<tr>
<td>Restraint</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>169</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>32</td>
<td>19.9%</td>
</tr>
<tr>
<td>Patient care</td>
<td>28</td>
<td>17.4%</td>
</tr>
<tr>
<td>Communications</td>
<td>24</td>
<td>14.9%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of a care package)</td>
<td>23</td>
<td>14.3%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>16</td>
<td>9.9%</td>
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<td>Trust admin/policies/procedures including patient record management</td>
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<td>Consent</td>
<td>3</td>
<td>1.9%</td>
</tr>
<tr>
<td>Staff numbers</td>
<td>3</td>
<td>1.9%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>161</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

From August 2018 to July 2019 there were 2,767 compliments about medical care at the trust. Of these compliments, 2,363 (85.4%) were for Royal Cornwall Hospital.

The trust provided information relating to learning from compliments which were received in the last 12 months.

The compliment numbers above are those recorded and taken from the trust’s wonder walls, compliment letters and gifts/cards received into departments. The trust recording system did not record themes. However, where compliments name specific members of staff these are routed through to the learning from Excellence team for learning opportunities and to give personal thanks to the staff members). The patient experience team also share (via social media and newsletters) positive feedback for service areas.

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

Is the service well-led?

Leadership

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

At our last inspection, we found leadership from the board was not evident to all staff. Several staff expressed the wish for a consistent and visible board leadership, but after numerous changes the ward and unit level staff had become concerned about the instability. At this inspection we found that a change in management model had created an improved morale amongst staff.
Since our last inspection, the trust had undergone an organisational restructure, moving from four divisions to seven clinical care groups. The care groups were led by a triumvirate leadership team consisting of a clinical director, head of nursing and general manager. The management of the specialities followed a similar leadership structure. Each care group consisted of a range of specialities. Medical care was delivered through specialities spanning three care groups. Staff commented positively about the new organisational structure, describing it as a flatter hierarchy reducing the distance from ward to board. Staff told us they considered that for the first time that quality of care was the emphasis, that reengagement with staff was evident and that they felt supported to develop their services.

The restructuring added a new layer of management beneath the leadership team in the care groups, providing managers for each of the specialities within the care groups. Members of the care group management teams explained this new structure allowed them to focus on leading rather than managing their care groups, giving them the space to reflect, innovate and design the service.

Leaders explained the new structure allowed for better engagement and participation from all medical care specialities in the care groups. Similarly, the arrangements allowed greater multi-professional and multi-disciplinary involvement in the running and design of services.

The leadership team had the appropriate range of skills, knowledge and experience to perform its role. The leaders were leading a service challenged in many ways, including unique geographical challenges, whilst overseeing significant restructuring in the service. However, leaders understood and sought to manage the priorities and issues the service faced. Leaders were open and transparent about their challenges, and the challenges they identified matched the issues raised by front line staff.

Leaders across the medical care core service spoke positively about the support and level of engagement they had from the trust board. They said the board provided challenge and held them to account but also provided appropriate support as well as suggestions for improvement.

An executive and non-executive member of the board was assigned to each care group. Care group leaders explained this further improved their accessibility and gave them an even greater voice with the trust management and board.

There had been recent changes to the leadership team, and some positions remained vacant at the time of our inspection. However, the leadership team was becoming more stable, and this was a welcomed by many of the staff we spoke with.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Royal Cornwall Hospitals Trust vision and values were clear and easily accessible on the trust's 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.

Staff knew and understood the trust’s vision, values and strategy and how achievement of these applied to the work of their team. The trust’s values were care and compassion, inspiration and innovation, working together, pride and achievement, trust and respect.
Some levels of leadership staff had completed the “Being Brilliant” programme and spoke positively about its impact on morale and focus on the future.

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.

**Culture**

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

At our last inspection 2018 we found Staff felt their pride in the role and work they undertook was undermined by the higher-level management instability. None of the staff we spoke with knew who the Chief Executive told us they never saw members of the board on the wards. At this inspection we found a significant shift in staff morale and approach to change. There were cooperative, supportive and appreciative relationships among staff. Staff and teams shared responsibility and resolved conflict quickly and constructively. We saw staff communicate in a respectful way.

The culture centred on the needs and experiences of people who use services. All staff spoke positively about patient focus and that they wanted to provide over and above care every day. They were proud of the team working and felt reassured by the feedback from patients.

Most staff we asked said they felt able to speak up about any issues or make suggestions for improvement without fear of reprisals, confident they would be listened to and their issues acted upon. Staff we asked were able to describe the different ways they could speak up about an issue, including concerns about a colleague’s practice. However, some staff we asked told us they thought there remained a feeling among some staff that issues staff speak up about would not always be acted upon. Staff told us this was because operational pressures and the need to prioritise meant some issues were ignored.

Senior staff, including leaders, in the service told us there was, at least historically, a feeling among many staff that it was futile to speak up because their concerns or suggestions for improvement would not be acted upon. Leaders said this perception was changing, but they said it would take time to rebuild trust.

Senior ward staff spoke positively about their teams. Comments we heard included the following: "I am very proud of the team. We work really well together." "It’s an amazing team."

The trust held annual staff awards to thank and recognise staff achievements. Staff we asked spoke of the ‘feeling of community’ at the trust’s ‘Brilliant You’ festival where these awards were handed out, and they spoke proudly about their own or their team’s recognition at the awards.

Staff had access to counsellors, occupational health and reflective sessions for support for staff in recognition that caring roles can have a big impact on staff. Staff we spoke with told us the service had improved on how well it looked after staff. We were told of one example where a member of staff was given extended leave and support when they were going through a stressful time in their family life.

Staff received training on, and understood, the duty of candour. We saw examples of staff having applied the duty of candour in response to incidents. The culture in medicine sought to encourage openness and honesty at all levels, including with service users, in response to incidents. Safety
performance information such as the latest number of falls and pressure ulcers were presented in the medical wards we visited for the information of patients and their families and carers.

Staff we asked were aware of the trust’s Freedom to Speak-up Guardian, who provided independent and impartial support to workers to speak up. The service also had multiple freedom to speak up champions who supported the role of the guardian and listened to staff who raised concerns and ensured appropriate action was taken. During our inspection we saw staff with badges identifying themselves as champions as well as posters with the photos, names and contact details of the trust’s freedom to speak up network.

Patients and relatives told us they too felt confident about speaking up without fear.

**Governance**

*Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.*

There was a governance structure within the medical care group, with reporting lines from ‘ward to board’ and ‘board to ward’. Staff were clear about their roles and responsibilities and understood to whom they were accountable to. There were assurance systems to ensure that appropriate action had taken place and that the information used to monitor and manage quality and performance was accurate, valid, reliable, timely or relevant.

The triumvirate leadership team of each of the care groups met monthly with the trust board to provide an update on the performance of their respective care groups. In addition to representatives from the board, the panel at these performance review meetings included representatives from the trust’s human resources and finance departments. The meetings followed a set agenda with discussions of the care groups’ top priorities, areas of excellence and concern, and other key data and indicators. The care group leadership teams were challenged, held to account and supported with regards to their performance in these meetings. The trust management team, in turn, reported to the board assurance committees and the trust board.

Performance review meetings directly informed and were informed by other meetings held at care group and speciality level. This included care group and speciality level monthly governance meetings where incidents, events and learning were shared. Senior leaders we spoke with explained there was a focus on learning from other care groups. Forums were in place to allow for cross-care group learning including senior leaders’ meetings and ward leaders’ meetings.

Senior management meetings and huddles were also held at care group level (or more locally). There were various forums in which learning from patient mortality and morbidity were identified and discussed, including meetings of consultants as well as governance meetings. The systems and processes offered senior leaders the ability to see trends, identify issues and make directions for improvements.

The governance arrangements were regularly reviewed and improved to better manage current and future performance.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care. The trust had an arrangement with a local private hospital for specific simple procedures and outpatient appointments to also be carried out at this private hospital. The arrangement sought to increase the trust’s capacity to deliver its services.
Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a multi-layered framework for the management of risk.

Leaders explained recruitment was a challenge due to national staff shortages and the trust's unique geographical position. The service was meeting this challenge by being creative about how it delivers its services, including proactive attempts to look at new staffing models. There was also an emphasis on what one leader described as 'growing our own' by investigating and upskilling existing staff.

Leaders identified consultant cover in the cardiology and neurology specialities, staffing issues more generally in cardiology and the impact this was having on staff wellbeing, as well as the trust’s worsened referral to treatment times. Consultants told us that the smaller speciality groups were often dominated by the larger groups with higher risks, but the new management was aware and more supportive of the smaller specialities.

The service was also challenged by changes to tax law which have discouraged some senior staff from taking on extra work and, thereby, reducing the service's capacity to meet demand. The trust was proactively working with staff affected by this change in tax law to explore options to maintain capacity.

The new arrangements in the service allowed care groups and the specialities within them to more effectively learn from each other, including learning from incidents. Care group leaders we spoke with told us sharing and learning from each other was a focus for them as part of their risk management strategy. This included weekly governance huddles to discuss issues. Across the care groups delivering medical care, weekly governance huddles were used as forums to discuss lower rated risks to keep these risks up to date and determine what can be done about them. Higher scored risks were discussed in governance meetings and performance meetings.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

An internal process of ward accreditation was underway. The tool was being used a set of indicators that, taken together, give an indication of how well an individual team is functioning. It also provides an early warning, pre-empting more serious concerns and enabling action to be taken before things go wrong.

Ten inpatient areas had triggered including seven areas of speciality medicine. All areas now have action plans that they are completing to improve their performance. The main themes included sickness, vacancies, new leaders in post and appraisals. All action plans were to be implemented and monitored by the Head of Nursing.

Engagement
Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

At our last inspection in 2018 we found feedback from patients and relatives was not consistently used for learning or celebration opportunities. At this inspection we found that staff celebrations were evident and appreciated. Each month staff could elect a winner in their area and a small celebration in recognition took place.

Staff were engaged so their views were reflected in the planning and delivery of service. ‘What matters to you?’, events were held as a forum to bring staff from across different bands and professions together and to give them a voice to share their thoughts on what concerned them most. Leaders described their fellow staff as the ‘eyes and ears’ of the service, and these meetings allowed them to find out potentially significant issues about the service.

A multi-disciplinary summit was also held this year, bringing together staff working in gastroenterology to discuss concerns and suggestions for improvement. A member of staff who had attended the meeting described it as an example of a change in the way the service was run with greater involvement of all staff. They explained they were encouraged and supported to speak freely about their suggestions for improvement. An output from the summit was a targeted and comprehensive action plan to improve the service with an effective monitoring and evaluation system with indicators.

Patients were encouraged to comment on wards and units. The endoscopy unit had a ‘wonder wall’ where patients could leave comments and messages. We saw patients being asked to complete questionnaires and staff explained they wanted to learn from patient experience to develop their services.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff were enthusiastic about developing their own services and were keen to tell us about the ideas they had and how they were supported to drive them forward, for example the transplant service told us about the support they had received to develop their service.

The trust undertook a sleep deprivation study as previous studies had shown how lack of sleep disrupts normal physiology, 89 patients were audited, and the study highlighted the benefits of ear plugs and eye masks to improve patient health and experience. This learning was being cascaded through areas of the hospital.

### Surgery

#### Facts and data about this service

There are three sites which provide elective surgery within the trust:

- Royal Cornwall (who also provide emergency surgery)
- West Cornwall Hospital
- St Michaels Hospital
At this inspection we inspected the Royal Cornwall site only.

Surgery is provided by four care groups:

General Surgery & Cancer; Specialist Services and Surgery; Anaesthetics, Critical Care and Theatres; and Urgent, Emergency and Trauma. Specialist Services & Surgery provide ENT, Oral and Maxillofacial Surgery and Ophthalmology.

There are three designated orthopaedic theatres and an accredited trauma unit consisting of 56 beds, this is part of the Peninsula Trauma network. The only elective lists operating with this care group are for the hand and paediatric services.

St Michael's Hospital delivers elective orthopaedic and breast surgery. There are four laminar flow theatres and two wards; one 31 bedded in-patient ward and one 24 bedded admission, day case, and discharge ward.

Specialist Services and Surgery provide:

- Inpatient Dermatology services: in reach cover five days a week Monday to Friday.
- Inpatient Ophthalmology: in reach service five days a week, on-call service: seven days a week and 24 hours. Ophthalmology is supported by GPs, orthoptists, optometrists and cancer nurse specialists (CNS’s)
- Oral surgery, maxillo-facial surgery and orthodontics are sited at Royal Cornwall Hospital in a bespoke unit, they are supported by a trust middle grade and associate specialists.

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

The trust had 36,397 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 10,411 (28.6%), of which 21,302 (58.5%) were day cases, and the remaining 4,684 (12.8%) were elective.

(Source: Hospital Episode Statistics)

**Is the service safe?**

**Mandatory training**

**Mandatory training completion rates**

The service provided mandatory training in key skills to staff but did not ensure everyone completed it. The trust set a target of 95% for completion of mandatory training. We were informed the system used to capture this information was reporting inaccurate data and this was being reviewed by the trust at the time of our inspection. The nurse in charge on each ward tracked the mandatory training rates for nurses and kept up to date records on each ward. The records we reviewed showed mandatory training rate targets were achieved on each ward.

Most nursing staff received mandatory training in the safety systems, process and practices which kept people safe. Nursing staff told us they had enough time to complete mandatory training and could access e-learning modules from home.

However, not all medical staff had received this training. Staff 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. Senior staff had oversight of the issues regarding training and knew where training rates were low. However, they also acknowledged that staffing pressures impacted the time available to staff to complete training.
**Trust level**

A breakdown of compliance for mandatory training courses from April 2019 to July 2019 at trust level for qualified nursing staff in surgery is shown below, but we saw this information did not accurately reflect nurse training compliance:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Dementia awareness (inc privacy &amp; dignity standards)</td>
<td>378</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>251</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>372</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>371</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>369</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>369</td>
</tr>
<tr>
<td>Information governance</td>
<td>361</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>350</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>344</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>343</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>339</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>304</td>
</tr>
<tr>
<td>NHS CSTF resuscitation - level 2 - paediatric basic life support - 1 year</td>
<td>82</td>
</tr>
</tbody>
</table>

In surgery, the 95% target was met for seven of the 13 mandatory training modules for which qualified nursing staff were eligible.

For the previous financial year; April 2018 to March 2019 at trust level, qualified nursing and midwifery staff achieved a 92% completion rate for mandatory training.

A breakdown of compliance for mandatory training courses from April 2019 to July 2019 at trust level for medical staff in surgery is shown below:

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>241</td>
</tr>
<tr>
<td>Dementia awareness (inc privacy &amp; dignity standards)</td>
<td>240</td>
</tr>
<tr>
<td>Information governance</td>
<td>225</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>224</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>222</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>221</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>216</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>215</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>207</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>205</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>198</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>155</td>
</tr>
<tr>
<td>NHS CSTF resuscitation - level 2 - paediatric basic life support - 1 year</td>
<td>45</td>
</tr>
</tbody>
</table>

In surgery, the 95% target was met for two of the 13 mandatory training modules for which medical staff were eligible.
For the previous financial year; April 2018 to March 2019 at trust level, medical staff achieved an 83% completion rate for mandatory training.

**Royal Cornwall Hospital**

A breakdown of compliance for mandatory training courses from April 2019 to July 2019 for qualified nursing and midwifery staff in the surgery department at Royal Cornwall Hospital is shown below:

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<thead>
<tr>
<th>Training module 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 (inc privacy &amp; dignity standards)</td>
<td>318</td>
<td>319</td>
<td>99.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>196</td>
<td>197</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>313</td>
<td>319</td>
<td>98.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>312</td>
<td>319</td>
<td>97.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>309</td>
<td>319</td>
<td>96.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>309</td>
<td>319</td>
<td>96.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>305</td>
<td>319</td>
<td>95.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>289</td>
<td>319</td>
<td>90.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>289</td>
<td>319</td>
<td>90.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>289</td>
<td>319</td>
<td>90.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>283</td>
<td>319</td>
<td>88.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>256</td>
<td>319</td>
<td>80.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS CSTF resuscitation - level 2 - paediatric basic life support - 1 year</td>
<td>82</td>
<td>134</td>
<td>61.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery, the 95% target was met for seven of the 13 mandatory training modules for which qualified nursing staff were eligible.

For the previous financial year; April 2018 to March 2019 at Royal Cornwall Hospital, qualified nursing and midwifery staff achieved a 92% completion rate for mandatory training.

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<tr>
<th>Training module name</th>
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<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>235</td>
<td>240</td>
<td>97.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (inc privacy &amp; dignity standards)</td>
<td>234</td>
<td>240</td>
<td>97.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>220</td>
<td>240</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>218</td>
<td>240</td>
<td>90.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>216</td>
<td>240</td>
<td>90.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>215</td>
<td>240</td>
<td>89.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>210</td>
<td>240</td>
<td>87.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>209</td>
<td>240</td>
<td>87.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>201</td>
<td>240</td>
<td>83.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>199</td>
<td>240</td>
<td>82.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>192</td>
<td>240</td>
<td>80.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>150</td>
<td>240</td>
<td>62.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS CSTF resuscitation - level 2 - paediatric basic life support - 1 year</td>
<td>45</td>
<td>157</td>
<td>28.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In surgery, the 95% target was met for two of the 13 mandatory training modules for which medical staff were eligible.

For the previous financial year; April 2018 to March 2019 at Royal Cornwall Hospital, medical staff achieved an 83% completion rate for mandatory training.

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

Senior medical staff told us mandatory training information had been presented and discussed at monthly governance meetings, as well as at weekly ward and theatre meetings. All areas had an action plan to improve compliance.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff understood the trust’s safeguarding policy and processes and were clear about their responsibilities. Staff had access to a safeguarding lead nurse and told us they gave good support. Policies about safeguarding children and vulnerable adults at risk of abuse were available on the trust’s intranet site, which were easily accessible to staff, along with contact details and phone numbers. Staff could clearly describe what action they would take if they had concerns regarding the welfare of a patient. For example, one clinical matron and nurse associate told us of a recent safeguarding incident raised by care home relating to a patient discharge. Learning was identified to improve communication on the ward, and a plan created to set up a drop-in time for families.

Staff we spoke with knew how to recognise and report safeguarding incidents. For example, when patients self-neglected.

Safeguarding incidents were reported and investigated. Staff sought advice from safeguarding leads and information was provided on the intranet site for staff to refer to. Staff we spoke with told us they were encouraged to and did report any potential safeguarding concerns. These were investigated by either a senior nurse or a safeguarding lead. Staff told us they usually received feedback on concerns they had raised if it was appropriate to share information.

Staff received training on how to recognise and report abuse and knew how to apply it. Staff on the wards and theatres told us they were trained to level two in safeguarding for adults and children and had completed on-line training. All staff we spoke with were clear about what constituted a safeguarding concern and how to escalate a safeguarding referral.

**Safeguarding training completion rates**

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

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 at trust level for qualified nursing and midwifery staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></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>Safeguarding adults (level 1)</td>
<td>375</td>
<td>380</td>
<td>98.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>374</td>
<td>380</td>
<td>98.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>367</td>
<td>380</td>
<td>96.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>355</td>
<td>380</td>
<td>93.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In surgery, the 95% target was met for three of the five safeguarding training modules for which qualified nursing and midwifery staff were eligible.

For the previous financial year; April 2018 to March 2019 at trust level, qualified nursing and midwifery staff achieved a 94% completion rate for safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 for medical staff in the surgery department is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>240</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>239</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>212</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>204</td>
</tr>
</tbody>
</table>

In surgery, the 95% target was met for two of the four safeguarding training modules for which medical staff were eligible.

For the previous financial year; April 2018 to March 2019 at trust level, medical staff achieved an 83% completion rate for safeguarding training.

**Royal Cornwall Hospital**

A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 for qualified nursing and midwifery staff in the surgery department at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>315</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>314</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>308</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>296</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>5</td>
</tr>
</tbody>
</table>

In surgery, the 95% target was met for three of the five safeguarding training modules for which qualified nursing and midwifery staff were eligible.

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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>234</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>233</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>206</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>198</td>
</tr>
</tbody>
</table>

In surgery, the 95% target was met for two of the four safeguarding training modules for which medical staff were eligible.
For the previous financial year; April 2018 to March 2019 at Royal Cornwall Hospital, medical staff achieved an 82% completion rate for safeguarding training.

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

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Standards of cleanliness and hygiene were maintained and there were systems to protect people from healthcare associated infections. Ward staff had access to side rooms for isolation of infectious patients which were clearly identified. Patients we spoke with on the wards said their environment was regularly cleaned.

There were good arrangements for cleaning surgical wards and theatres. There were dedicated teams of cleaners who ensured these areas were clean and tidy. There were daily schedules and weekly tasks, alongside deep cleaning as and when required. There were also details of the deep cleaning and double flushing of running water, to prevent legionella bacteria growing. Cleaning equipment was colour coded and stored in a locked area.

We saw that all clinical areas were audited monthly for cleanliness, and a report provided to each care group. Cleanliness audits and hand hygiene audits were completed monthly.

There were enough cleaning products available throughout theatres that could be used in a wide range of situations. Cleaning schedules were evident and up to date. A daily schedule of cleaning was completed with instructions about areas to clean. Audits of the checklists were completed in line with the national specifications for cleanliness.

Good infection control practice was followed by staff. All staff were seen to be following the trust dress code, for example in appropriate theatre clothing and bare below the elbow. Personal protective equipment (for example gloves and aprons) was readily available and used appropriately. We saw all clinical staff, including doctors, nursing staff and therapists washing their hands and using hand sanitiser gel in between taking patient observations, in line with infection prevention and control guidelines.

We saw nursing and medical staff in theatres use good hand cleaning technique in accordance with Association for Perioperative Practice guidelines. Staff cleaned patient’s skin with a skin preparation was carried out with solution that cleaned the skin in accordance with national Institute for Health and Care Excellence CG74, prevention and treatment of surgical site infection. Theatre staff were observed to follow best practice principles for ‘scrubbing up’ (decontaminating hands and arms up to the elbow and wearing sterile gowns and gloves), before surgery and wore correct theatre attire.

In all areas ward areas visited, the floors, walls, curtains, trolleys and areas in general were visibly clean. Bed 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. We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal. Disposable sharps were managed and disposed of safely, with sharps boxes correctly labelled and not overfilled. This complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

The risk of infection was reduced through systems and processes implemented within the service. The service screened new admissions for healthcare-associated infections by swabbing at risk.
patients and logging the information onto the infection control system, which would flag if patients required further screening or isolation.

Throughout wards, all privacy curtains were disposable. The disposable curtains had dates on them indicating when they were put up and routine changes were scheduled in accordance with Health Building Note (HBM) 00-09: Infection control in the built environment regulations which states there should be a local policy on the changing of privacy curtains, both for routine changing when the curtains become soiled and after the discharge of a patient with a known or suspected infection.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment kept people safe. **Staff were trained to use them. Staff managed clinical waste well.**

The service did not always have suitable premises, but mostly looked after equipment well. During the inspection we visited eight different surgical wards and areas as well as theatres, looked at the environment on each of them and randomly sampled the equipment in use on those wards. We saw that store rooms were mostly tidy, well-ordered and well stocked. However, on Trauma 1 ward, we found a room which was used for both storage of equipment and as a patient waiting area. Dirty utility rooms were clean and substances hazardous to health were well managed.

There was not enough space in the St Mawes lounge. The lounge comprised of two treatment rooms and small waiting area (15 chairs and 3 treatment/recliner chairs). The areas were used for scans in the morning. We were told by staff, and we observed, that doctors would arrive to see patients, but have to leave without assessing patients as there are no available rooms. They sometimes tried to use rooms on Theatre Direct but those were not close by and were also sometimes in use. We observed three patients having their observations taken in the waiting area, with one patient standing up to have their observations done as no chair was available.

The surgical admissions lounge was also being used as an escalation area.

All anaesthetic machines within the anaesthetic room and theatres conformed to the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance which was seen attached to each machine. We saw that anaesthetic machines were checked at the start of each operating list by staff trained to do so.

The systems and processes for ensuring equipment was serviced, maintained, tested or calibrated were effectively managed. Equipment was well maintained and regularly serviced. We reviewed a random selection of equipment and it was clear the equipment had an in-date service. ‘I am clean’ stickers were put on items for staff to easily identify clean equipment.

Resuscitation trolleys were accessible to all surgical areas, and regularly checked to ensure they were available and ready for use in case of an emergency. In all patient areas we visited, staff had access to emergency resuscitation equipment. Resuscitation trolleys and emergency call bells were checked regularly by staff that were competent to do so. Resuscitation trolleys were locked with a breakable seal, which demonstrated the trolley had not been opened or equipment used or tampered with. Records we looked at showed that the resuscitation trolleys were all checked daily with stocks of equipment and consumables maintained by designated staff.

There were adult resuscitation guidelines on the difficult airway trolley. We saw trolleys in the main theatre area and the day care theatre area, which contained emergency intubation equipment. The contents of the trolleys met national guidance and current best practice, and we saw daily checks were completed in line with trust policy.
The design and use of the facilities in the ward areas was suitable for patients. The surgical wards were observed to be visibly clean and fire exits were not obstructed. We saw sluices were locked and substances were stored in line with control of substances hazardous to health legislation. Linen stores were well stocked and organised. Sharps bins were closed and secure and out of reach of children.

The operating theatres were a good size, visibly clean and relatively uncluttered. We observed the handling of instruments prior to, during and after surgery and their arrival at the sterilising department. We observed instruments being handled and returned to the sterile services department (SSD) packaged appropriately.

**Assessing and responding to patient risk**

*Staff completed and updated risk assessments for each patient. Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.*

Risk assessments relating to patients needs were completed and evaluated. Patients for elective surgery attended a pre-operative assessment consultation prior to their operation in line with national guidance. During the assessment required tests were undertaken; for example, MRSA screening and any specific blood test and risk assessments.

Nurses placed patients with higher dependency in enhanced care bays. For example, on the trauma unit two wards were used as enhanced care bays and there was always a member of staff observing patients on these bays.

The service used the American Society of Anaesthesiologists (ASA) classification system to grade a patient’s level of risk. Nursing staff and anaesthetists recorded the levels of risk during pre-assessment and on admission for surgery.

The service managed patient’s risk of venous thromboembolism (VTE) well. VTE is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis) and travels in the circulation, lodging in the lungs (known as pulmonary embolism). It is important that VTE assessments are undertaken prior to surgery to reduce the occurrence of an embolism. NICE guidance (NG89) for March 2018 states that all surgical and trauma patients should be assessed to identify the risk of venous thromboembolism (VTE) and bleeding as soon as possible after admission to hospital, or by the time of the first consultant review and that reassessments for VTE and bleeding should be at the point of consultant review or if their clinical condition changes. The service audited compliance with VTE every three months and this was reported in the care group performance scorecard. It was then also reported every quarter to the Trust Board. In the months from between April 2019 and June 2019 the VTE compliance was 99% with completion of VTE assessments.

There was clear escalation of a deteriorating patient. There were processes and policies used to monitor, assess, identify and respond to patient risks. Staff were trained in the diagnosis of sepsis and recognition of a deteriorating patient. The service used nationally recognised early warning scores to help detect if a patient’s condition had deteriorated. Patients were assessed and monitored using the National Early Warning System (NEWS). This was a system to alert staff to a patient deteriorating when certain clinical ‘triggers’ were reached. Staff were knowledgeable in responding to any changes in the observations which necessitated the need to escalate the patient to be seen by medical staff. We reviewed 10 patient records and saw they had been completed according to guidance.
The trust had a hospital wide approach to managing deteriorating patients. We reviewed 10 sets of surgical notes and found NEWS was recorded and acted upon appropriately in all cases. The national early warning score (NEWS) was used to identify deteriorating patients in accordance with NICE Clinical Guidance (CG) 50: ‘acutely ill adults in hospital: recognising and responding to deterioration’ (2007). Staff used the NEWS to record routine physiological observations, such as blood pressure, temperature, heart rate and the monitoring of a patient’s clinical condition. There were clear directions for actions to take when patients’ scores increased, indicating a deterioration and members of staff spoken with were aware of these. If a patient deteriorated significantly, the service had 24-hour, seven-day access to the critical care outreach team. The team would be able to visit the wards to assess the patient.

Staff we spoke with all knew how to escalate patients presenting with sepsis. The sepsis six pathway was in use on the wards. Sepsis six is the name given to the process followed to reduce the mortality in patients with sepsis with six diagnostic and therapeutic steps.

Nurses we spoke with were positive about the support from doctors when a patient deteriorated, and doctors we spoke with were confident about nurse’s ability to escalate deteriorating patients.

The World Health Organisation’s (WHO) five steps to safer surgery process was well embedded and followed within theatres. The five steps to surgical safety checklist were used to check and approve all safety elements of a patient’s procedure. This included, checking it was the correct patient, the correct operating site, and that all the staff were clear in their roles and responsibilities. We observed active involvement of all team members when following the checklist. We saw the results of the monthly audit for theatre patient’s safety which included the who safety checklist and saw compliance was over 99% since November 2018. WHO audits were encompassed within the specialty governance newsletters for information which was disseminated to clinical team members of all specialties within the care group in their individual governance newsletters. This was for information only and where there was lack of compliance it would be tabled for discussion and action. There had not been any actions to report about compliance.

There were effective handovers and shift changes to ensure staff could manage risks to patients. There were also safety briefings held twice each day. The purpose of the safety briefing was to alert staff to any patient care issues, concerns or risks and to give update information on policies or procedures.

We observed the morning safety briefing on one ward. It was attended by a range of ward staff and focused on patient risk. We saw a discussion about each patient. Staff also attended a ward round in the morning to discuss risks relating to patients, including mental health needs. Staff could then identify any patients with mental health needs. A folder with safety briefing forms also was kept on the ward, and included: NEWS score, falls, infection, pressure ulcer, resuscitation status, nil by mouth, end of life care, enhanced care.

**Nurse staffing**

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Nursing staffing in the surgical division remained 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 inspections of the service in July 2017 and September 2018. There were difficulties in ensuring a well-established and sustainable workforce. Therefore, the trust was using
a high number of agency staff to backfill the vacancies. On Trauma 1 and Trauma 2 wards we saw that there were usually between 30 and 50% agency staff, and managers confirmed this diluted the skill mix. For example, this meant that the nurses in charge had to be aware of what skills each nurse had – such as who was able to cannulate patients. On the surgical admissions lounge there was an average of three agency staff every day, which amounted to 50% of staff.

The trust used an electronic system to allocate staff, and matrons met twice daily to review safe staffing across the trust. Additionally, the head of nursing reviewed nursing establishments twice yearly. Staff and managers told us that surgical registered nurses were not often moved across the trust, more often it was medicine nurses moving to surgery wards to support with medical outliers.

The trust was looking at moving towards e-rostering. The electronic system will flag if a ‘rule’ has been broken, such as too many hours in a week, not long enough rest between shifts.

**Allied Health Professional staffing**

There was safe provision of physiotherapy and occupational therapy for patients following surgery. There was joint working between physiotherapy and occupational therapy giving comprehensive assessments of mobility and independence and medical fitness for discharge.

Allied health professionals worked seven days per week, with core hours from 8am to 4.30pm Monday to Friday, although some staff worked until 5.50pm. They provided an on-call service from 4.30pm to 8am. A reduced service was provided on Saturdays and Sundays.

**Trust level**

The table below shows a summary of the nursing staffing metrics in surgery at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>3.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>All staff</strong></td>
<td>1,437.7</td>
<td>15%</td>
<td>6%</td>
<td>5.2%</td>
<td>53,647 (7%)</td>
<td>48,575 (6%)</td>
<td>15,659 (2%)</td>
</tr>
<tr>
<td><strong>Qualified nurses</strong></td>
<td>465.0</td>
<td>19%</td>
<td>7%</td>
<td>6.4%</td>
<td>53,647 (7%)</td>
<td>48,575 (6%)</td>
<td>15,659 (2%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

The data for sickness rates was provided for a different time period (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

Nurse staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank use. There is not enough variation over the last 12 months for qualified nurses, health visitors and midwives to comment on the performance of these metrics over time.

**Vacancy rates**
Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed an upward trend from March to July 2019.

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

Bank and agency staff usage

Monthly agency rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from February to July 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Royal Cornwall Hospital

The table below shows a summary of the nursing staffing metrics in surgery at Royal Cornwall Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>1,283.6</td>
<td>15%</td>
<td>6%</td>
<td>4.8%</td>
<td>42,067 (6%)</td>
<td>44,926 (7%)</td>
<td>12,540 (2%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>395.4</td>
<td>19%</td>
<td>7%</td>
<td>5.9%</td>
<td>42,067 (6%)</td>
<td>44,926 (7%)</td>
<td>12,540 (2%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)
The data for sickness rates was provided for a different time period (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

Nurse staffing rates within surgery at Royal Cornwall Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank use. There is not enough variation over the last 12 months for qualified nurses, health visitors and midwives to comment on the performance of these metrics over time.

**Vacancy rates**

![Vacancy rate - qualified nurses, health visitors and midwives](image)

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from November 2018 to March 2019.

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

**Bank and agency staff usage**

![Agency hours - qualified nurses, health visitors and midwives](image)

Monthly agency rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from February to July 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for surgery.
Trust level

The table below shows a summary of the medical staffing metrics in surgery at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>3.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>1,437.7</td>
<td>15%</td>
<td>6%</td>
<td>5.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>296.1</td>
<td>14%</td>
<td>5%</td>
<td>2.3%</td>
<td>0 (0%)</td>
<td>31,512 (53%)</td>
<td>14,829 (25%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The data for sickness rates was provided for a different time period (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

From August 2018 to July 2019 the annual unfilled hours rate was 25% and the annual locum hours rate was 53%; this may need to be investigated to determine why the rates have been high.

Medical staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and bank use. There is not enough variation over the last 12 months for medical staff to comment on the performance of these metrics over time.

Vacancy rates

Monthly vacancy rates over the last 12 months for medical staff showed a shift from February 2019 to July 2019.

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

Sickness rates
Monthly sickness rates over the last 12 months for medical staff showed a shift from January 2019 to June 2019.

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

Bank and locum staff usage

Monthly agency rates over the last 12 months for medical staff showed an upward trend from November 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

Royal Cornwall Hospital

The table below shows a summary of the medical staffing metrics in surgery at Royal Cornwall Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
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<td>10%</td>
<td>10%</td>
<td>3.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>290.1</td>
<td>13%</td>
<td>5%</td>
<td>2.3%</td>
<td>0 (0%)</td>
<td>31,512 (53%)</td>
<td>14,829 (25%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)
The data for sickness rates was provided for a different time period (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

From August 2018 to July 2019 the annual unfilled hours rate was 25% and the annual locum hours rate was 53%; this may need to be investigated to determine why the rates have been high.

Medical staffing rates within surgery at Royal Cornwall Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and bank use.

**Sickness rates**

![Sickness rate - medical staff graph]

Monthly sickness rates over the last 12 months for medical staff showed a shift from January 2019 to June 2019.

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

**Bank and locum staff usage**

![Agency hours - medical staff graph]

Monthly agency rates over the last 12 months for medical staff showed an upward trend from November 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

There were arrangements for consultant surgical presence. Consultants were available 8am to 8pm every day on-site and would attend if a review was required.

The trust employed five orthogeriatricians. They attended daily board rounds, including on weekends.

**Records**

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and available to all staff providing care.
Staff told us there was a mixed system of record keeping which included paper records, and an electronic system to observe patients.

As part of our inspection, we reviewed the records of 10 patients. All those reviewed included patient details, medical history and a range of clinical risk assessments such as cognitive functioning, screening to identify risks associated with dementia, pressure ulcers, nutrition, and falls. The records also included evidence of input from multidisciplinary teams, discussions with families, and ‘do not resuscitate’ forms, where appropriate. Nursing documentation was audited by the trust every week, and this included checking the quality of documentation, and infection prevention risks.

Patient care records were securely stored in keypad lockable trolleys. Computer screens were attended when displaying patient information.

Pre-operative checklists were documented which included a record of consent. These checklists ensured certain safety elements were completed prior to any surgical procedure. For example, patient identification, allergies, correct consent and the time of last food and drink.

Patient records showed a multidisciplinary collaborative approach to care. They were well written and managed in a way that kept people safe (including ensuring people’s records were accurate, complete, legible, and up to date) which was in line with the records management code of practice for health and social care. All documentation reviewed was signed, dated, legible, with clear communication from the nurses, consultants and allied health practitioners.

Discharge summaries were sent electronically or in the post to patients’ GPs to ensure continuity of care in the community. Discharge summaries included information about follow-up care.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely in locked trolleys and doors were locked to treatment rooms with access restricted to appropriate staff. Controlled drugs were stored securely and managed appropriately. However not all controlled drug records were completed in accordance with trust policy. There was a trust-controlled drug (CD) policy and standard operating procedures in place. However, CD record books did not always state the form or strength of medicine sat the top of each page, and on St Mawes lounge and Newlyn day unit we found the CD check was missing a second signature on five occasions.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. We saw that nursing staff introduced themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them. A pharmacist visited daily to review prescriptions and advise medical staff when doses needed to be revised.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. Medicines fridge and treatment room temperature records showed medicines were stored at the correct temperatures. The electronic prescribing and medicines administration (EPMA) system was password protected and secure.

Staff followed current national practice to check patients had the correct medicines. Policies and procedures were available and accessible to staff via the trust intranet. Policies we viewed as part
of our inspection were in date and in line with best practice and national guidelines. Clinical
guidance was also available on the trust intranet. Patient's medicines were reconciled in line with
current national guidance on admission and when transferring between locations.

When patients were discharged from the day surgery unit after the pharmacy had closed some of
the discharge medicines supplied were not labelled in accordance with trust policy.

The service had systems to ensure staff knew about safety alerts and incidents, so patients
received their medicines safely. Managers investigated incidents and shared lessons learned with
the whole team and the wider service. Staff knew how to report incidents or near misses via the
trust’s electronic reporting system. Staff we spoke with felt confident in raising an incident should
they need to. They gave us examples of what they would report as an incident and how they
would respond to the person involved.

Decision making processes were in place to ensure people’s behaviour was not controlled by
excessive and inappropriate use of medicines. Staff supported patients to make informed
decisions about their care and treatment. They followed national guidance to gain patients’
consent.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents
and near misses. 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. Managers ensured that actions from
patient safety alerts were implemented and monitored.

The service managed patient safety incidents well. We found a culture of learning from incidents.
Staff recognised some incidents and reported them appropriately. Managers were responsible for
investigating incidents and sharing the learning. When things went wrong, staff apologised and
gave patients honest information and suitable support. However, staff did not regularly report lack
of staffing on wards, as this was felt to be a common issue and that there was nothing to gain from
reporting. This meant that managers were not always aware of the impact of being understaffed
on wards.

We asked staff if they knew how to report incidents. All told us that they had received training in
how to use the incident reporting system, but they did not always received feedback on incidents
they reported. For example, surgical admissions lounge nurse reported inappropriate transfers to
the surgical admissions lounge ‘all the time’ but did not get feedback on actions and learning.

Staff also confirmed that they would be happy to raise any concerns and would not feel like they
were causing trouble or that it would have an adverse effect on them. Staff we spoke to could give
examples where changes had been made following incidents. For example, staff on St. Mawes
ward were aware of an unsafe discharge incident, which had led to changes to the documentation
of discharge notes. On Wheal Coates ward staff were aware of a recent increase in falls, which
had led to reminders to staff to be observant, and clear bed spaces of obstacles.

Staff we spoke with described how details of incidents were communicated in daily handovers,
and through newsletters. We also saw learning from incidents displayed on all wards we visited.

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 October 2018 to September 2019, the trust reported two never events within surgery:

- February 2019 – retained foreign object at Royal Cornwall Hospital
- March 2019 – wrong side surgery at West Cornwall Hospital

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported 18 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from October 2018 to September 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>4</td>
<td>22.2%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>4</td>
<td>22.2%</td>
</tr>
<tr>
<td>VTE meeting SI criteria</td>
<td>3</td>
<td>16.7%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>2</td>
<td>11.1%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>2</td>
<td>11.1%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>Apparent/actual/suspected self-inflicted harm meeting SI criteria</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Duty of Candour

Staff showed an understanding of their responsibilities with the 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. Duty of candour was also covered in the mandatory training programme and the induction for new staff.

Staff we spoke with were able to describe what they would do if something went wrong with a patient’s care. We were told about specific examples where this had happened.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

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. The service monitored the incidents of avoidable harm to patients from pressure ulcers, falls, catheter-associated urinary tract infections, and venous thromboembolisms and took part in the national safety thermometer performance.
Staff collected safety information and shared it with staff, patients and visitors. There was a public display on the surgical wards we visited, which showed how many avoidable patient harms had occurred in the previous month including the last incidence of MRSA and *C. Difficile*, cleanliness scores, hand hygiene, the last pressure ulcer and the last fall with harm.

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 that the trust reported 37 new pressure ulcers, 15 falls with harm and four new catheter urinary tract infections from July 2018 to July 2019 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Royal Cornwall Hospitals NHS Trust**

1. Total Pressure ulcers (37)
2. Total Falls (15)
3. Total CUTIs (4)

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)

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The service provided care and treatment based on national guidance and evidence of its effectiveness. They continually reviewed guidance to help improve services.
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). Policies were available to all staff via the trust intranet system and staff showed they knew how to access them.

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.

We found information about the outcomes of patients’ care and treatment were routinely collected and monitored. The surgical division participated in several clinical audits based on national and local guidance.

Staff were not always aware of how to manage violent situations. If a patient became violent on the ward, staff could request urgent support from the hospital security staff. If a patient was admitted under section or known to be aggressive staff alerted security with the date and time of their admission or appointment, so they were on alert. However, we found two nurses who had dealt with aggressive patients and were not aware of how to request urgent support.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Special feeding and hydration techniques were used when necessary. Nurses used and completed food and hydration charts to record what patients had eaten and drunk.

Before surgery, patients were given information about when to stop eating and drinking before their operation. Staff confirmed patients would be encouraged to drink when ready, providing there were no contraindications. Patients we spoke with told us that fasting times were explained to them and they were offered refreshments after their operation.

We saw there was input from dieticians. Staff worked together to assess each patient’s dietary needs, including risks for malnutrition and dehydration. 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. Staff used evidence-based assessment tools to assess patients’ nutrition such as the malnutrition universal scoring tool (MUST).

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients’ pain was managed effectively for patients who had the capacity to communicate effectively. Staff supported those unable to communicate using suitable assessment tools, such as the Abbey Pain scale, and gave additional pain relief to ease pain.

Staff assessed pain and prescribed pain medicine in line with the Core Standards for Pain Management Services Faculty of Pain Management (2015). We saw that patients’ pain
assessments were carried out by staff correctly and patients told us they had access to pain control medication when required.

Pain was managed effectively. We saw patients provided or offered pain relief regularly and without delay. All the patients we spoke with said they were asked if they were in any pain usually during most interactions with staff. We observed staff discussing pain during handovers and during conversations with patients.

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 inpatients 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.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

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.

**Relative risk of readmission**

**Trust level**

From February 2018 to January 2019, all patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.

Urology, trauma and orthopaedics and ear, nose and throat (ENT) 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 elective admissions](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 represents the opposite. Top three specialties for specific trust based on count of activity.*

From February 2018 to January 2019, all patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
General surgery, trauma and orthopaedics and urology patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Non-Elective Admissions – Trust Level**

![Graph showing readmission rates](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 represents the opposite. Top three specialties for specific trust based on count of activity.*

(Source: Hospital Episode Statistics - HES - Readmissions (01/02/2018 - 31/01/2019))

**Royal Cornwall Hospital**

From February 2018 to January 2019, all patients at Royal Cornwall Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

Urology, ear, nose and throat (ENT) and oral surgery patients at Royal Cornwall Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions - Royal Cornwall Hospital**

![Graph showing readmission rates](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 represents the opposite. Top three specialties for specific site based on count of activity.*

From February 2018 to January 2019, all patients at Royal Cornwall Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

General surgery, trauma and orthopaedics and urology patients at Royal Cornwall Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Non-Elective Admissions - Royal Cornwall Hospital**

![Graph showing readmission rates](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 represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

National Hip Fracture Database

Royal Cornwall Hospital

The table below summarises Royal Cornwall Hospital’s performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, ‘similar’ means that the trust’s performance fell within the middle 50% of results nationally.
<table>
<thead>
<tr>
<th>Metrics (Audit indicators)</th>
<th>Hospital performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case ascertainment</strong> (Proportion of eligible cases included in the audit)</td>
<td>96.9%</td>
<td>Worse</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Crude proportion of patients having surgery on the day or day after admission</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)</td>
<td>80%</td>
<td>Worse</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Crude peri-operative medical assessment rate</strong></td>
<td>96.8%</td>
<td>Worse</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude proportion of patients documented as not developing a pressure ulcer</strong></td>
<td>98.3%</td>
<td>Worse</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient’s admission); this measures an organisation’s ability to report ‘documented as no pressure ulcer’ for a patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crude overall hospital length of stay</strong></td>
<td>15 days</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>(A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk-adjusted 30-day mortality rate</strong></td>
<td>7.4%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Hip Fracture Database)

The service has introduced dedicated fractured neck of femur theatre lists to protect theatre times and avoid potential breaches. These are run twice weekly. The surgeons conduct internal audits to measure performance and to look for improvement opportunities. There was also a theatre data dashboard to help prevent potential breaches.

**Bowel Cancer Audit**

The table below summarises trust name’s performance in the 2018 National Bowel Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case ascertainment</strong> (Proportion of eligible cases included in the audit)</td>
<td>102%</td>
<td>Good</td>
<td>Good is over 80%</td>
</tr>
<tr>
<td><strong>Risk-adjusted post-operative length of stay &gt;5 days after major resection</strong></td>
<td>42%</td>
<td>Better than national aggregate</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
(A prolonged length of stay can pose risks to patients)

<table>
<thead>
<tr>
<th>Risk-adjusted 90-day post-operative mortality rate</th>
<th>4.2%</th>
<th>Within expected range</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk-adjusted 2-year post-operative mortality rate</th>
<th>18.2%</th>
<th>Within expected range</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk-adjusted 30-day unplanned readmission rate</th>
<th>11.4%</th>
<th>Within expected range</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A potential risk for early/inappropriate discharge is the need for unplanned readmission)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection</th>
<th>52.8%</th>
<th>Within expected range</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Bowel Cancer Audit)

National Vascular Registry

The table below summarises Royall Cornwall Hospital’s performance in the 2018 National Vascular Registry.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Aortic Aneurysm Surgery (Surgical procedure performed on an enlarged major blood vessel in the abdomen)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>105%</td>
<td>Not applicable</td>
<td>Met</td>
</tr>
<tr>
<td>Risk-adjusted post-operative in-hospital mortality rate (Proportion of patients who die in hospital after having had an operation)</td>
<td>2%</td>
<td>Within the expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Carotid endarterectomy (Surgical procedure performed to reduce the risk of stroke; by correcting a narrowing in the main artery in the neck that supplies blood to the brain)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>98%</td>
<td>Not applicable</td>
<td>Met</td>
</tr>
<tr>
<td>Crude median time from symptom to surgery (Average amount of time patients wait to</td>
<td>13 days</td>
<td>Not applicable</td>
<td>Met</td>
</tr>
<tr>
<td>Metrics (Audit measures)</td>
<td>Trust performance</td>
<td>Comparison to other Trusts</td>
<td>Met national standard?</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------</td>
<td>----------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>have surgery after the onset of their symptoms)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk adjusted 30 day mortality and stroke rate (Proportion of patients who die or have a stroke within 30 days of their operation)</td>
<td>3.5%</td>
<td>Within the expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Vascular Registry)

National Oesophago-gastric Cancer Audit

The table below summarises Peninsula Cancer Alliance’s performance in the 2018 National Oesophago-gastric Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level metrics (Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>81 - 90%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>Age and sex adjusted proportion of patients diagnosed after an emergency admission (Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)</td>
<td>12.4%</td>
<td>Positive outlier</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality rate (Proportion of patients who die within 90 days of their operation)</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
</tr>
</tbody>
</table>

(Source: National Oesophago-Gastric Cancer Audit)

National Emergency Laparotomy Audit

Royal Cornwall Hospital

The table below summarises Royal Cornwall Hospital's performance in the 2018 National Emergency Laparotomy Audit. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard).
### Metrics (Audit measures)

<table>
<thead>
<tr>
<th>Case ascertainment (Proportion of eligible cases included in the audit)</th>
<th>Hospital performance</th>
<th>Audit's Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>79%</td>
<td>Amber</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>

| Crude proportion of cases with pre-operative documentation of risk of death (Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation) | 58% | Amber | Did not meet |

| Crude proportion of cases with access to theatres within clinically appropriate time frames (Proportion of patients who were operated on within recommended times) | 88% | Green | Met |

| Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre (Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation) | 89% | Green | Met |

| Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively (Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation) | 54% | Red | Did not meet |

| Risk-adjusted 30-day mortality rate (Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider) | 5% | Better than expected | No current standard |

(Source: National Emergency Laparotomy Audit)

### National Ophthalmology Database Audit

The table below summarises the trust’s performance in the national ophthalmology database audit, which is an audit of patients undergoing cataract surgery.

The trust was ‘within expected range’ for the two metrics in this audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
</table>

| Trust-level metrics (Measures of hospital performance in the treatment of cataracts) |
|---|---|---|---|

| Case ascertainment (Proportion of eligible cases included in the audit) | 98% | N/A | No current standard |

| Risk-adjusted posterior capsule rupture rate (Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.) | 1% | Within expected range | No current standard |

(Source: National Emergency Laparotomy Audit)
Risk adjusted visual acuity loss
(The most important outcome following cataract surgery is the clarity of vision)

| 0.6% | Within expected range | No current standard |

(Source: National Ophthalmology Database 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 that they feel worse can be viewed on the left. These changes are measured in several different ways, descriptions of some of the indicators presented are below.

Visual analogue scale (EQ-VAS)

Visual analogue scale (EQ VAS) is, asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific issues namely mobility self-care usual activities pain or discomfort anxiety or depression. The EQ-5D-5L uses 5 levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.

In 2016/17 performance on groin hernias was better than the England average.

For varicose veins, performance was better than the England average.
For hip replacements, performance was worse than the England average.
For knee replacements was better than the England average.

(Source: NHS Digital)

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 development.

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

The service supported new staff well. Inductions were undertaken by new ward staff. New starters completed an orientation of the ward they were to be working on. A checklist was completed to ensure that all required processes were covered. New staff were supernumerary until they were signed off as competent.

Staff had good opportunities to develop in the trust and access to further training and development. For example, we spoke nurses who completed competencies on epidurals, insulin pumps, and patient controlled analgesia’s. One nurse told us they had been funded for a three-month course in critical care. Staff also had access to simulation training on the third Thursday of every month, including scenarios often relate to sepsis. One recovery nurse had been funded to do a masters course researching the use of text messages to communicate with relatives about patients coming out of theatre.

However, the surgical admissions lounge was used as an escalation area and not adequately staffed with appropriately trained nurses. Surgical nurses were not trained to look after the acutely unwell medical patients on surgical admissions lounge.

Appraisal rates

From August 2018 to July 2019, 82.7% of staff within surgery at the trust received an appraisal compared to a trust target of 95%.

Trust level

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>48</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>6</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>21</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>165</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>280</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>280</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>56</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>10</td>
</tr>
</tbody>
</table>

The estates and ancillary and healthcare scientists staff group exceeded the trust’s 95% completion target with 100% of staff having received an appraisal. The remaining seven staff groups failed to meet the trust’s target.

Royal Cornwall Hospital
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received appraisal</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and Ancillary</td>
<td>48</td>
<td>48</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>21</td>
<td>24</td>
<td>87.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>162</td>
<td>189</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>242</td>
<td>285</td>
<td>84.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>46</td>
<td>57</td>
<td>80.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>238</td>
<td>297</td>
<td>80.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The estates and ancillary and healthcare scientists staff group exceeded the trust’s 95% completion target with 100% of staff having received an appraisal. The remaining five staff groups failed to meet the trust’s target.

**Multidisciplinary working**

*Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.*

Staff we spoke with were consistently positive about the way teams worked together at the hospital.

There was a multi-disciplinary approach to the discharge of patients via board rounds. These were made up of doctors, nursing staff, physiotherapists, discharge coordinators, occupational therapists and pharmacists. We observed a rapid round on trauma unit and saw nurses, doctors, physios, discharge coordinators and pharmacist all worked well together to make decisions about patient’s care, treatment and discharge plans.

Nursing handovers were completed at the start and end of each shift. Handovers we observed included all relevant patient information.

Nursing staff told us speech and language therapy staff were very responsive.

**Seven-day services**

*Key services were not available seven days a week to support timely patient care.* The surgical division did not meet the seven-day service standards. Allied health professionals worked seven days per week, with core hours from 8am to 4.30pm Monday to Friday, although some staff worked until 5.00pm. They provided an on-call service from 4.30pm to 8am. A reduced service was provided on Saturdays and Sundays.

**Health promotion**

*Staff gave patients practical support and advice to lead healthier lives.*

Health promotion was a routine part of care provided to patients. All staff worked collaboratively to assess all aspects of general health and to give support and advice to promote healthy lifestyles.

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.

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

*Staff supported patients to make informed decisions about their care and treatment.* They
followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. We spoke to nursing and medical staff who were aware of consent, mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) and knew how to access advice if required.

When reviewing patients' care records, we saw information about the person's mental capacity had been recorded correctly and the best interest decision had been reached involving the most appropriate people. We saw evidence of ongoing capacity assessments for further treatment. All paperwork had been sent to the people involved in the decision.

Not all staff understood their roles and responsibilities under the Mental Health Act 1983. We identified one patient experiencing poor mental ill health and who lacked the capacity to make decisions about their care. A ward matron was not able to locate the patient’s mental health act section papers and told us there was no mental health paperwork in the detained patient’s notes. The matron did not know why the patient had been sectioned and was unaware of any risks associated with the patient’s diagnosis. The matron expressed concern that she had received no training on mental health medications and did not know if the patient’s current anti-psychotics would have any interactions with medication given on the ward. However, a ward manager we spoke with had received mental health first aid training and every six months, link nurses attended relevant mental health training to cascade any relevant information to the team. However, the ward manager said they felt ill equipped to support patients with mental health needs.

The manager said that the ward did receive patients with mental health needs, some quite serious and some sectioned patients. The team received support from the psychiatric liaison team who visited patients on the ward for support.

Staff we spoke with had a good working knowledge of the MCA and DoLS and had evidence of completed referrals.

**Mental Capacity Act and Deprivation of Liberty training completion**

**Trust level**

The trust set a target of 95% for completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training courses from April 2019 to July 2019 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>378</td>
</tr>
</tbody>
</table>

In surgery, qualified nursing staff exceeded the 95% completion target for mental capacity act level 1 training.

A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 at trust level for medical staff in surgery is shown below:
In surgery, medical staff exceeded the 95% completion target for mental capacity act level 1 training.

**Royal Cornwall Hospital**

The trust set a target of 95% for completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training courses from April 2019 to July 2019 at Royal Cornwall Hospital for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></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>Mental Capacity Act level 1</td>
<td>241</td>
<td>246</td>
<td>98.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In surgery, medical staff exceeded the 95% completion target for mental capacity act level 1 training.

A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 at Royal Cornwall Hospital for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></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>Mental Capacity Act level 1</td>
<td>235</td>
<td>240</td>
<td>97.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In surgery, medical staff exceeded the 95% completion target for mental capacity act level 1 training.

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

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.

**Is the service caring?**

**Compassionate care**

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

The patients we spoke with during this inspection were positive about the care and treatment they received. We observed positive interactions from the multidisciplinary team with their patients.

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. We saw that all patients on wards had an assigned nurse which was noted on a whiteboard.

The comments we received and saw included:
• Excellent care so far, food has been average. Staff introduce themselves and explained my treatment. Last Sunday the staff mentioned they were short staffed. Have been offered pain relief. No delays or cancellations of my operation.

• Have had a good stay with no complaints. The care has been good, the doctors and consultants are excellent and explained my treatment. Food has been ok. Staff seem run off their feet. Had to request pain relief rather than be offered but have received.

• Very nice staff, not been in pain and have been asked several times. No reason to feel unsafe or neglected. Feel involved in care and aware of treatment plan.

• Was admitted last night, was on a trolley for five and a half hours, was very busy. Staff have been fantastic, this was actually a planned visit, I arrived at 11:30am then got my bed at 5pm. This is actually the second attempt at this appointment, I had an appointment on Saturday, I missed a day of work and had to get a taxi here, I waited around until 6pm in a gown to be told by the surgeon that I should have been told to go home hours ago as there was no time to fit me in. I have been very pleased with the surgeon, he offered me a spinal anaesthetic instead of a general, he explained my options and I have to say it has been a fantastic choice for me. The service has been fantastic, if not overstretched. Staff are really great and have a good laugh. I have always been asked if I need anything, including pain relief. Aware of discharge plan and going home soon. My surgeon even came onto the ward this morning at 7:30am to check that I was ok.

• Been on ward since Monday. Nursing staff are wonderful, and they work very hard. It does feel a bit short staffed, they are superb, and I can’t fault them, but they need more help. They call me by my Christian name, are friendly and nothing is too much trouble, they put themselves out and keep me informed. I’m allowed flexible visits and they inform my family of what’s going on. There’s one nurse in particular I’m so glad to hear her voice, it really lifts me up. Call bell answered and have received pain relief when needed. Not felt frightened, feel supported.

There was a person-centred culture. Staff were motivated and inspired to offer care that was kind and promotes people’s dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive.

We saw a healthcare assistant knocking on a toilet door before entering to help a patient.

A significant amount of positive feedback was displayed on wards. We saw staff went out of their way to improve the experience of patients during their stay. For example, we observed privacy and dignity, with curtains around beds used. We saw a doctor speaking with a patient, they introduced themselves, bent down to give the patient eye contact, explained they had received their operation. The patient was confused and did not know where they were. The doctor explained they were being transferred to another hospital for their family to be able to visit. They were polite and kind to patient and checked they had call bell which they could reach.

Staff understood the totality of patients’ needs, including the need for social interaction and support. All staff we spoke with were confident to raise concerns to their manager about disrespectful, discriminatory or abusive behaviour or attitudes.

Staff made sure people’s privacy and dignity was always respected. For example, we saw nurses closing curtains around patients when delivering personal care and treatment. All patients we spoke with were positive about the way staff maintained their privacy and dignity. Patients had access to chaperones if required and information about how to access a chaperone was displayed.
clearly in treatment rooms. The service had a chaperone policy and staff were aware of their responsibilities.

Staff responded in a compassionate, timely and appropriate way in response to people experiencing physical pain, discomfort or emotional distress. For example, at the eye unit we saw a nurse respond sensitively to patient who wanted their cannula removed. We observed physiotherapists were encouraging and supportive when helping patients to move following surgery.

**Friends and Family test performance**

We are unable to validate the ward breakdown response scores due to inconsistencies within the data therefore cannot comment on this section.

*(Source: NHS England Friends and Family Test)*

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff were observed communicating with patients with kindness and in a way which took in to account their emotional needs. A healthcare assistant told us of being attentive to the moods of patients and adapting their manner. We saw a patient being reassured that their family had visited earlier but the patient had been sleepy

Patients had access to a multifaith chaplaincy. We observed a family member request chaplaincy service visits, which the ward clerk requested through the switchboard. We also spoke with a pastoral volunteer, based with the chaplaincy team. They visited the ward once a week and met with patients’ relatives. They were trained as a mealtime companion and would stay during lunchtimes to assist patients.

Patients were given appropriate and timely support and information emotionally with their care, treatment or condition. Staff signposted people to other support services as appropriate.

Staff considered the emotional impact on people close to patients including carers, family and dependants.

Patients we spoke to told us staff were caring and supportive. They said they had been treated well and they trusted the opinion of their doctor.

**Understanding and involvement of patients and those close to them**

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

We saw staff explaining things to patients in a way they could understand. The patients spoken with felt well informed as to their diagnosis and care plans, they felt the management of their care and treatment was being discussed with them as much as possible.

Patients we spoke with confirmed they had enough information about the risks and benefits of their surgery. Patients we spoke with people feel listened to, respected and have their views considered.

Nurses on the wards kept patients well-informed of timings and delays to going to theatre. Patients we spoke with were happy with the way nurses kept them updated on when they were going to theatres.
Is the service responsive?

Service delivery to meet the needs of local people

The service did not always plan and provide care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

The surgical division was regularly reviewing the service they provided to meet the needs of the local population. As recognised by staff, the main difficulties facing the trust were a lack of permanent staff and medical outliers in surgical areas.

Prior to the inspection all elective orthopaedic and breast surgery had been transferred to St Michael’s Hospital. This meant that most of the work at the Treliske site was focused on emergency surgery.

There were systems to identify and support the care of patients with learning disabilities or cognitive impairments. For example, patients living with dementia were identified at pre-operative assessment and flagged on the electronic system so staff were aware of their needs. Staff had access to trust learning disability nursing team and a dementia link team to support patients.

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.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

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.

Not all staff had received training on meeting the needs of patients living with dementia. Patients living with a diagnosis of a dementia or a learning disability were flagged to staff on their electronic system. However, we saw that on the Trauma ward there was work under way to improve dementia care for patients. A two-day bespoke dementia course had been arranged for December 2019 working to improve knowledge of HCAs. Staff also gave examples of how they would support patients living with dementia. We were given an example where a patient was agitated all morning. When the family came in at lunch time nurses realised family called them by their middle name, which was the patients was preferred name and when nurses used middle name the patient was no longer distressed.

Surgery for patients with complex needs was co-ordinated well. Patients with additional needs would be booked earlier in the list. Staff liaised with the learning disability team and carers to meet patients’ needs. Staff could meet patients and their families or carers in the car park and bring straight to theatre if necessary. Theatre lists were prioritised in term of clinical need and additional needs.

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

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 including the surgical admission lounge, and Wheal Coates. On one day of the inspection we saw 16 medical outliers (out of a total of 18 surgical inpatient beds and four day-case beds).

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. On the surgical admissions lounge medical patients were overseen by the endocrine team, regardless of the specialty of the medical patient. Staff informed us that it could take up to three days to get a cardiology or gastroenterology patient reviewed by an appropriate member of staff. This had also been an issue at the previous inspection.

There was not enough space in the St Mawes lounge, and it was not always used appropriately. The lounge comprised of two treatment rooms and small waiting area (15 chairs and 3 treatment/recliner chairs). The lounge was officially open from 7:30am to 7:00pm. It was set up for patients admitted directly to hospital by their GP, patients admitted via the emergency department and nurse specialist referrals. Observations and bloods were taken on arrival, as well as scans if needed. There was a one-hour target to be assessed by a junior doctor. However, junior doctors could not order CT scans without a senior review. Not all registrars attend the lounge – according to staff it depended if registrars saw the lounge as a priority. One member of staff told us the trust was short of an on-call vascular registrar which lead to a patient who arrived at 9am was not seen by registrar until 1pm.

The statement of purpose for the use of St. Mawes lounge stated there should be a maximum of 12 patients in the lounge but we were told recently there were 17 patients in the lounge. During the inspections we saw that 15 patients were waiting in the lounge. We spoke to senior staff who told us that they were reluctant to stop the taking patients from the emergency department, as the lounge was a more suitable place for patients than the corridor in the emergency department. Senior staff were aware that the lounge was exceeding capacity on a regular basis, and plans were underway to restructure some of the ward areas.

We observed three patients having their observations taken in the waiting area, with one patient standing up to have their observations done as no chair was available.

**Average length of stay**

**Trust Level – elective patients**

From March 2018 to February 2019 the average length of stay for patients having elective all surgery at the trust was 2.9 days. The average for England was 3.8 days.

- the average length of stay for patients having elective trauma and orthopaedics surgery at the trust was 3.0 days. The average for England was 3.7 days.
- the average length of stay for patients having elective urology surgery at the trust was 2.3 days. The average for England was 2.5 days.
- the average length of stay for patients having elective colorectal surgery at the trust was 5.4 days. The average for England was 7.0 days.
Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Trust Level – non-elective patients

The average length of stay for patients having non-elective all surgery at the trust was 4.0 days. The average for England was 4.7 days.

- the average length of stay for patients having non-elective General surgery at the trust was 3.3 days. The average for England was 3.6 days.
- the average length of stay for patients having non-elective trauma and orthopaedics surgery at the trust was 5.7 days. The average for England was 8.4 days.
- the average length of stay for patients having non-elective urology surgery at the trust was 2.1 days. The average for England was 2.7 days.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Royal Cornwall Hospital - elective patients

The average length of stay for patients having elective all surgery at Royal Cornwall Hospital was 3.2 days. The average for England was 3.8 days.

- the average length of stay for patients having elective urology surgery at Royal Cornwall Hospital was 2.3 days. The average for England was 2.5 days.
- the average length of stay for patients having elective trauma and orthopaedics surgery at Royal Cornwall Hospital was 3.6 days. The average for England was 3.7 days.
- the average length of stay for patients having elective colorectal surgery at Royal Cornwall Hospital was 5.4 days. The average for England was 7.0 days.

Elective Average Length of Stay - Royal Cornwall Hospital
Royal Cornwall Hospital - non-elective patients

The average length of stay for patients having non-elective all surgery at Royal Cornwall Hospital was 3.9 days. The average for England was 4.7 days.

- the average length of stay for patients having non-elective general surgery at Royal Cornwall Hospital was 3.3 days. The average for England was 3.6 days.
- the average length of stay for patients having non-elective trauma and orthopaedics surgery at Royal Cornwall Hospital was 5.7 days. The average for England was 8.4 days.
- the average length of stay for patients having non-elective urology surgery at Royal Cornwall Hospital was 2.1 days. The average for England was 2.7 days.

Non-Elective Average Length of Stay - Royal Cornwall Hospital

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From July 2018 to June 2019 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was generally worse than the England average. In the latest month, June 2019, trust performance was similar to the England average.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty
No specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Six specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>67.7%</td>
<td>72.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>65.3%</td>
<td>75.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>59.0%</td>
<td>62.8%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>51.4%</td>
<td>55.8%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>50.4%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>47.8%</td>
<td>58.6%</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.

Over the two years, the percentage of cancelled operations at the trust showed a trend of improvement; in Q4 2017/18, 41% cancellations were not treated within 28 days. In the latest period, Q1 2019/20, 11% of cancellations were not treated within 28 days.

The overall performance was worse than the England average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Royal Cornwall Hospitals NHS Trust**

![Graph showing percentage of cancelled operations over time]

Cancelled Operations as a percentage of elective admissions - Royal Cornwall Hospitals NHS Trust

![Graph showing percentage of cancelled operations as a percentage of elective admissions]

Over the two years, the percentage of cancelled operations at the trust showed a trend of improvement, from Q1 2018/19 trust performance was similar to the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

**Patient moving wards per admission**
From August 2018 to July 2019, within St Mawes ward, 35% of individuals did not move wards during their admission, and 65% moved once or more.

From August 2018 to July 2019, within St Mawes lounge, 37% of individuals did not move wards during their admission, and 63% moved once or more.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

**Patient moving wards at night**

From August 2018 to July 2019, there were 2,182 patients moving wards at night within surgery.

The three wards with the highest number of moves were:

- St Mawes ward with 1,071
- St Mawes lounge with 195
- Trauma unit 1 with 176

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

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. Rapid rounds in the morning and afternoon were focused on discharge through a multidisciplinary approach. Flow matrons also held ‘flow hub’ meetings three times a week, where patients who were medically stable and fit for discharge reviewed were reviewed. Flow matron visits wards twice a week. Staff and managers told us the main challenge to discharge remained a lack of access to community beds.

The trust had employed three discharge coordinators on the Trauma ward, who supported staff with discharge liaison and paperwork. Staff also had access to homelessness officer and social workers to support discharge of patients with complex needs or social situations.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Staff we spoke with explained they got more positive feedback than complaints. Senior nurses shared feedback from patients and learning from complaints and safety briefing meetings that were held every morning.

Information about making complaints was available in all surgical areas we visited. We saw leaflets on wards, and in corridors outside wards, including how to access the Patients Support and Complaints Team.

Staff 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 Friends and Family Test surveys were available to patients on surgical wards.

**Summary of complaints**

**Trust level**
From August 2018 to July 2019 the trust received 104 complaints in relation to surgery at the trust (20% of total complaints received by the trust). The trust took an average of 83 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be closed within 30 days. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>36</td>
<td>34.6%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>14</td>
<td>13.5%</td>
</tr>
<tr>
<td>Values and Behaviours (Staff)</td>
<td>10</td>
<td>9.6%</td>
</tr>
<tr>
<td>Admissions and Discharges (Excluding Delayed Discharge Due to Absence of a Care Package - See Integrated Care)</td>
<td>9</td>
<td>8.7%</td>
</tr>
<tr>
<td>Communications</td>
<td>9</td>
<td>8.7%</td>
</tr>
<tr>
<td>Trust Admin/Policies/Procedures including Patient Record Management</td>
<td>7</td>
<td>6.7%</td>
</tr>
<tr>
<td>Appointments</td>
<td>5</td>
<td>4.8%</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>4</td>
<td>3.8%</td>
</tr>
<tr>
<td>Access to Treatment or Drugs</td>
<td>3</td>
<td>2.9%</td>
</tr>
<tr>
<td>Privacy, Dignity and Well Being (PDW)</td>
<td>2</td>
<td>1.9%</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>2</td>
<td>1.9%</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>104</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Royal Cornwall Hospital**

From August 2018 to July 2019 Royal Cornwall Hospital received 98 complaints in relation to surgery. A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of complaint</strong></td>
<td><strong>Number of complaints</strong></td>
<td><strong>Percentage of total</strong></td>
</tr>
<tr>
<td><strong>Clinical Treatment</strong></td>
<td>33</td>
<td>33.7%</td>
</tr>
<tr>
<td><strong>Patient Care</strong></td>
<td>14</td>
<td>14.3%</td>
</tr>
<tr>
<td><strong>Values and Behaviours (Staff)</strong></td>
<td>10</td>
<td>10.2%</td>
</tr>
<tr>
<td><strong>Admissions and Discharges (Excluding Delayed Discharge Due to Absence of a Care Package - See Integrated Care)</strong></td>
<td>9</td>
<td>9.2%</td>
</tr>
<tr>
<td><strong>Communications</strong></td>
<td>7</td>
<td>7.1%</td>
</tr>
<tr>
<td><strong>Trust Admin/Policies/Procedures including Patient Record Management</strong></td>
<td>6</td>
<td>6.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>98</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Number of compliments made to the trust**

From August 2018 to July 2019 there were 1,682 compliments received for surgery at the trust (22.4% of all received trust wide).

A breakdown of compliments by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>1,475</td>
<td>19.7%</td>
</tr>
</tbody>
</table>

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

Is the service well-led?
Leadership

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

The leadership, governance and culture were used to drive and improve the delivery of person-centred care. Leaders demonstrated the experience, capacity and capability needed to deliver sustainable care.

The leadership team felt supported by the executive team to drive progress and make improvements. They had a good awareness of risks and the challenges to the service. Most staff we spoke with in theatres and on the wards also told us the executive team were visible and listened to their feedback and concerns.

The surgical leaders came from four care groups: General Surgery and Cancer; Anaesthetics, Critical Care and Theatres; Urgent Emergency and Trauma; and Specialist Surgery. Each care group had a leadership team which included a clinical director, a general manager and a head of nursing. Each care group also had had a specialty lead, governance lead and service manager. The care groups had been newly established and leaders across all care groups we spoke with were hugely positive about the newly created groups and spoke positively about share proactive and learning lessons within and across care groups.

We found the leaders highly energised and enthusiastic about shaping the future of surgical services in Cornwall, focusing on patient experience.

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.

Comprehensive and successful leadership strategies were being developed to ensure and sustain delivery and to develop the desired culture. Leaders had a good understanding of issues, challenges and priorities in their service, and beyond.

The local leadership team were experienced and demonstrated a good understanding of the performance challenges and risks within the surgical services. Leaders were clear about the challenges of managing demand for emergency and planned operations. The main challenge was improving patient flow and the impact this had on patients and outcomes.

Leaders were mostly visible and available to staff. The matron and ward sisters were an experienced and strong team with a commitment to the patients who used the service, and to their staff and each other. We saw matrons and ward sisters were integral in the areas they worked in and highly visible to staff and patients. Most nurses and healthcare assistants in areas we visited spoke highly of their managers and told us they were available to listen and act upon concerns. However, not all staff were aware of who the care group leadership team were.

Vision and strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action.

The trust had a vision and strategy, but the service did not. The trust’s vision was “aspiring to provide brilliant care to One + All”, with three key strategic goals: Brilliant Care; Brilliant People and Brilliant Improvement.
The leadership team were clear about the priorities for the division and were keen to make changes which were sustainable to ensure improvements. A strategy for breast surgery had been approved, and strategies for haematology, oncology, urology, vascular surgery, and general surgery were in development at the time of the inspection.

Staff were aware of the priorities for the trust and they key challenges which were faced.

**Culture**

**Staff did not always feel respected, supported and valued.** Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Leaders had a shared purpose to deliver and motivate staff to succeed. However, that purpose was not always clear to ward staff. Staff we spoke with were proud to work for the trust and serve the local community but did not always feel valued. They spoke of good, supportive team working within their team, but did not always feel that senior staff recognised the pressures of understaffing, the number of medical outliers and patient flow. Staff were not aware of future plans for the department and this impacted on the culture and were not generally positive about the future. We spoke to several ward staff who wished to leave their current roles because of the work pressures.

However, leaders were aware of issues that ward staff were facing and acknowledged that their future plans had not been shared with staff. This was because the care groups had only been recently established and plans were still being developed.

**Governance**

**Leaders operated effective governance processes, throughout the service and with partner organisations.** Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance arrangements were proactively reviewed and reflected best practice. There were improved governance processes and oversight in the care groups, which were now embedded.

A systematic approach was taken to working with others to improve care outcomes. Monthly care group governance meetings took place. We saw these meetings were well attended, including representatives for all clinical sites and all clinical specialities. Representatives from anaesthetics, therapies, critical care, business partners, finance were all in attendance. The governance meetings had recently invited a patient to share their experience of their care at the hospital, so all staff could listen and understand the patient experience and reflect on their role and the impact it may have had. The care groups plan to have a patient story at all future meetings. Other standing agenda items included quality of care, including the risk register, quality dashboards and summary outcomes of clinical reviews. Performance, finance and workforce were also on the agenda.

All levels of governance and management functioned effectively and interacted with each other appropriately. The governance teams told us the route to board was working well, and had improved greatly since the last inspection, as information was now cascaded back down to the ward. We saw standardisation across templates for meetings and teams could show us examples where learning had been shared across care group. The governance leads for each care group worked in the same location which has improved shared learning and best practice.
Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Governance teams could now be proactive rather than reactive to issues, as all staff understood that they each had a key role to play. Newsletters were shared with all staff, both clinical and administrative, and governance meetings were now attended by all staff groups which has promoted team working. Staff in theatres told us they felt their concerns were now heard and dealt with.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was a commitment to best practice performance and risk management systems and processes.

The management and oversight of the risk register was clear. We saw that risks and concerns staff talked to us about were on the care groups’ risk registers, and that these were discussed and updated every month.

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.

The trust had effective systems for identifying risks and had the action summary and actions completed. Risk was identified and managed at a local level, for example in wards, units and theatres and included in the departmental risk register. Higher risks were escalated to the care groups risk registers, and then corporate risk register, dependent on severity of risk. Staff at all levels we spoke with told us that they were confident that the risks they were aware of were included in risk registers.

We saw risk registers where risks were well defined, with mitigating controls in place. Actions were detailed with due dates noted. We noted that actions were reviewed and updated regularly.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The information used in reporting, performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant. 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.

There was a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement. The care groups held monthly governance meetings. Detailed quality data and performance information was provided at these meetings.

**Engagement**

*Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.*

The trust engaged with staff through multiple channels. Staff we spoke with were aware of trust wide communication emails and bulletins. However, leaders within the care groups we spoke with stated that they had yet to fully engage with staff regarding future plans as they were still at a very early stage.

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.

**Learning, continuous improvement and innovation**

*All staff were committed to continually learning and improving services. They had a basic understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.*

There was a fledgling approach to improvement. Improvement was seen as the way to deal with performance and for the organisation to learn.

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.

Innovation was celebrated. There was a strong record of sharing work locally, nationally and internationally.

The staff teams told us they were always keen to learn and develop the service. Innovation and improvement were encouraged with a positive approach to achieving best practice.

The breast service was working with the trust strategy team to develop plans to increase capacity, with a standalone service with onsite theatres, ward beds and imaging facilities.

A theatre utilisation programme had made a substantial improvement on referral to treatment times, and a nurse led triage service had improved two week waits on prostate cancer pathways.

A three-dimension visualisation project allows patients to see inside theatres via the internet.
Maternity services at the Royal Cornwall Hospitals NHS Trust provide 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 are part of the women, children and sexual health care group within the trust. Some of the buildings and facilities within the maternity service are acknowledged to be outdated, although at the time of our inspection the Helston birth centre was due to reopen following refurbishment. The trust was in the process of consultation for the complete redevelopment and relocation of the maternity services on the acute site.

The Royal Cornwall Hospitals NHS Trust has 56 maternity beds across four sites plus four community birth rooms. Of these beds 47 are located within an antenatal ward, delivery suite and the postnatal and transitional care ward at Royal Cornwall Hospital. Antenatal care including monitoring and induction of labour is provided from Wheal Rose ward which had 11 beds, a bereavement suite and a licensed (small) mortuary facility. Wheal Rose has three side rooms and two four-bedded bays. A maternity day assessment unit and triage is linked to Wheal Rose ward. This service provides appointments for monitoring, treatment and care for women with health issues related to pregnancy. Delivery suite contains ten beds including recovery facilities. Postnatal care for women and neonates who require ongoing treatment or monitoring post birth is provided on Wheal Fortune (postnatal and transitional care) ward 25 beds. This had four-bedded bays with shared bathroom facilities, side rooms and a combined day/discharge lounge.

The remaining nine beds are located at the trust’s midwife-led birthing centres. Four beds are available at the birthing centre at Royal Cornwall Hospital, three beds at the stand-alone Penrice birthing unit at St Austell, one bed at the stand-alone Helston birth centre (this is not a 24-hour service and patients must call the on-call midwife when they are in labour) and one bed at the stand-alone birthing centre at St Mary’s Hospital on the Isle of Scilly. Women living on the Isle of Scilly assessed with high risks or due to personal choice are transferred to one of the maternity services available on the mainland.

In 2018/19 there were 4,077 births. 29.2% (1,189) of these births were at home or in one of the four low risk birth centres.

(Source: Trust Provider Information Request – Acute context)

A comparison of the number of deliveries at the trust and the national totals during this period is shown below.

Number of deliveries at Royal Cornwall Hospitals NHS Trust – Comparison with other trusts in England.
(Source: Hospital Episode Statistics (HES))

A profile of all deliveries and gestation periods from January 2018 to December 2018 can be seen in the tables below.

### Profile of all deliveries (January 2018 to December 2018)

<table>
<thead>
<tr>
<th></th>
<th>ROYAL CORNWALL HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>3,730</td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>55</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>130</td>
<td>3.4%</td>
</tr>
<tr>
<td>20-34</td>
<td>2,900</td>
<td>76.6%</td>
</tr>
<tr>
<td>35-39</td>
<td>630</td>
<td>16.6%</td>
</tr>
<tr>
<td>40+</td>
<td>125</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3,785</td>
<td></td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

Values greater than 7 rounded to the nearest 5 with the delivery rate calculated with the rounded figures. This does not apply to the 'other/unrecorded' method of delivery as patients are not identifiable.
Notes: This table does not include deliveries where delivery method is 'other', 'Missing' or 'unrecorded'.

To protect patient confidentiality, figures between 1 and 7 have been suppressed and replaced with *** (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed. Values greater than 7 rounded to the nearest 5 with the delivery rate calculated with the rounded figures. This does not apply to the 'other/unrecorded' method of delivery as patients are not identifiable.

Gestation periods were unrecorded for 15.7% of deliveries at this trust compared to 18.7% nationally.

(Source: Hospital Episode Statistics (HES))

During this inspection we observed care provided by staff and spoke with four women about their care and treatment and three relatives of women receiving care. We spoke with 95 staff, including two clinical directors, the care group manager, the head of midwifery and deputy head of midwifery/consultant midwife, two midwifery matrons, the care group governance lead, obstetric consultants, obstetricians, anaesthetists, junior through to senior midwives, specialist midwives, maternity support workers, maternity voices partnership leads, administrative and domestic staff.

We observed four ward handovers, a multidisciplinary team (MDT) meeting, safety briefing and two ward huddles. We reviewed ten sets of clinical care records of women who had received maternity services and reviewed data provided to us by the trust.

<table>
<thead>
<tr>
<th>Gestation periods (January 2018 to December 2018)</th>
<th>ROYAL CORNWALL HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>205</td>
<td>6.4%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>2,975</td>
<td>93.3%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Total number of deliveries with a valid gestation period recorded</strong></td>
<td><strong>3,190</strong></td>
<td><strong>472,062</strong></td>
</tr>
</tbody>
</table>

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff but not everyone completed it.

The mandatory training was comprehensive and met the needs of women and staff. The service had developed a mandatory training week every month to improve training rates. Although mental health, manual handling and infection control training were still part of the trust-wide programme, managers planned them to be part of the mandatory training week. The week was designed to be multi-professional, although staff commented the medical staff were not always released from their clinical role for training other than the clinical skills and drills practical emergency obstetric training (PROMPT) day. The PROMPT day was multi-professional with midwives, maternity support workers, obstetricians and anaesthetists attending.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers booked staff returning from long term sickness, maternity leave, newly qualified midwives and those new to the trust onto the next mandatory training week. Some part-time staff
chose to attend half of the training week one month and half the next month. Attendance at mandatory training was monitored by the learning and development team.

**Mandatory training completion rates**

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

**Service level**

A breakdown of compliance for mandatory training courses from April 2019 to July 2019 for qualified midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module 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>177</td>
<td>177</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>175</td>
<td>175</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>175</td>
<td>177</td>
<td>98.90%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS core skills training framework (CSTF) resuscitation - level 2 – new born basic life support - 1 year</td>
<td>169</td>
<td>172</td>
<td>98.30%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>173</td>
<td>177</td>
<td>97.70%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>170</td>
<td>177</td>
<td>96.00%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>167</td>
<td>177</td>
<td>94.40%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>165</td>
<td>177</td>
<td>93.20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>163</td>
<td>177</td>
<td>92.10%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>162</td>
<td>177</td>
<td>91.50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>157</td>
<td>177</td>
<td>88.70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>133</td>
<td>177</td>
<td>75.10%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>132</td>
<td>177</td>
<td>74.60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS CSTF resuscitation - level 3 - adult immediate life support - 1 year</td>
<td>1</td>
<td>0</td>
<td>N/A</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In maternity the 95% target was met for six of the 13 mandatory training modules for which qualified midwifery staff were eligible. This included community midwifery staff.

All staff were trained in dementia awareness and medicine management whereas only 74.6% of staff were trained in level two infection prevention and 75.1% were trained in level two manual handling people. There was one member of staff trained in level three adult immediate life support resuscitation however, it was reported that no members of staff were eligible for this training.

For the previous financial year; April 2018 to March 2019 qualified midwifery staff achieved a 90% combined completion rate for mandatory training.

**Royal Cornwall Hospital maternity department**

A breakdown of compliance for mandatory training courses from April 2019 to July 2019 for qualified nursing and midwifery staff in maternity at Royal Cornwall Hospital is shown below. This does not include community midwifery staff.

<table>
<thead>
<tr>
<th>Training module 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>115</td>
<td>115</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Training Area</td>
<td>Eligible</td>
<td>Trained</td>
<td>Completion Rate</td>
<td>Target</td>
<td>Status</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>----------</td>
<td>---------</td>
<td>-----------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>115</td>
<td>115</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>114</td>
<td>115</td>
<td>99.10%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS CSTF resuscitation - level 2 – newborn</td>
<td>108</td>
<td>110</td>
<td>98.20%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>basic life support - 1 year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>112</td>
<td>115</td>
<td>97.40%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>110</td>
<td>115</td>
<td>95.70%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>110</td>
<td>115</td>
<td>95.70%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>109</td>
<td>115</td>
<td>94.80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>109</td>
<td>115</td>
<td>94.80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>108</td>
<td>115</td>
<td>93.90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>105</td>
<td>115</td>
<td>91.30%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>92</td>
<td>115</td>
<td>80.00%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>88</td>
<td>115</td>
<td>76.50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS CSTF resuscitation - level 3 - adult</td>
<td>1</td>
<td>0</td>
<td>N/A</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>immediate life support resuscitation - 1 year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This table does not include community midwifery staff. It shows an improvement in the information governance training rates which met the 95% trust target for hospital maternity staff.

Midwifery staff received and mostly kept up to date with their mandatory training. The 95% trust target was met for seven of the 13 mandatory training modules for which qualified nursing and midwifery staff at Royal Cornwall Hospital were eligible. All staff were trained in dementia awareness and medicine management. There were two modules close to the 95% target, health and safety and moving and handling level one which both had completion rates of 94.8%. However only 76.5% of staff were trained in level two manual handling people. Managers had plans for specialist midwives to be trained to deliver the level two manual handling people training, to improve compliance rates. There was one member of staff trained in level three adult immediate life support resuscitation although it is reported that no members of staff were eligible for this training.

For the previous financial year; April 2018 to March 2019 qualified midwifery staff achieved a 90% completion rate for mandatory training. A maternity mandatory training week was introduced in January 2019 to improve the mandatory training rates. The training week was protected time away from the clinical area and staff felt happier knowing they would not be expected to work clinically to meet demand.

Following our inspection, we requested maternity specific and trust mandatory training compliance data. On 31 October 2019 the midwifery training compliance was consistent with 94.8% midwives having attended the maternity update day and 97.2% attended the multi-professional clinical emergency study day, although a breakdown of the training delivered on the maternity update day was not provided. There was not a clear breakdown of the trust mandatory training compliance between maternity staff including midwives, maternity support workers and clerical staff. Therefore, we could not be fully assured that infection control and manual handling people level two had reached the 95% trust target, although this was a high target level.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities and autism. Mental health training was included in the mandatory training week. Day three of the training contained updates from the perinatal mental health team, learning disabilities nurse and complex social issues. These included adverse childhood experiences (ACEs), substance misuse, child sexual exploitation (CSE), young parents and neglect. There was a session for scenario discussion and sharing of learning to improve staff recognition of mental health concerns.
During our inspection most staff were found to have basic mental health awareness. Staff were able to access additional information related to maternal mental health on the trust intranet and knew how to contact the designated perinatal mental health nurse for support. The perinatal mental health team also offered additional bespoke training to maternity teams, although this was not mandatory.

Medical staff received but were not up to date with their mandatory training.

The trust did not report maternity and gynaecology staff training separately, therefore a breakdown of compliance for mandatory training courses from April 2019 to July 2019 at trust level for medical staff reported as gynaecology is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Dementia awareness (including privacy &amp; dignity standards)</td>
<td>39</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>38</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>34</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>32</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>32</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>32</td>
</tr>
<tr>
<td>Information governance</td>
<td>32</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>32</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>31</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>30</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>27</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>12</td>
</tr>
</tbody>
</table>

In maternity and gynaecology, the 95% target was met for two of the 12 mandatory training modules for which medical staff were eligible.

All medical staff had received dementia awareness training. Only 30.8% of medical staff were trained in level two infection prevention which equated to 12 out of 39 staff having received the training. There was not a clear breakdown of the trust mandatory training compliance between gynaecology and maternity staff. Following the inspection, we requested a breakdown of training rates to identify maternity medical staff compliance, however this was not provided. We could not be assured medical staff had reached the trust target for training. This meant some medical staff may have been unfamiliar with the latest practice updates for infection prevention, conflict resolution and adult basic life support.

For the previous financial year; April 2018 to March 2019 medical staff achieved an 80% completion rate for mandatory training.

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

**Safeguarding**

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.

Midwifery staff received training specific for their role on how to recognise and report abuse. Staff had a good awareness of the signs of safeguarding and the actions they should take to keep
people safe. Staff asked women questions about domestic abuse when admitted and discussed any concerns during each ward handover. Women attending the day assessment unit were seen privately to discuss any concerns. Staff reported knowing how to contact the safeguarding midwives for support.

Staff usually knew how to make a safeguarding referral and who to inform if they had concerns. The mandatory training week included a safeguarding training session from a social worker. This explained the safeguarding thresholds, signs of safety and referral process.

The safeguarding midwife team had been increased to two midwives. They attended the morning safety huddle on labour ward and offered advice, identified women at risk and took referrals. All women under the age of 19 were routinely referred to the safeguarding team, usually by community midwives at booking. The teenage pregnancy pathway was reviewed to provide support for women under the age of 25 who were at risk.

**Safeguarding training completion rates**

The trust set a target of 95% for completion of role specific, midwifery, safeguarding training. Within the midwifery staff group all targets were exceeded. This meant staff were knowledgeable about safeguarding. This was an improvement from the last inspection in 2018.

**Service level**

A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 at service level for qualified nursing and midwifery staff in maternity is shown below. The data provided by the trust did not identify maternity support workers or clerical staff.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>176</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>176</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>175</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>174</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>174</td>
</tr>
</tbody>
</table>

In maternity the 95% target was met for all the five safeguarding training modules for which qualified nursing and midwifery staff were eligible.

For the previous financial year; April 2018 to March 2019 qualified nursing and midwifery staff achieved a 94% completion rate for safeguarding training.

**Royal Cornwall Hospital maternity department**

A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 for qualified nursing and midwifery staff in maternity at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>114</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>114</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>114</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>114</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>113</td>
</tr>
</tbody>
</table>

The 95% target was met for all the five safeguarding training modules for which qualified nursing and midwifery staff in maternity at Royal Cornwall Hospital were eligible. This did not include community midwifery staff, although the trust target was still met within community.

For the previous financial year; April 2018 to March 2019 qualified nursing and midwifery staff achieved a 93% completion rate for safeguarding training.

After the inspection we requested updated training compliance rates. In November 2019 midwifery safeguarding training had improved for safeguarding adults and children level one at 99.5%, although safeguarding adults level two was 98.5%, children level two was 99% and children level three was 98.1%. This small reduction in training compliance may have been because of staff turnover, but the trust target of 95% was still met for midwifery staff.

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

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. The service had a dedicated team to provide care for the travelling community. A multi-agency approach was used to engage these women and families with healthcare needs to improve access to services.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Within the unit, and the community, there was dedicated safeguarding supervision for midwives, provided by the safeguarding midwives team or community team leaders who were supported by the safeguarding team. The supervision enabled midwives to reflect on the safeguarding needs of women they cared for. The maternity caseload included women and families with complex social needs including young parents, previous social care involvement, mental health issues, substance misuse and women with learning disabilities. The safeguarding team provided practical support on the wards and at staff huddles, which staff found beneficial.

There were mandatory questions in the maternity booking system to recognise female genital mutilation (FGM). All staff undertook training for FGM, although they rarely cared for women with FGM.

Health visitors attended the maternity safeguarding training day. This encouraged sharing of ideas and approaches to care which aided in identifying adults and children at risk.

A safeguarding record was maintained for women at risk. The patient specific record was accessible by all midwives within a shared folder which was protected from editing. Only band seven midwives, community team leaders and the safeguarding midwives had permission to save new entries. This provided an opportunity for oversight of the concerns, assessment of appropriate actions and allowed for feedback to the midwife adding to the record. The safeguarding record included entries from the antenatal, labour and birth and postnatal period. It was designed in a format similar to a neighbouring trust where a proportion of the local community chose to give birth. This assisted in the handover of safeguarding concerns.

Staff were aware of the baby abduction policy and undertook baby abduction drills. The abduction policy and procedures detailed actions to be taken at the time of an abduction. A baby abduction drill had been undertaken within the past three months on the delivery suite.

Medical staff received training on how to recognise and report abuse but did not meet the trust target and were not trained to level 3 safeguarding children.
The trust did not report maternity and gynaecology staff training separately, therefore a breakdown of compliance for safeguarding training courses from April 2019 to July 2019 at trust level for medical staff reported as gynaecology is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>37</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>35</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>29</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>21</td>
</tr>
</tbody>
</table>

*All medical staff in maternity and gynaecology are based in Royal Cornwall Hospital.

In maternity and gynaecology, the 95% target was met for one of the four safeguarding training modules for which medical staff were eligible.

For the previous financial year; April 2018 to March 2019 medical staff achieved an 80% completion rate for safeguarding training.

After the inspection we requested updated safeguarding training compliance for medical staff. The trust told us training in November 2019 met the target at 95% for level one adults and children for medical staff. Compliance rates for level two had improved but not yet met the trust target, with 72.5% medical staff trained to level two adults and 85% trained to level two children. However, we were not provided with a breakdown of this data. As a result, it was not clear what percentage of medical maternity staff had completed safeguarding training in comparison to gynaecology staff. The trust advised this was due to the obstetricians and gynaecologists sharing the same cost centre.

The trust advised that level three safeguarding training was not required, however this did not follow guidelines set out in the safeguarding intercollegiate document (Safeguarding children and young people: roles and competencies for healthcare staff, 2019) which states that all health professionals working with children should be trained to safeguarding children level three. There was a risk that without the training medical staff would not recognise safeguarding concerns.

**Cleanliness, infection control and hygiene**

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect women, themselves and others from infection. They generally kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The two obstetric theatres were clean and well-equipped and attached to the central delivery suite. Equipment was visibly clean. We saw evidence of ‘I am clean’ stickers being used which indicated when equipment was last cleaned.

Most, but not all staff followed infection control principles including the use of personal protective equipment (PPE). Most staff were bare below the elbow in clinical areas and PPE was used appropriately. We saw three members of staff wearing jewellery which was not in line with trust policy. Staff followed aseptic non-touch techniques in theatre to prevent contamination of key equipment. Staff washed their hands and used hand gel before and after patient contact. However, we observed 11 members of staff who failed to use the hand gel on entering the delivery suite. While this was in line with trust policy, there was a risk of bacteria present on staff member’s
hands affecting the health and wellbeing of women, their visitors and staff during unplanned contact outside of the bed space.

Hand hygiene audits were completed, and results were displayed for the public to see. Compliance of 100% was achieved on the last audit in October 2019. Antibacterial hand gels were available at the entrance of each ward and throughout the wards.

Staff mostly cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, the birthing pools on the birthing suite did not have documented records to show they had been cleaned. Staff told us there was a cleaning procedure, however they were unable to confirm whether the birthing pools were clean on our inspection, so we could not be assured they were clean. The birth pools did not have an ‘I am clean’ sticker attached to them. When requested, documented records of the cleaning of birth pools were not provided although we saw evidence of daily room cleaning but did not include the birth pool.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment usually kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Daily and weekly safety checks of specialist emergency equipment were not always completed on the birth centre. 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.

At the last inspection in 2018 we found equipment checks were not always documented and completed. At this inspection we found staff still did not always carry out daily safety checks of adult and neonatal resuscitation equipment on the birthing centre. This had not improved since the last inspection. We found 10 weekly checks of the birth centre adult emergency resuscitation trolley had not been completed in the time from August 2019 to the inspection in November 2019. 12 daily checks were also not documented. The neonatal crash trolley daily checks were missed 14 times in nine months and the full content weekly check was missed 19 times in seven months. There was the potential for equipment to have expired, be unavailable or in need of repair. However, checks on the specialist equipment on the Delivery Suite, Wheal Rose and Wheal Fortune wards were completed.

The resuscitation algorithm was not available on all neonatal resuscitaires. Only one of the five resuscitaires checked on the inspection had the resuscitation algorithm available for staff to refer to in the event of neonatal resuscitation. There was a risk of delays in the provision of emergency care.

Staff were aware of where emergency equipment was located. This included resuscitation equipment and equipment to respond in the event of an emergency haemorrhage. Training had been provided to ensure staff followed standard procedures in the event of an emergency.

Security arrangements on wards and the labour ward was by means of security intercoms. Members of staff gained entry through a card swipe system. Staff identified visitors using CCTV to grant them access. There were notices on ward doors to remind visitors not to let anyone in before staff had identified them. We heard staff asking appropriate questions to visitors before admission to the unit.
The service had enough suitable equipment to help them to safely care for women and babies. At the last inspection in 2018 we found a damaged shower, birth pool and infant feeding equipment not replaced or repaired to prevent infection risks. At this inspection we found this had improved and showers were in a good state of repair throughout the unit. Toilets had been added to shower rooms to improve privacy, dignity and comfort. All electrical equipment we checked had ‘in date’ safety testing stickers on them.

The birth pool evacuation process was understood by staff but not supported by guidelines. At the last inspection in 2018 we found the emergency birth pool evacuation processes in the community were not appropriate and not understood by all staff. At this inspection we found some improvement with photos and videos available as prompts for staff to show the step-by-step process of pool evacuation. However, there was inconsistency between the guidance and what staff told us was expected in terms of numbers of staff required to evacuate a woman from the pool. We spoke with staff on the birth centre and managers who were trained in pool evacuation. A typing error was found in the guideline, which altered the instructions and staff requirements. Managers agreed to amend the guideline to match the risk assessed pool evacuation process which staff were trained in. The guidelines were updated in December 2019.

Babies who had died and products of conception were stored in an orderly and dignified way. Temperatures of the main fridges in the mortuary were connected to a central system that monitored fluctuations and alerted relevant people in the event of a malfunction. Capacity of the dedicated fridges met demand.

The mortuary had an electronic tracking system of all bodies in the mortuary which logged their length of stay and any decisions that were needed. For example, whether a post-mortem was required. The local Coroner also had access to this system. There was a clear identification process which included wristbands.

Women could reach call bells and staff would respond quickly when called. Staff ensured women who had limited mobility, particularly immediately following birth, had call bells to hand.

The service had suitable facilities to meet the needs of women's families. Partners could stay overnight with women and reclining chairs and temporary beds were provided for them to sleep in. Curtains were provided around the bed space to provide privacy; however, these did not display a replacement date. We could not be assured there was a system to replace curtains periodically, to keep them clean.

Staff disposed of clinical waste safely. Waste was segregated and managed according to the risk of infection. Sharps boxes were labelled appropriately, not overfilled, usually closed and tagged to prevent access to discarded sharp items. The sharps bins that were not closed were stored in locked rooms.

The second theatre was recognised as being too small but there were plans to increase its size. The second theatre was on the risk register for being too small for routine surgeries, although staff said it was still useable. It was also rated high on the risk register due to not having a dedicated resuscitaire for neonatal resuscitation, which could cause treatment delays. To reduce this risk, staff used the first theatre for routine lists and the second theatre for emergencies, although there was potential for neonatal resuscitation to be more likely in emergency situations. The trust had plans to increase the size of the second theatre in January 2020 to meet the demands of the elective caesarean list.
Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and acted quickly when women were at risk of deterioration.

At the last inspection in 2018 we found risk assessments were not completed in full and actioned in a timely manner. At this inspection we reviewed 10 sets of notes and found risk assessments were completed and updated, and action was taken to remove or minimise risks. This included comprehensive risk assessments for women at the time of their first antenatal appointment. These included body mass index (BMI), smoking, gestational diabetes, pre-eclampsia, mental health issues and pre-existing health problems or vulnerable circumstances. This was an improvement on the last inspection in 2018.

Staff knew about and dealt with any specific risk issues. Women received a risk assessment for venous thromboembolism (VTE) and bleeding at booking, in labour and during post-natal care in line with national guidance.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. There were processes to identify and respond to changing risk, deteriorating health and medical emergencies. There were procedures to aid decision-making and staff told us of circumstances when they had escalated concerns and the support they had received. Modified early obstetric warning system (MEOWS) was used to monitor women’s health and wellbeing and to identify deterioration using physiological parameters.

Staff completed risk assessments for each woman on admission / arrival using a recognised tool, and reviewed this regularly, including after any incident. Observations were performed and recorded on the MEOWS chart and recorded in the women’s notes. Records documented correct scores. Staff understood and used the sepsis screening tool and knew when to perform screening for sepsis.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

Staff were supported by the psychiatric liaison team and the perinatal mental health team for advice with any mental health concerns. Staff knew how to contact the psychiatric liaison team and told us they responded quickly. Staff described how the team responded within one hour following an incident on Wheal Fortune. Staff felt the daily safety huddle was a supportive forum which allowed discussion of concerns with the perinatal mental health team.

A laminated record of contact details for the learning disabilities and mental health specialist nurses was available on the wards. Staff contacted the teams for support as needed.

Women with identified mental health concerns who were known to the perinatal mental health team would attend the ward with personalised plans. We found a detailed personalised plan which included goals and outcomes, medication, impact of medication on feeding, triggers, relapse indicators and crisis and contingency contact numbers. However, we found not all eligible women had a personalised plan, despite having identified mental health concerns.

Staff shared key information to keep women safe when handing over their care to others. The service had introduced a new process to identify women frequently attending the day assessment unit. Women who attended had a red stamp on their paper notes and attendance was noted in
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Electronic records. If a woman attended by self-referral three times, the community midwife responsible for her care was notified to investigate any underlying problems. A chronology of visits would commence, and a safeguarding referral considered. It was too early to evaluate the effectiveness of this process.

Shift changes and handovers included all necessary key information to keep women and babies safe. Ward handovers were informative and included the women's risks, support and family situation.

Cardiotocograph (CTG) recordings for women could be viewed in real time on the delivery suite, even when they were completed on a different ward. A CTG is a machine used to record the fetal heartbeat and uterus contractions during pregnancy, to assess fetal wellbeing and the progress of labour. This meant doctors or senior midwives could offer advice without leaving the delivery suite.

**Theatre safety**

There were arrangements to ensure checks were made before and after surgical procedures. During our inspection we observed safety briefings and a team briefing in obstetric theatres prior to a procedure. We observed the World Health Organisation (WHO) checklist, used to identify risk factors, undertaken prior to a procedure. The use of the checklist is a requirement of the National Safety Standards for invasive procedures, introduced by NHS England in 2015 to improve patient outcomes. A maternity documentation pack for theatre was introduced in August 2019 which included the WHO checklist and comprehensive proformas for before and after theatre use.

The WHO checklist audit for 2018 demonstrated a compliance rate of 100%. Following the inspection, we requested the results of the 2019 audit.

<table>
<thead>
<tr>
<th>Theatre Suite</th>
<th>Lists Performed Month</th>
<th>Submitted Forms Month</th>
<th>Overall compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity 1</td>
<td>74</td>
<td>56</td>
<td>Oct 2019 75.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sept 2019 75.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>August 2019 80%</td>
</tr>
<tr>
<td>Maternity 2</td>
<td>9</td>
<td>4</td>
<td>Oct 2019 44.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sept 2019 NO DATA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>August 2019 85.70%</td>
</tr>
</tbody>
</table>

For August, September and October 2019 the WHO checklist compliance was variable and did not meet 100%. Within maternity overall compliance was 60.05% for October 2019 compared to September 2019 of 37.7% and August 2019 of 82.85%. Compliance had reduced. This meant we were not assured compliance was sustained.

**Mental Health**

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman’s mental health.

If a patient was assessed to be at risk of suicide or self-harm, the perinatal mental health midwife was made aware, and the perinatal mental health nurse could be contacted for support. The service had an out of hours number to contact the Psychiatric Liaison team.

Wheal Fortune ward did not have any specific designated mental health beds and could not always offer women with mental health concerns a side room as there were only five side rooms on the ward. Women at risk of self-harm or suicide were placed near to the midwives’ station where possible. On Wheal Rose women had side rooms next to the midwives’ station so they were in clear sight of staff.

Not all staff were familiar with the holding powers under the Mental Health Act (s5(2) doctor’s holding power and s5(4) nurse’s holding power). If staff felt concerned and needed to prevent
someone leaving they would bleep the perinatal mental health team, or they would call security if there was a risk of harm to the person or someone else. Rapid tranquilisation had not been required for any women, but staff would contact the perinatal mental health team if this was considered necessary.

**Triage**

There were systems to assess (triage) women in the antenatal or postnatal period, who contacted the central delivery suite with concerns. The service had an antenatal day assessment unit (DAU) for women who had appointments for daily blood pressure checks, cardiotocographs (CTG’s), repeat blood sampling or pre-operative assessment. The DAU worked closely with the fetal medicine team and had two emergency scanning slots available if required. The service also offered same day emergency appointments. They took referrals from GPs; community midwives’; other parts of the hospital or women could self-refer. The DAU was midwife led but, if necessary, women could be reviewed by doctors and admitted to the antenatal ward.

**Midwifery staffing**

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

The service had enough nursing and midwifery staff to keep women and babies safe. During the inspection the service was supporting many midwives who were new to the trust, some of whom were newly qualified. There were minimal vacancies following this recruitment. Core and rotational roles were available within each maternity team. The supernumerary band seven delivery suite midwife and clinical skills facilitators supported midwives to develop their clinical competencies. Managers recruited to staff the continuity of carer teams and midwives who had completed their 12-month preceptorship were encouraged to rotate to the community. Staff explained this was to consolidate junior midwives’ practice and to help maintain adequate staffing within the community. A comprehensive competency programme was used to train band two maternity support workers to band three. The competencies included taking bloods and cannulation. Staff explained there were minimal maternity support worker vacancies because bank maternity support workers were trained to meet the clinical skills required by a band three, during their bank shifts. Bank shifts were completed by the flexible workforce to fill the rota gaps experienced due to permanent staff sickness and vacancy. This meant bank staff had the skills to apply for a band three position when a post became available.

Managers accurately calculated and reviewed the number and grade of midwives and maternity support workers needed for each shift in accordance with national guidance. The service was anticipating an external workforce review the week after the inspection. This was organised in response to the change in community working to achieve the continuity of carer targets. The last external review was two years previously with an internal review presented to board in October 2019. The service had a rota coordinator who was responsible for managing the maternity rotas and reviewing the skill mix. This was a full-time role and staff felt it was improving the filling of bank shifts.

The ward manager could adjust staffing levels daily according to the needs of women. During the inspection, managers were observed discussing staffing levels and requesting specialist midwives to work clinically. Staff explained how birth centre midwives worked on the delivery suite when there were no low risk women in labour. A sign was put on the birth centre doors to
advise women arriving to contact the delivery suite and staff would return to the birth centre.

**Trust level**

The table below shows a summary of the nursing and midwifery staffing metrics in maternity at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate (Jul-18 – Jun-19)</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>3.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>221.9</td>
<td>8%</td>
<td>2%</td>
<td>5.1%</td>
<td>24,237 (8%)</td>
<td>94 (&lt;1%)</td>
<td>13,149 (4%)</td>
</tr>
<tr>
<td>Qualified midwives</td>
<td>167.3</td>
<td>7%</td>
<td>2%</td>
<td>4.8%</td>
<td>24,237 (8%)</td>
<td>94 (&lt;1%)</td>
<td>13,149 (4%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The data for sickness rates was provided for a different time period (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

Midwifery staffing rates within maternity were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for bank use and agency use. There is not enough variation in the turnover rates over the last 12 months for qualified midwives to comment on the performance of this metric over time.

**Vacancy rates**

![Vacancy rate - qualified nurses, health visitors and midwives](image)

Monthly vacancy rates over the last 12 months for qualified midwives shows a downward trend from November 2018 to March 2019. In addition, it shows an upward trend from March 2019 to July 2019. During this time the service recruited several specialist midwives’ roles, leaving vacancies when staff progressed internally. The service experienced several retirements but responded to the vacancy by recruiting 14 midwives who joined the trust in September 2019.

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

The service had reducing vacancy rates. 14 new midwives were employed in September 2019 in response to rising vacancy rates. We requested the latest vacancy rates, but the information was not made available. Managers told us the high level of recruitment had reduced the vacancy rate.
Sickness rates

Monthly sickness rates over the last 12 months for qualified midwives shows a shift from January 2019 to June 2019.

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

The service had mostly reducing sickness rates. Sickness rates for hospital based maternity support workers were reduced in October 2019 at 3% with hospital midwives sickness relatively stable at 5%. However, community midwife sickness rates were high in the community at 11% and 12% in September 2019 and October 2019 due to long term sickness. Despite this rise, there was no community maternity support worker sickness, although these staff numbers were significantly lower.

Royal Cornwall Hospital

The table below shows a summary of the midwifery staffing metrics in maternity at Royal Cornwall Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate (Jul-18 – Jun-19)</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>140.5</td>
<td>10%</td>
<td>10%</td>
<td>3.8%</td>
<td>22,746 (11%)</td>
<td>94 (&lt;1%)</td>
<td>13,055 (6%)</td>
</tr>
<tr>
<td>Qualified midwives</td>
<td>101.9</td>
<td>6%</td>
<td>4%</td>
<td>4.3%</td>
<td></td>
<td>3.8%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The data for sickness rates was provided for a different time period (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

Midwifery staffing rates within maternity at Royal Cornwall Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness, bank use and agency use. There is not enough variation in the turnover rates over the last 12 months for qualified midwives to comment on the performance of this metric over time.
The service had reducing rates of bank staff usage. This was because the service had recently recruited 14 midwives in response to the vacancy rate. Although bank shifts were still advertised and filled to cover the midwife and maternity support worker sickness levels.

**Vacancy rates**

Monthly vacancy rates over the last 12 months for midwives shows a shift from February 2019 to July 2019. This increase in vacancy rate linked with the introduction of specialist midwife roles, uplift in staffing to provide continuity of carer within the community teams and rise in the number of staff retiring from the service.

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

**Midwife to birth ratio**

From January 2018 to December 2018 the trust had a ratio of one midwife to every 25.8 births. This was similar to the England average of one midwife to every 24.6 births.

(Source: Electronic Staff Records – EST Data Warehouse)

For October 2019 the unit had a ratio of one midwife to every 29 births, which, although higher than the England average, was within accepted levels on the maternity dashboard. The maternity dashboard is a monthly score card used to record the performance of the maternity unit and identify patient safety issues in a timely manner. Safe staffing was monitored on the monthly dashboard and changes would be identified and reviewed if they deviated from the normal levels. Staff explained women awaiting an induction of labour on the labour ward would remain on the Wheal Rose antenatal ward until one to one care was able to be provided, to promote safer labour care.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough medical staff to keep women and babies safe. The consultant presence in the delivery suite met the Royal College of Gynaecologists and Obstetricians Good Practice Guidelines (2010). The recommended consultant cover for a unit with up to 4,000 births was 60 hours per week. Consultant cover was planned between 8.30am and 7.30pm on weekdays, four hours on a Saturday and two hours on Sundays, although staff commented they often worked longer hours. Staff spoke of having easy access to consultants out of hours, with consultants on site within 30 minutes of a call.
The medical staff matched the planned number. We reviewed obstetrician rotas and found the on calls were covered. This corresponded with obstetricians reporting they were fully staffed. A duty anaesthetist was available 24 hours a day and a theatre team were assigned to staff theatre one. In the daytime a consultant anaesthetist was working with a registrar and junior anaesthetist in training. Between 8pm and 8am one anaesthetist was available for maternity with an operating department practitioner, but a consultant anaesthetist was on call and could be called in within 20 minutes.

**Trust level**

The trust did not report maternity and gynaecology medical staff separately, therefore the table below shows a summary of the medical staffing metrics reported in both maternity and gynaecology at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate (Jul-18 – Jun-19)</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>72.3</td>
<td>6%</td>
<td>0%</td>
<td>1.8%</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Medical staff</td>
<td>37.6</td>
<td>6%</td>
<td>0%</td>
<td>0.3%</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The data for sickness rates was provided for a different time period (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

There is not enough variation in the turnover rates, bank use and locum use to comment on the performance of these metrics over time. However medical staffing appeared stable with minimal turnover.

**Vacancy rates**

Monthly vacancy rates over the last 12 months for medical staff shows a shift from February 2019 to July 2019. This could be an indicator of change.

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

**Sickness rates**
Monthly sickness rates over the last 12 months for medical staff shows a shift from January 2019 to June 2019. At the time of the inspection medical rotas were complete and we were not informed of an increase in medical sickness.

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

**Staffing skill mix**

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Middle grade medical staff provided overnight and weekend cover but called upon consultants for support.

In May 2019, the proportion of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust was about the same as the England average.

**Staffing skill mix for the 33.3 whole time equivalent staff working in maternity 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>44%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>42%</td>
<td>44%</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

(Source: NHS Digital Workforce Statistics)

The service always had a consultant on call during evenings and weekends. Midwives were able to call in a consultant out of hours. Staff told us consultants were on site within 30 minutes of a call. We found no gaps in the on-call rota.

**Records**

Staff kept detailed records of women’s care and treatment. Records were clear, up to date, easily available to all staff providing care. They were not always stored securely.
Women's notes were comprehensive, and all staff could access them easily. We reviewed ten sets of clinical records and found good record keeping. Records were clear, up to date, stored securely and easily available to all staff providing care, although not all entries were timed. This was particularly evident in the antenatal note entries. Notes were a mixture of paper and electronic records. The trust had invested in a digital midwifery team (currently two members of staff) to progress the local maternity system plans to plan and prepare for a paperless electronic system. Since July 2019, women had access to their own personal health record as well as their written notes. At the 12-week booking appointment, women were given a password and logging in details to the ‘Wellbeing Personal Health Record’. Women could access ‘read only’ copies of their notes.

All records were accessible to a range of healthcare professionals during pregnancy, labour and the postnatal period. Therefore, when women transferred to a new team, there were no delays in staff accessing their records. Community midwives were contacted when a woman was discharged, and an electronic discharge summary sent to the GP.

Records were not always stored securely in ward areas. We found a computer unlocked and unattended on the antenatal ward with patient identifiable information displayed.

Records identified mental health concerns, although personalised mental health plans were not always available. It was flagged on a woman’s paper records that mental health concerns had been identified. If seen by the perinatal mental health team a yellow perinatal mental health plan was created with the woman. This was scanned and uploaded onto the woman’s electronic records system. The plan included discussion around triggers and monitoring of a woman’s mental health, however this process had not been used consistently as one of the two records of women with mental health concerns did not contain a personalised mental health plan.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines, but these were not always followed.

Staff mostly followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely in locked trolleys and doors were locked to treatment rooms with access restricted to appropriate staff. Controlled drugs were stored securely, but records were not always completed in line with trust policy. There was no second signature on nine administration records dated between 23 October 2019 and 4 November 2019. The name, form and strength of controlled drugs was not always recorded on the top of the record book on the delivery suite, Wheal Rose and Wheal Fortune. Regular balance checks were performed in line with trust policy.

Community midwives administered flu vaccinations under a patient group direction (PGD) but most did not contain an authorising signature. PGDs were in use and there was a procedure in place to review them. PGDs are written instructions which allow specified healthcare professionals to supply or administer particular medicines in the absence of a written prescription. Of the 19 flu PGD records reviewed, 12 did not contain an authorising manager’s signature. Of the pertussis (whooping cough) PGDs only three of 17 contained an authorising manager’s signature. This was not in line with the PGD policy.

Staff reviewed women's medicines regularly and provided specific advice to women and carers about their medicines. A pharmacist visited the wards daily to review prescriptions and advise medical staff when doses needed to be revised. Calling cards were left at the bedside of women who had left the ward to visit their baby on the neonatal unit. The calling cards informed women they had missed their medication and to contact a midwife on returning to the ward.
Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Medicines fridge and treatment room temperature checks were completed, and records showed medicines were stored at the correct temperatures.

The electronic prescribing and medicines administration (EPMA) system was password protected and secure. Other prescription stationary was stored securely.

Staff followed current national practice to check women had the correct medicines. Policies and procedures were available and accessible to staff via the trust intranet. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines. Clinical guidance was also available on the trust intranet.

Patient’s medicines were reviewed in line with current national guidance on admission and when transferring between locations.

On Wheal Fortune postnatal ward staff told us they sometimes had patients on the ward with a methadone script. Under these circumstance staff would seek additional support from a local substance misuse charity.

Midwifery exemptions complied with national legislation. Midwives exemptions allow midwives to supply some medicines without the need for a prescription or instruction from a medical practitioner.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. Staff told us how they reported incidents relating to medication errors through the trust’s electronic reporting system. Staff we spoke with felt confident in raising an incident. Managers investigated incidents and shared lessons learned with the whole team and wider service.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent.

Women were not always prepared for an extended stay in hospital for additional monitoring of their baby. Neonatal observations are recommended for babies of mothers who took antidepressant medication, prescription pain relief or misused substances in pregnancy. The observations assess a baby’s wellbeing once they stop receiving the substances through the placenta, with some babies displaying symptoms of withdrawing from the medication. However, we saw some evidence of this discussion within maternity records, although staff felt some women could have been more prepared for an extended postnatal stay. The head of midwifery advised the patient information was being updated in response to the opening of the transitional care beds in November 2019.

Incidents

The service managed safety incidents well. Staff recognised incidents and near misses 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 women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with trust policy. At the last inspection in 2018 we found learning from incidents was
not shared. Learning and actions from perinatal mortality and morbidity reviews were not documented and were therefore not open to challenge, debate or discussion. At this inspection we found good sharing of learning from incidents. This was improved from 2018.

Staff were aware of the incident reporting trigger list which detailed the typical reasons for completing an incident report. Staff were aware they could also report incidents which were not on the trigger list.

**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.

The service had no never events on any wards. From October 2018 to September 2019, the trust reported no never events for maternity. At the time of our inspection there were no reported never events since September 2019.

*Source: Strategic Executive Information System (STEIS)*

**Breakdown of serious incidents reported to STEIS**

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported 19 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from October 2018 to September 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: baby only</td>
<td>17</td>
<td>89.5%</td>
</tr>
<tr>
<td>(this include foetus, neonate and infant)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td>VTE meeting SI criteria</td>
<td>1</td>
<td>5.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

*Source: Strategic Executive Information System (STEIS)*

Managers investigated incidents thoroughly. Clear reviews of the events leading up to the incident were visible in the last three serious incident reports, reviewed as part of the inspection. A detailed action plan was included in each report. Staff, women and their families were involved in these investigations. Weekly patient safety meetings reviewed incidents and monitored action plans to ensure lessons were learnt and investigations completed. We reviewed the last three serious incident reports and action plans. Incident reviews were clear and detailed with relevant action plans.

Managers debriefed and supported staff after any serious incident. The service had a professional midwifery advocate (PMA) team and were awaiting a full-time position which they had recruited to. The PMA was introduced to replace midwifery supervision and was being used to debrief midwives after serious incidents or practice concerns. The PMA’s were accessible by medical staff as well as midwives and the team used a room off site to debrief away from the maternity setting.

The service used the perinatal mortality review tool, a national tool from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), to review all stillbirths and neonatal deaths over 22 weeks. Staff told us the mortality and morbidity meetings were multi-disciplinary and were documented, with the perinatal mortality review tool...
updated online in real time and an action log ensured actions were followed up. Following the inspection, we requested the minutes of the morbidity and mortality meetings. The minutes and action plan were clear with good meeting attendance. Questions from the family were discussed and a response agreed by the meeting attendees. Trust board was due to be updated by a bereavement midwife and the lead for mortality review in the trust at the next board meeting.

Staff met to discuss feedback from investigation of incidents and look at improvements to women’s care. Learning was disseminated through the monthly patient safety newsletter and tip of the week updates which were emailed to all staff. Serious incident summaries and Healthcare Safety Investigation Branch (HSIB) investigations were included in the patient safety newsletter. The informative monthly bereavement newsletter included learning points following perinatal mortality reviews with reminders of best practice and recommendations to improve care. Staff told us the emails were helpful to inform their practice. Community staff had laptops and were able to regularly access their emails, although hospital staff commented they were not always able to read their emails during their work hours. Specific feedback was given if staff requested feedback when using the incident reporting system. Important updates were also shared at the daily safety huddle.

We reviewed the ‘tip of the week’ emails and found them to be clear and informative. However, in the last six months only 15 updates had been sent. This meant updates were sent to staff 50% less frequently than expected.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Staff were familiar with duty of candour and knew when to apply it. We reviewed action plans from the three last serious incidents and saw that women and their families were given full explanations following an investigation.

There was evidence that changes had been made as a result of feedback. The antenatal day assessment unit (DAU) used the Birmingham Symptom-specific Obstetric Triage System as there was no standardised triage system within maternity for women who attended for unscheduled appointments. Previously, they were usually seen in the order in which they arrived, which resulted in delays. As a result of learning from a serious incident, the antenatal day assessment unit had introduced an initial triage in a separate room so that women were seen within 15 minutes of arrival. However, it was too early to evaluate its success.

**Safety thermometer**

The service used monitoring results to improve safety although they were not clearly displayed for staff, women and visitors.

Information about patient safety was not clearly displayed. This meant women, their families and staff would be unaware of how the service was performing. We reviewed all clinical areas and found no safety thermometer results, although in public areas some information such as hand hygiene audit results were displayed and in date. Managers had access to the maternity dashboard and were aware of the service performance. Team leaders also maintained social media sites and displayed performance statistics for staff and women to see, for example, for the birth centres.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.
Staff followed up to date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed the following policies, guidelines and care pathways: shoulder dystocia, tongue tie division, infant feeding, waterbirth, did not attend or booked late for antenatal care, increased body mass index (BMI) in pregnancy and hypertension. All had clear pathways for treatment, referenced to the appropriate Royal College of Obstetricians and Gynaecologists guidelines and NICE clinical guidelines. Guidelines were all in date, with most having been reviewed in October 2019 or November 2019. There was a rolling programme of guidelines managed by the practice development midwife who reminded guideline owners when their guideline was six months from the review date. Structured guideline meetings were held monthly and included a multi-disciplinary approach. A maternity voices partnership (MVP) representative attended the meetings to provide a service user view on the wording and impact of the guidelines.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. Any concerns about a patient’s mental health would be flagged to the perinatal mental health team or community midwife before discharge. Staff on the wards used the GAD (generalised anxiety disorder) and PHQ (patient health questionnaire) questionnaires if they had any concerns.

We attended handover meetings throughout the unit and found staff routinely referred to the psychological and emotional needs of women, their relatives and carers. Staff discussed the needs of women and their families, especially when relatives stayed overnight on the antenatal and postnatal ward. Staff considered the emotional and psychological impact on women whose relatives did not stay overnight.

**Nutrition and hydration**

**Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women’s religious, cultural and other needs.**

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff accurately completed women’s fluid and nutrition charts where needed. There was plenty of choice from the menu and women told us the food was good. Snacks and drinks could be purchased from vending machines outside of mealtimes and there was an ‘out of hours’ menu from the trust kitchen.

There was specialist support from staff. Women were supported to feed their babies by the infant feeding support team who had a dedicated room on the postnatal ward. Women told us staff were reassuring, supportive and knowledgeable, with maternity support workers available to assist. Staff took time to discuss feeding options available, including breast and bottle feeding. We saw written information readily available for both methods of feeding and information boards displaying illustrations / photos of breastfeeding positions and methods. We observed staff assisting women to feed their babies. Women who could not breastfeed were supported to express milk.

**Pain relief**

**Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
Staff assessed women’s pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff prescribed, administered and recorded pain relief accurately.

Women received pain relief soon after requesting it. Women received both written and verbal information about pain relief options available to them in labour during antenatal classes. Staff responded quickly to requests for pain relief and were understanding of women’s pain, including during times of labour.

There were several birthing pools which could be used for pain relief in the birthing centre but not on the labour ward. These were supported by an up to date policy. Birthing pools were not available when the rooms were in use by another woman.

Women who underwent a caesarean section were given advice about pain relief. When at home, they were encouraged to contact their midwife or GP if they needed more than ‘over the counter medicines’.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The service participated in relevant national clinical audits. These included the national maternity and perinatal audit and the national pregnancy in diabetes audit. As part of the inspection we requested a record of all the audits completed in maternity.

Maternal, fetal and neonatal health outcomes had improved since the creation of the Teyluva team, introduced to reduce the miscarriage and fetal loss rate of the travelling community. The uptake vaccination rate improved to 100%.

Managers and staff used the results to improve women’s outcomes. The maternity dashboard was reviewed by the service. It demonstrated performance metrics including; types of delivery including assisted delivery, smoking related indicators, rates of breast feeding, morbidity and mortality. Outcomes were rated as below, in line and above the national average. However, the dashboard did not include data for the number of shoulder dystocia’s experienced or associated brachial plexus injuries. This is when the baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body. A brachial plexus injury is where the baby's neck is stretched to one side. A strong force increases the angle between the neck and shoulders, the brachial plexus nerves might stretch or tear. We could therefore, not be assured the service had oversight of the number of shoulder dystocia or brachial plexus injuries, to improve women’s and neonatal outcomes.

**National Neonatal Audit Programme**

The table below summarises Royal Cornwall Hospital’s performance in the 2018 National Neonatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids? (Antenatal steroids reliably reduce the</td>
<td>82.8%</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
</tbody>
</table>

20190416 900885 Post-inspection Evidence appendix template v4 Page 202
chance of babies developing respiratory distress syndrome and other complications of prematurity)

| Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery? (Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later develop cerebral palsy) | 60% | Within expected range | No current standard |

(Source: National Neonatal Audit Programme)

Managers and staff carried out a programme of audits to check improvement over time. We reviewed the audit programme for 2019 and 2020. We saw evidence on audits of recommendations, progress of actions identified during the audit and plans to re-audit items. This included further review of the causes of postnatal readmissions and any delays experienced on the elective theatre list.

Managers shared and made sure staff understood information from the audits. Learning was shared at audit meetings, in patient safety and practice development newsletters and during the maternity mandatory training week.

Improvement is checked and monitored. We reviewed audits including the neonatal readmission audit. There was a clear plan for further audit and monitoring to identify the causes of maternal and neonatal readmission, to improve care and reduce future readmissions.

**National Maternity and Perinatal Audit Programme**

The table below summarises Royal Cornwall Hospital’s performance in the 2017 National Maternity and Perinatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>98.9%</td>
<td>N/A</td>
<td>Met</td>
</tr>
<tr>
<td>Antenatal measures (before birth, during or relating to pregnancy)</td>
<td>61.0%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date (Babies who are small for their age at birth are at increased risk of problems before, during and after birth)</td>
<td>N/A</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
<tr>
<td>Intra-partum measures (during labour and birth)</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery (For babies with a planned (or elective) birth, being born before 39 weeks is</td>
<td>N/A</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
associated with an increased risk of breathing problems. This can lead to admission to the neonatal unit. There is also an association with long term health and behaviour problems

<table>
<thead>
<tr>
<th>Case-mix adjusted overall caesarean section rate for single, term babies (The overall caesarean section rate is adjusted to take into account differences which may be related to the profile of women delivering at the hospital)</th>
<th>24.5%</th>
<th>Within expected range</th>
<th>No current standard</th>
</tr>
</thead>
</table>

Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7 (The Apgar score is used to summarise the condition of a new-born baby; it is not always a direct consequence of care given to the mother during pregnancy and birth, however a 5 minute Apgar score of less than 7 has been associated with an increased risk of problems for the baby)

<table>
<thead>
<tr>
<th>Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7</th>
<th>1.3%</th>
<th>Within expected range</th>
<th>No current standard</th>
</tr>
</thead>
</table>

Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear (Third or fourth degree tears are a major complication of vaginal birth. Only tears that are recognised are counted therefore a low rate may represent under-recognition as well as possible good practice)

<table>
<thead>
<tr>
<th>Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear</th>
<th>N/A</th>
<th>N/A</th>
<th>No current standard</th>
</tr>
</thead>
</table>

Case-mix adjusted proportion of women with severe post partum haemorrhage of greater than or equal to 1500 ml (Haemorrhage after birth is a major source of ill health after childbirth. Blood loss may be estimated by visual recognition or by weighing lost blood. High rates may be due to more accurate estimation and low rates due to under recognition)

<table>
<thead>
<tr>
<th>Case-mix adjusted proportion of women with severe post partum haemorrhage of greater than or equal to 1500 ml</th>
<th>1.9%</th>
<th>Within expected range</th>
<th>No current standard</th>
</tr>
</thead>
</table>

Post-partum measures (following birth)

Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit (Breastfeeding is associated with significant benefits for mothers and babies. Higher values represent better performance)

<table>
<thead>
<tr>
<th>Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit</th>
<th>79.6%</th>
<th>Middle 50%</th>
<th>No current standard</th>
</tr>
</thead>
</table>

(Source: National Maternity and Perinatal Audit Programme)
Standardised Caesarean section rates and modes of delivery

From January 2018 to December 2018 the total number of caesarean sections was lower than expected. The standardised caesarean section rates for elective sections were similar to expected and rates for emergency sections were 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></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.8%</td>
<td>385</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>16.5%</td>
<td>450</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>29.3%</td>
<td>635</td>
</tr>
</tbody>
</table>

Notes: Standardisation 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. This table includes all deliveries, including where the delivery method is 'other' or 'unrecorded'.

In relation to other modes of delivery from January 2018 to December 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>ROYAL CORNWALL HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections</td>
<td>835</td>
<td>22.1%</td>
</tr>
<tr>
<td>Instrumental deliveries</td>
<td>350</td>
<td>9.2%</td>
</tr>
<tr>
<td>Non-interventional deliveries</td>
<td>2,600</td>
<td>68.7%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>3,785</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

1 Includes elective and emergency caesareans
2 Includes forceps and ventouse (vacuum) deliveries
3 Includes breech and vaginal (non-assisted) deliveries

The percentage of non-interventional deliveries at Royal Cornwall Hospitals NHS Trust was 10.3% higher than the England average and caesarean section rates were 7.2% lower than the England average. We reviewed the latest data for October 2019 and the caesarean rate had increased to 24.4% but was still below the England average. The instrumental deliveries had increased to 12.6% and the percentage of non-interventional births had reduced slightly to 61.6%, although it was 66.8% of births when reviewed over the period of March 2019 to October 2019.

(Source: Hospital Episode Statistics (HES))

Maternity active outlier alerts

As of September 2019, the trust had no active maternity outliers.

(Source: Hospital Evidence Statistics (HES))

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other trusts with similar service provision</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stabilised and risk-adjusted perinatal mortality rate (The death of a baby in the time period before, during or shortly after birth is a devastating outcome for families. There is evidence that the UK’s death rate varies across regions, even after taking into account differences in poverty, ethnicity and the age of the mother.)</td>
<td>4.88 (4.24 to 6.52)</td>
<td>Up to 10% lower than the average for the comparator group</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: MBRRACE-UK)

**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 development.

Midwifery staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. The service had a team of clinical skills facilitators to oversee and conduct training for all midwifery and support staff.

Training for New-born Infant Physical Examination (NIPE) was offered inhouse by the trust or a stand-alone university degree module. As NHS Resolution no longer recognised inhouse training for NIPE the trust had plans to send midwives who required this accreditation to a local university. However, this would no longer be an issue for newly qualified staff as NIPE training was to be incorporated into the midwifery degree. This meant all midwifery staff should be suitably accredited in the future.

Managers gave all new staff a full induction tailored to their role before they started work. Staff felt supported with training and supervision. All newly qualified midwives undertook a 12-month rotational post within the preceptorship programme. This programme supported the newly qualified midwives to build confidence and consolidate learning gained as a student. The clinical skills facilitators had also developed a training programme for maternity support workers. Managers also identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers supported staff to develop through regular, constructive clinical supervision of their work. The service had recently appointed a professional midwifery advocate (PMA) who was an experienced practising midwife to provide supervision and pastoral support to midwifery and medical staff. The PMA was due to start the role in the two months after the inspection. Supervision was accessed through group meetings and one to one contact with the advocate. Junior doctors were also supported through the professional support unit at the Deanery. The clinical skills facilitators supported the learning and development needs of staff.
Managers identified poor staff performance promptly and supported staff to improve. At the time of the inspection there were no restrictions on clinical practice. The clinical skills facilitators (CSF) team included four midwives who supported midwives and maternity support workers with clinical skills and competencies. The CSF’s provided additional support for staff returning from long term sickness or maternity leave, while also supporting community midwives who sometimes transferred labouring women to the delivery suite.

**Appraisal rates**
Managers supported staff to develop through appraisals of their work. Staff mostly had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff spoke of being encouraged to attend conferences and courses to develop their knowledge and expertise.

**Trust level**
From August 2018 to July 2019 83% of required staff in maternity received an appraisal compared to the trust target of 95%. The trust does not report maternity and gynaecology medical staff separately, therefore medical staff reported under gynaecology have been included in the figures below.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Midwifery registered</td>
<td>128</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>38</td>
</tr>
<tr>
<td>Medical</td>
<td>22</td>
</tr>
</tbody>
</table>

None of the three staff groups in maternity met the 95% trust target for completion of appraisals. Medical staff had the lowest appraisal completion rate of 73.3%.

**Royal Cornwall Hospital**
From August 2018 to July 2019 80% of required staff in maternity at Royal Cornwall Hospital received an appraisal compared to the trust target of 95%. The trust did not report maternity and gynaecology medical staff separately, therefore medical staff reported under gynaecology have been included in the figures below.

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<th>Staff group</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Midwifery registered</td>
<td>76</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>24</td>
</tr>
<tr>
<td>Medical</td>
<td>22</td>
</tr>
</tbody>
</table>

None of the three staff groups in maternity at Royal Cornwall Hospital met the 95% trust target for completion of appraisals. Medical and dental staff had the lowest appraisal completion rate of 73.3%. The data within this table did not include the community midwives, reducing the completion rate for midwifery registered staff by 2.2%.
Following the inspection, we requested more recent appraisal data. As of 28 November 2019, 100% of appraisals were completed for additional clinical services; 87.5% of appraisals for administrative and clerical staff; 95% of midwifery staff and 78.6% of medical staff. This was an improvement with two of the staff groups meeting the trust target, although medical appraisal rates remained a concern.

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

Multidisciplinary working

Doctors, midwives, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. We observed a multidisciplinary handover on the labour ward at the start of the day, where all women were discussed. There was a safety huddle at 3pm attended by the matron, ward managers, midwives, labour ward coordinator and roster coordinator. This meeting checked staffing, prioritised and agreed management plans for access and flow especially for women admitted for induction of labour. Doctors and midwives reported good working relationships with each other and there was mutual respect for each other’s professions. Midwives told us if they needed a medical opinion, they were able to get this without delay.

Staff worked across health care disciplines and with other agencies when required to care for women. The fetal medicine team had close links with an NHS trust for advice and support of high-risk women. The service also worked closely with a bereavement charity based at the hospital, the local mental health trust and a local hospice.

Staff referred women for mental health assessments when they showed signs of mental ill health or depression. The mental health assessments were provided by the psychiatric liaison service within the hospital. Women discharged to the community were followed up by the community midwife and mental health service.

The specialist perinatal mental health midwife worked closely with the specialist perinatal mental health team (based in the mental health trust). For women who did not meet their threshold for input, the specialist midwife offered support through listening and signposting.

Staff were able to contact the learning disability team and link nurse, who would visit the ward on request. Wheal Fortune had a folder with easy read leaflets used to discuss child care with parents with a learning disability. This included an all care checklist that new parents could use to mark off when they had completed particular child caring tasks. Staff used this as an observation tool to support parents in caring for their new baby.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including at weekends and out of hours. Women were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Obstetricians were always available, either in person or on call, as well as scanning and diagnostic services. Routine ultrasound scans were available Monday to Friday, although some midwives had been trained to undertake scans out of hours when required.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Community midwives were available at
clinics Monday to Friday and saw women at home. There was an on-call system for bank holidays and weekends. Midwives provided care in the antenatal day assessment unit, seven days per week, 12 hours per day to women who required care either as an outpatient or triage assessment for admission to antenatal or intrapartum services.

Health promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. The trust had input from the local council with a Healthy Pregnancy Team based on the birthing centre. All women were seen after their 12-week appointment and scan where they were given advice about smoking cessation and healthy lifestyle choices. Family members were also given advice and carbon monoxide measurements were completed. This complemented the measurements taken by midwives on the wards and in the community.

Staff assessed each woman’s health when admitted and provided support for any individual needs to live a healthier lifestyle. The service promoted healthy lifestyle choices to women during their pregnancy. Women were encouraged to maintain a healthy diet and there was written information and practical support to help them with this. Specialist advice was also available to women who were alcohol or substance dependant. Women were encouraged to contact their GP, or their midwife, for advice and support. They could be referred to other organisations for specialist support.

Women were encouraged and supported to breastfeed their babies. Women were given written and practical advice by midwives, and breastfeeding support workers. All women had access to information posters and leaflets. All women were offered a breastfeeding booklet which was customised to Cornwall and the Isles of Scilly.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women’s consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff mostly understood how and when to assess whether a woman had the capacity to make decisions about their care. We spoke with eight members of staff regarding consent, capacity and deprivation of liberty safeguards although staff were uncertain about when to use Gillick competence and Fraser Guidelines. Gillick competency is an assessment of a child’s capacity to consent. Fraser guidelines are used to decide if a child can consent to contraceptive or sexual health advice and treatment. Staff usually had knowledge of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983, Mental Capacity Act 2005 and the Children Acts 1989 and 2004. For mental health difficulties, staff were aware of and knew how to approach the perinatal mental health specialist midwife for advice and support. If staff lacked confidence in assessing vulnerable patients, they knew who to contact for assistance.

If a woman had learning disabilities a flag was added to the notes and a learning disabilities nurse would visit and accompany the woman to her scan appointments.

Staff gained consent from women for their care and treatment in line with legislation and guidance. Care records showed that there was a process for women to consent to their midwifery/medical assessment in the hospital and we found these were completed accurately. This meant staff could be assured that consent was appropriately obtained.
Staff clearly recorded consent in the woman's records. Staff always had access to up-to-date, accurate and comprehensive information on women’s care and treatment. All staff had access to the electronic records system that they could all update.

When women could not give consent, staff made decisions in their best interest, considering the woman's wishes, culture and traditions. We saw evidence of consideration and recording of consent to undergo a caesarean section in patient records and were told this discussion always took place between the woman and consultant.

**Mental Capacity Act and Deprivation of Liberty training completion**

Midwifery and medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff were trained to Mental Capacity Act level one. If a patient were to self-discharge staff would assess and record if they had capacity to make this decision on the self-discharge form. However, midwifery staff were unaware of where to record the four-stage test of capacity on the online recording system, although the consultant would typically complete mental capacity assessments.

**Trust level**

The trust set a target of 95% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA training modules from April 2019 to July 2019 at trust level for qualified midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>177</td>
</tr>
</tbody>
</table>

In maternity the target was met for the MCA level one training for which qualified nursing and midwifery staff were eligible; 100% of staff completed the module.

For the previous financial year; April 2018 to March 2019 qualified midwifery staff achieved 100% completion for MCA level one training.

The trust did not report maternity and gynaecology staff separately, therefore a breakdown of compliance for MCA training modules from April 2019 to July 2019 at trust level for medical staff reported as gynaecology is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>39</td>
</tr>
</tbody>
</table>

In maternity and gynaecology, the target was met for the MCA level one training for which medical staff were eligible; 100% of staff completed the module.

For the previous financial year; April 2018 to March 2019 medical staff achieved 100% completion for MCA level one training.

**Royal Cornwall Hospital**

The trust set a target of 95% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.
A breakdown of compliance for MCA training modules from April 2019 to July 2019 at Royal Cornwall Hospital for qualified nursing staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>115</td>
</tr>
</tbody>
</table>

In maternity the target was met for the MCA training module for which qualified nursing staff at Royal Cornwall Hospital were eligible; 100% of staff completed the module.

For the previous financial year; April 2018 to March 2019 qualified midwifery staff achieved 100% completion for MCA level one training.

The trust did not report maternity and gynaecology staff separately, therefore a breakdown of compliance for MCA training modules from April 2019 to July 2019 at Royal Cornwall Hospital for medical staff reported as gynaecology is shown below:

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<tr>
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<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>39</td>
</tr>
</tbody>
</table>

In maternity and gynaecology, the target was met for the MCA training for which medical staff at Royal Cornwall Hospital were eligible; 100% of staff completed the module.

For the previous financial year; April 2018 to March 2019 medical staff achieved 100% completion for MCA level one training.

Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. Staff were committed to supporting women during pregnancy, labour and postnatally to ensure women, and their families, had a positive experience. Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. Staff demonstrated great empathy towards women who experienced loss before, during or after birth.

Women said staff treated them well and with kindness, dignity and respect. Staff introduced themselves by name to women and their partners. Staff described their role and discussed their care and what would happen next. Staff asked women and their partners if they understood everything and asked if they had any questions. Feedback from women, their partners and family were excellent. Comments included, “amazing care”, “blown away by your expertise”, “being able to have a water birth in a calm and relaxed setting made the labour and birth everything I wanted” and “thank you for your patience throughout the birth of our son”.

Staff understood and respected the individual needs of each women and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. If a patient became distressed or anxious, staff told us they would pull a curtain around them for
privacy and would try to move them to a side room if possible. They would offer emotional support and spend time with the woman, referring them to the perinatal mental health midwife if needed. A birth reflections service was run twice a week by midwives to support women who experienced traumatic births.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. Women told us they felt heard and understood by staff. They felt like genuine partners in their care. Staff explained treatment options to women and made decisions together. The Teyluva team of midwives supported the travelling community and provided continuity of midwife to help build relationships with the women and their families.

Staff had arranged for the hospital choir to visit the postnatal ward at lunchtime to sing for patients. Staff had organised a buffet lunch for women and the hot meal was to be served at night so that dinner did not interrupt the concert.

Staff followed policy to keep women’s care and treatment confidential.

**Friends and Family test performance**

**Friends and family test performance (antenatal), Royal Cornwall Hospitals NHS Trust**

From July 2018 to June 2019 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average. Performance ranged from 93% to 100% in the 12-month period with 100% of patients recommending the trust in four of the reported months.

**Friends and family test performance (birth), Royal Cornwall Hospitals NHS Trust**

From July 2018 to June 2019 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average. Performance ranged from 97% to 100% in the 12-month period with 100% of patients recommending the trust in eight of the reported months.

**Friends and family test performance (postnatal ward), Royal Cornwall Hospitals NHS Trust**
From July 2018 to June 2019 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average. 

Performance ranged from 94% to 100% in the 12-month period compared to the England average range of 94% to 95%.

Friends and family test performance (postnatal community), Royal Cornwall Hospitals NHS Trust

From July 2018 to June 2019 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average. In four months, performance was worse than the England average, but the number of responses were low (between five and seven patients responded to the survey in these months) which skew the figures. In a further three months (Dec-18, May-19 and Jun-19) not enough patients responded to the survey to be able to report recommended figures. This was due to a change in the way the service collected feedback from women and their families. Staff advised women and their families preferred giving electronic feedback through a national healthcare feedback website, social media and the maternity voices partnership, instead of using the paper friends and family test cards.

(Source: Friends and Family Test – NHS England)

CQC Survey of women’s experiences of maternity services 2018

The trust performed about the same as other trusts for all of 19 questions in the CQC maternity survey 2018.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score (0-10)</th>
<th>Compared with other trusts</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>8.3</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></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</td>
<td>9.8</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>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time</td>
<td>8.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.5</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.1</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Looking back, was there a delay in being discharged from hospital?</td>
<td>5.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?</td>
<td>7.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?</td>
<td>8.0</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.1</td>
<td>About the same</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2018)

**Emotional support**

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. The service employed a team of specialist bereavement midwives. In the event of a stillbirth or unexpected death in-utero, women and their families were cared for sensitively away from areas where women had delivered their babies. Specially trained midwives, and the chaplaincy if appropriate, supported these women and families including those who had experienced the loss of a baby previously. They worked with women and their families to ensure the precious time they spent with their babies, was as they wanted.

Following delivery, parents made all the decisions. When the baby was delivered, parents were encouraged to bathe and dress their baby including making baby’s handprints and footprints for memory boxes provided to them. The service had provision for photographs to be taken when a
baby had died, to help families remember their baby. Cooled cots (a cooling unit that allowed families to spend extra time with their baby by regulating its temperature) were provided and could be placed in a cot or even a pram. This allowed parents to stay with their babies before their funeral. Babies were kept in a special “daisy” room until transported to the mortuary. Parents were kept informed of their babies’ journey at every step.

All women who lost a baby were supported with postnatal care. The bereavement midwives offered support dependant on individual needs and parents chose the level of support they wanted. The hospital bereavement charity offered counselling one day a week for parents, away from the unit.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. The chaplaincy supported parents and if the situation was urgent, could respond within an hour, 24 hours a day, seven days a week. If parents wanted a blessing, baptism, christenings and other religious or non-religious ceremonies, they met them to discuss their needs. An annual baby remembrance service was held, and parents were offered an entry into the baby remembrance book kept in the chapel. The chaplaincy also conducted funeral services at no charge to parents.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. There was provision for one relative to stay overnight on Wheal Rose and Wheal Fortune wards, to support their loved one. Staff explained relatives mostly stayed on Wheal Fortune postnatal ward, although during the inspection there were relatives staying on the antenatal ward. We observed staff discussing the emotional impact of antenatal hospital stays on women and their families and the impact on women whose relatives chose to not stay overnight.

Understanding and involvement of patients and those close to them

Staff supported women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment. In order to ensure partners were involved in care, the service provided a ‘DadPad’ flip book style pad which was also available to download as an application or access online. It provided information on the midwifery service, health visiting service, feeding, handling, crying, sleeping, changing, cleaning, getting to know your baby, home safety, first aid, child development, supporting each other, legal information.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback was given to the maternity service using social media, through a national website seeking opinions of care and through contact with the active maternity voices partnership (MVP). The maternity voices partnership is a volunteer-led organisation for women and their families to share their experiences and be involved in the transformation of local maternity services. Team leaders monitored and responded to the social media pages. Staff commented that social media allowed women and their families to give prompt feedback which was informative and specific to care settings.

Staff talked to women in a way they could understand, using communication aids where necessary. All women and partners we spoke with talked of positive experiences and how the staff explained things to them.
Staff supported women to make informed decisions about their care. Women were encouraged to ask questions and seek support when they needed it. They were also encouraged to make advanced decisions about their care by completing their birth plan.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Processes were being followed to ensure the maternity services reflected the needs of the local population. The Princess Alexander Wing was opened in 1965 with an expected lifespan of forty to fifty years. Six rooms on the delivery suite were considered too small for assisted deliveries and recovery care. This had been rated as high risk on the risk register. Whilst the trust continued to invest in updates and repair, they were only a temporary solution. Managers felt the chief executive was supportive of plans for a new maternity build in the Royal Cornwall Hospital site. Staff told us the new build was anticipated to be completed in five to seven years.

Flu and whooping cough vaccines were provided by midwives in the community. This avoided women and their families travelling long distances to the hospital. Consultants travelled to community locations to provide the antenatal clinics for women with more complicated pregnancies.

The mandatory training week was not run in August due to the summer holidays and temporary increase in Cornwall's population due to tourism. With increased tourism the unit experienced an increase in out of area admissions. Most management meetings were cancelled in August to avoid poor attendance due to annual leave and to ensure leaders were able to work clinically to support the service.

Facilities and premises were mostly appropriate for the services being delivered. The postnatal ward was provided in the form of a modular ward and renovations had been completed with service user feedback to create a more relaxing environment. Staff told us the temperature on the postnatal ward was often very warm. A garden area was being created to allow better air flow within the ward. This was in response to feedback by staff, women and their families.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems and learning disabilities. Patients who found the environment difficult were supported to spend time in the day room or dining room on Wheal Fortune, although there was limited space for them to access a quiet area. The ward was in the process of arranging for an accessible garden area for patients who needed some quiet space.

The service had systems to help care for women in need of additional support or specialist intervention. The high level of tourism within Cornwall meant women would sometimes attend the maternity unit without their maternity records. All midwives and ward clerks had access to a national child protection information system (CPIS). If women attending the maternity unit were unknown to the service staff could view the information system to find out if there were safeguarding concerns. Accessing the CPIS record automatically notified the relevant social worker that the woman had accessed care within the hospital. However not all counties were registered on CPIS so some information would be unavailable.
Managers ensured that women who did not attend appointments were contacted. A policy was available for staff to refer to. The policy provided clear expectations and management of women who did not attend hospital or community appointments. Women who did not attend their appointments were contacted or visited by midwives and were offered an alternative appointment.

**Bed Occupancy**

From January 2018 to June 2019 the bed occupancy levels for maternity were generally similar to the England average, except in the most recent quarter (Q1 2019/20) with the trust having 51.0% compared to the England average of 58.4%.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

**Meeting people’s individual needs**

The service was inclusive and took account of women’s individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Staff understood and applied the policy on meeting the information and communication needs including women or their partners with a disability or sensory loss. Managers made sure staff, women and their loved ones and carers could get help from interpreters when needed. Information leaflets and website information were available to women in multiple languages and in an easy read format where required. Staff knew how to access the interpretation service. The electronic personal health record had access to information leaflets, some hyperlinked to other languages.

The trust used a ‘DadPad’ flip book style pad. This was also available to download as an application or accessed online. This provided information on the midwifery service, health visiting service, feeding, handling, crying, sleeping, changing, cleaning, getting to know your baby, home safety, first aid, child development, supporting each other, legal information. Partners confirmed it helped them to feel included and they were very positive about it.
Staff made sure women living with mental health problems and learning disabilities received the necessary care to meet all their needs. Women who had mental health needs were under the care of the perinatal mental health team and were seen in the dedicated clinic. Their mental health was assessed at every appointment they attended. The service worked closely with a local mental health trust to improve perinatal mental health with clinics held monthly. The mental health trust also had access to the maternity electronic notes system.

Staff supported women living with learning disabilities or sensory loss. If a pregnant woman had a known learning disability, upon booking in with the community midwife, it would be flagged on the electronic system. The learning disability nurse for the trust would contact the woman and offer to accompany her to appointments to ensure she understood. Women with extra needs had yellow care and birth plans written by the midwife in consultation with the woman. This meant they were easily identifiable. There was a poster next to the intercom at the entrance to wards. The poster advised women and visitors with hearing loss to press the buzzer three times to notify staff they were unable to hear the intercom. A staff member would respond by meeting them at the door.

The community midwives were also in the process of redesigning their way of working to offer more continuity of care for women. This could help support women with learning disabilities as the midwives and woman would be known to one another and would be likely to have identified the most appropriate way to share information.

There was a bereavement suite available for women and families to be cared for whilst grieving which met needs of bereaved women and their partners. The Daisy Suite comprised of a birthing room with en-suite bathroom facilities and a kitchen for parents to use. The suite had its own external entrance and a small garden for women and relatives to use. All normal maternity care was provided to pregnant women from 12 weeks and over for termination for fetal abnormalities and over 14 weeks for intra-uterine death.

The specialist perinatal mental health midwives were in the process of requesting funding for setting up an antenatal choir for mothers with mental health difficulties. The plan was to offer a supportive environment for a group singing experience, also enabling them to offer antenatal checks and individual support during the group as needed.

Care was provided in the community setting, to improve the health outcomes of vulnerable women and their families who were known to have challenges accessing care. The Teyluva midwives team consisted of two midwives who were based in the hospital but visited the community each Wednesday. The team supported gypsy and traveller women and their families through pregnancy, birth and the postnatal period.

A young people’s pathway was used to support young people under the age of 19. In response to staff feedback the pathway was adapted to include women under 25 years who were vulnerable. This included mental health concerns and substance misuse. The pathway recognised the additional support needs of these women, to help improve their pregnancy outcomes, health and wellbeing. Within the community maternity support workers were trained to provide personalised classes to prepare women for parenting a new-born baby. Staff explained this was popular with young people as they often avoided group antenatal classes.

**Access and flow**

Women received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards. Women could not always access the service when they needed it.
Managers monitored waiting times and made sure women could access services when needed and received treatment within agreed timeframes and national targets. Antenatal services were delivered as locally as possible to where pregnant women lived. Community midwives ran antenatal clinics from local GP surgeries and community premises. However, the flow for women requiring induction of labour was, at times, fragmented. Women were admitted but then sent home as capacity issues on the labour ward meant they could not be induced. We spoke to women whose induction had been delayed; they felt staff kept them informed. Staff were aware of the pressures of increasing induction levels in response to saving babies lives. The percentage of inductions were recorded on the maternity dashboard. Between April 2019 and October 2019, the percentage of women being induced ranged from 28% to 37.9% with two months identified as red in the RAG rating, three amber and only two green. A RAG rating is a visual method of analysing a performance target. This meant the induction rate for most months was at a level which could impact upon flow within the unit. However, management were in the process of auditing the length and reason for delays in induction of labour.

The trust was about to introduce an electronic booking system for planned caesarean sections to improve access and flow.

Waiting times from referral to treatment and arrangements to admit, treat and discharge women were usually in line with national standards. The service monitored flow, staffing and efficiency to ensure women could be supported to give birth where they chose, unless complications prevented this.

The midwifery team supported women, who were assessed as being low risk, to choose to have their babies at home or in one of the four birthing centres. Options were discussed at the beginning and during pregnancy and care plans developed. These were tailored to individual women’s needs and preferences. Women who were assessed as being high risk had care plans to offer safe choices of delivery.

Managers and staff worked to make sure women did not stay longer than they needed to. Women were discharged home from the delivery suite or admitted to the postnatal ward for additional care. There was a transitional care ward (within the postnatal ward), which provided additional specialist care for babies. However, the neonatal unit was not close to the postnatal ward.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns and told us they would feel comfortable raising concerns directly with staff. They felt confident their concerns would be taken seriously.

The service clearly displayed information about how to raise a concern in patient areas. Formal complaints were centrally managed by the trust’s complaints team, who acknowledged concerns in writing and allocated them to the relevant managers. Complainants were engaged in and supported through the complaints process. We reviewed the last three complaints and saw evidence of relevant actions being taken because of a complaint. Patients had complained about people smoking outside the main maternity entrance. Women who were discharged with their babies had to walk through the smoke. A pilot had been launched using a recording of a child’s voice to discourage smoking. However, it was too early to evaluate its effectiveness.
Staff understood the policy on complaints and knew how to handle them. Complaints were dealt with locally by managers. The complainant would be offered a local resolution meeting with the ward manager. Managers investigated complaints and identified themes for learning. This was shared with staff.

### Summary of complaints

#### Trust level

From August 2018 to July 2019 the trust received 20 complaints in relation to maternity at the trust (4% of total complaints received by the trust). The trust took an average of 52.3 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 30 days. However, this had improved from the last inspection in 2018 when it took an average of 64.2 working days to investigate and close complaints.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment.</td>
<td>11</td>
<td>55%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharges due to absence of a care package).</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>Communications.</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>Values and behaviours (staff).</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>Privacy, dignity and wellbeing.</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Trust admin/policies/procedures including patient record management.</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Staff numbers.</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20</td>
<td>100%</td>
</tr>
</tbody>
</table>

All the complaints above were reported for Royal Cornwall Hospital. Over half of the complaints (55%) related to clinical treatment.

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

#### Number of compliments made to the trust

From August 2018 to July 2019 there were 143 compliments received for maternity at the trust (2% of all compliments received trust wide).

A breakdown of compliments by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth centre</td>
<td>57</td>
<td>40%</td>
</tr>
<tr>
<td>Delivery suite</td>
<td>36</td>
<td>25%</td>
</tr>
<tr>
<td>Wheal fortune</td>
<td>27</td>
<td>19%</td>
</tr>
<tr>
<td>Wheal rose</td>
<td>23</td>
<td>16%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>143</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

All the compliments above were reported for Royal Cornwall Hospital. The birth centre received the highest amounts of compliments. It is noted that 25 of the 36 compliments for delivery suite (69%) were received in just one month (March 2019). ‘Thank you’ cards and compliments were displayed in all areas of the unit.

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

Staff described knowing how to acknowledge complaints but we did not receive evidence of complaint management. Following the inspection, we requested the last three complaints and the trust response. Managers had spoken with women and their families and relevant action plans...
were created. We saw evidence this was the practice when managing serious incidents and investigations.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff were updated with learning from complaints at the mandatory training week and through brief but informative tip of the week emails. Managers explained additional updates would also be provided following the investigation of serious incidents and investigations.

Staff could give examples of how they used feedback to improve daily practice. Following feedback from service users past and present the maternity voices partnership (MVP) informed the head of midwifery of the impact of wording within the screening guideline. In response to the feedback the word ‘risk’ was replaced with ‘chance’ when referring to the likelihood of a baby having down’s syndrome. This was reinforced to staff by a representative from the MVP teaching on the midwives mandatory training week.

**Is the service well-led?**

**Leadership**

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

Managers were well respected and liked by staff. Maternity was led by the executive manager for the women’s, children’s and sexual health care group, supported by the care group manager, two clinical directors who shared a full-time role and a new interim head of midwifery who was appointed permanently since the 2018 inspection. The head of midwifery reported to the trust’s director of nursing and had direct access to board, where she felt supported. She provided strategic leadership and presented quality reports to the board. The next report was due in December, shortly after the inspection.

The head of midwifery was supported by the deputy head of midwifery who was also a consultant midwife. They were supported by a governance lead and three matrons, two based in the hospital for acute inpatient services and one community matron who worked within maternity and the Cornwall clinical commissioning group (CCG) to transform the maternity service as part of the local maternity system (LMS).

Matrons were visible in the hospital setting and contactable within the community, although not always visible due to the large geographical area covered by the community teams. They participated on the on-call rota for support out of hours and frequently walked around the unit to assess service performance.

The head of midwifery had an open-door policy and was approachable to staff with her office located next to the birth centre. Staff spoke positively of the impact she had on the service and had confidence in the leadership team.

Midwives were supported professionally by a newly appointed team of specialist midwives. This included clinical skills facilitators, bereavement midwives, perinatal mental health, safeguarding, patient safety, audit, practice development, diabetes, fetal monitoring, professional midwifery advocates, digital midwifery team and birth afterthoughts midwives. These specialist midwives were available to work clinically to meet service demands, but also had protected time to complete their specialist roles.
The management team told us of the challenges the service faced and described the aspirations of the service. Leaders were positive about the future of the service and were focused on listening to the ideas of staff to improve care provided to women and their families. The maternity voices partnership (MVP) was integrated into the development of the service and attended recruitment interviews, guideline review meetings, patient experience group. MVP reported to the LMS partnership board and the head of midwifery.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and strategy recognised by leaders and clinical staff. The service was working closely with the maternity voices partnership (MVP) to deliver the national priorities outlined in Better births: Five year Forward View for Maternity Services (NHS England 2016). Specialist midwife roles had been created and staff appointed to lead the service developments. For example, a digital team was developed to support the transition to electronic records and personal care records. Community working was being reviewed to meet the continuity of carer requirement. The perinatal mental health team were writing guidelines for staff to provide a recognised process of support for women with known or suspected mental health needs. Maternity voices partnership were involved in the interviewing of specialist midwives and managers to challenge and encourage the appointment of the best candidate for the role.

The trust was continuing to progress plans for the provision of a new build maternity service. The maternity voices partnership were actively involved in this process, and despite plans for a new build, staff were committed to improving care in the current setting.

**Culture**

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service had an open culture where women, their families and staff could raise concerns without fear. All staff reported a positive and improving culture. Staff recognised the improvements in morale and culture which were associated with the change in leadership and investment in specialist roles. Staff of all grades felt happy and supported in their roles. Specialist midwives were settling into their new roles and providing support to staff working clinically. There was opportunity for career progression, although leaders were aware of the need to ensure staff experience was recognised, when staff were not working in specialist roles. Job adverts were communicated in an email to all staff by the head of midwifery to ensure staff were aware and given the opportunity to progress.

The head of midwifery produced their own newsletter which was released monthly. Staff found this to be informative and supportive.

There was a focus on the wellbeing of staff to provide high quality care to women and their families. The unit had signed up to the ‘Caring for you’ Royal College of Midwives campaign to improve the health, safety and wellbeing of midwives and maternity support workers to enable them to provide safe, high quality care to women and their families. Both medical and midwifery
staff used the recently refurbished delivery suite break room to relax on their work breaks. The room had a massage chair. Staff spoke of a culture which valued their breaks and encouraged staff to avoid having work conversations in the break room. Mental health was considered very important to the wellbeing of women on the ward, and staff were quick to flag any concerns.

Staff we spoke with were pleased their wellbeing was a focus. We saw staff wearing badges to remind each other of the need to ‘be kind’ to one another. Other badges visually represented staff who were experiencing the menopause or who were likely to need additional support, so considerations could be made without staff having to explain. The badges were optional, so staff could choose if they wanted to wear them.

Medical and midwifery staff felt part of a team and described a supportive working relationship. Antenatal clinics held in the community meant there was good interaction between the community midwives and medical staff, with midwives able to contact consultants in person or by email for advice. However rotational midwives were disappointed there was not more advanced notice of where they would be rotating to. It was felt that more notice would improve staff preparation time and reduce anxiety. The head of midwifery was aware this was a concern and was reviewing methods to improve the rotation process.

Investment was being made into the professional midwifery advocate (PMA) role. A small room on the birth centre was being refurbished to provide a relaxing and safe space for staff to meet with the PMA and access support.

An ‘improve well’ application was created to gather the service improvement ideas from all staff. Staff spoke highly of the application as it provided a platform for ideas to be considered and taken forward. The head of midwifery was keen to consider all suggestions and we spoke with staff who were given permission and support to progress their ideas. Staff who worked in the community used the application but discussed their ideas with their teams and often started them before adding to the application.

**Governance**

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

During the last inspection in 2018, senior managers told us new governance reporting structures had been introduced. These included: divisional and clinical governance meetings which linked to the trust’s Quality Assurance Committee and to the Board. At this inspection the governance had improved as processes had stabilised.

Since the last inspection senior managers felt maternity was better recognised within the trust, with a maternity representative attending the daily bed meetings where night staffing plans were also discussed. Senior leaders met with the executive board once a month and had an open-door policy within the care group. Staff explained how they were able to discuss concerns at relevant times, rather than having to wait for planned meetings. The maternity dashboard was reviewed at board level and staff described this as a process of holding the care group leads to account.

There was a programme of clinical audit and regular audits were completed to monitor safety performance. There were investigations and remedial actions when data identified inconsistent or concerning practice. The practice development team sent out ‘tip of the week’ emails to raise awareness of practice concerns and junior staff were invited to the monthly audit meeting. This meeting reviewed the audits, benchmarking performance against other trusts and raised
awareness of the maternity dashboard. A monthly governance meeting provided a format to track action plans following audits while the monthly patient safety meeting reviewed recommendations made by MBRRACE-UK to improve patient care and safety in maternity in response to maternal deaths and baby loss. However, at the time of the inspection the service was not involved in any mental health related audits.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

During this inspection staff we spoke with were aware of the risk register and the current service risks. The service had a risk management midwife and a risk management lead obstetrician who worked closely with the governance lead for the care group. We met with the designated obstetrician and midwife who championed maternity safety in the trust with support of the board appointed maternity champion. A weekly incident review and learning group monitored the incident reporting and identified issues and risks affecting performance. These included a review of serious incidents, with learning shared with staff and trust governance leads through email updates. The risk management and patient safety midwife provided a regular report to the service leads and care group board, so the board had good oversight of the maternity risks. A detailed monthly patient safety newsletter was emailed to all staff to share learning.

The morning safety huddle meetings had continued since our inspection in 2018. An additional afternoon huddle was introduced to provide a forum to review the flow of the service and staffing levels. An example of this is staff from the antenatal ward reviewing the planned induction of labour list for the following day, in response to the increase in demand for inductions because of the saving babies lives care bundle. The saving babies lives care bundle was designed to support providers, commissioners and professionals to take action to reduce the rates of stillbirths. This afternoon huddle allowed staff to contact women prior to the day of their planned induction to rearrange their induction, should there not be capacity within the service. Staff found this to be a useful forum, although during the inspection women were experiencing delays in the induction process as there was not enough capacity on the delivery suite to provide one to one care in labour.

Reviews of deaths and unexpected outcomes were discussed at regular mortality and morbidity meetings. At our last inspection these meetings were not always minuted to evidence debate, discussion and attendance. During this inspection staff spoke positively of these meetings, with shared learning disseminated through the mandatory training and tip of the week emails. Staff described there being clear evidence of the meeting attendees, apologies and discussion. Following the inspection, we requested the minutes of the past three meetings. These showed evidence of multi-professional discussion of cases and review of the performance dashboard.

Managers recognised the effect of tourism on the service performance. To minimise the impact in the summer months specialist midwives were encouraged to work clinically to meet demands of the service and the maternity mandatory training week was not run in august. Meetings were also reduced in August, but leaders maintained an open-door policy whereby concerns were discussed as they were identified.

Information management
The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and usually secure. Data or notifications were consistently submitted to external organisations as required.

The service was compliant with accessible information standards (NHS England). Clinical guidelines and patient information leaflets were available to staff and the public on the trust website. These were able to be translated into several languages or provided in a read aloud format. A maternity performance dashboard was maintained and reported each month. Managers told us data was readily available and reliable.

During the inspection most staff were aware of their responsibility to protect personal data and took steps to ensure the safe storage and movement of records, although one computer was seen to be unlocked and unattended. Staff were seen to check they had the correct maternity records for the woman they were caring for.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service was committed to improving services by engaging with women and their families and capturing their feedback. The service worked closely with the Cornwall maternity voices partnership, which was a collaborative of parents, parents-to-be and other stakeholders, reviewing local maternity care and supporting service users to share their experiences to improve care. The maternity voices partnership periodically completed reviews of the ward environment and interacted with staff, women and their families. The report of their findings was shared with the head of midwifery who was found to be supportive.

Staff engagement

Staff felt informed and involved in the service. Key messages were communicated to staff during the daily huddles, at ward handovers and through email. Staff attended a protected mandatory training week once a year, or on return from long term sickness or maternity leave. This enabled staff to be up-to-date with service developments and practice.

Staff felt their ideas mattered and they were encouraged to submit improvement ideas to the ‘improve well’ application to improve performance and experience for women and their families.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and involvement of service users.

The Maternity voices partnership (MVP) were involved in innovation. The MVP visited the traveller community and reported the health and access to care concerns to the head of midwifery. Two midwives were passionate about providing support for vulnerable women and their families, establishing the Teyluva midwives team. Women’s Wednesdays were set up to enable a multi-agency approach to care, within the traveller community location. Following the introduction of the team it was recognised that patient outcomes had improved, with a 100% improvement on the uptake of vaccinations in pregnancy. Staff spoke of these vulnerable women being engaged with maternity services and contacting their midwives when concerns arose in pregnancy.
Services were improved in response to feedback from staff, women and families. Staff followed a list of incident reporting triggers and suggested service improvements through their managers and an ‘improve well’ app. This app was developed to record the suggestions from staff on how to improve services. The MVP engaged with former service users to improve the decoration of the wards, making it more relaxing and welcoming. Large photographs of coastal landscapes decorated the delivery suite and birthing rooms were named after the relevant beaches. Staff told us women and their families later visited the beach which their birth room was named after.

While the managers recognised there was limited involvement in research, the service was planning to raise the profile of research following the appointment of a consultant midwife.

There was a focus on recognising the success of staff, with many staff and developments having been nominated for awards. During our inspection midwives and leaders attended an awards presentation in London at the International Midwifery Conference awards. There were three highly commended prizes and an award was won for transformation innovation. This related to the Teyluva midwives. The head of midwifery received the South West and Wales leadership management award in 2019.
End of life care

Facts and data about this service

The trust provides end of life care at all three of its sites. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust and includes care for relatives and those people close to patients. It includes aspects of essential nursing care, specialist palliative care, bereavement and chaplaincy support and mortuary services.

The trust had 1,499 deaths from March 2018 to February 2019.

(Source: Hospital Episode Statistics)

The trust has an integrated specialist palliative and end of life care, nurse-led, seven-day service. There are six specialist palliative and end of lice care nursing staff. There are 3.4 whole time equivalent (WTE) palliative care consultants (1 WTE employed by the trust and 2.4 as an arrangement with a local hospice). The team provides a service across all three sites however most of the referrals are from the Royal Cornwall Hospital. An in-reach palliative care consultant is provided by a nearby hospice which supports consultant cover for the service to be seven days a week and the 24-hour consultant advice line.

End of Life care at Royal Cornwall hospitals trust was inspected in September 2018 and was rated as requires improvement. It had previously been inspected in January 2017, when it was rated as inadequate. End of life care had also been rated as inadequate in January 2016 during a comprehensive inspection.

During this inspection we visited seven wards and specialist departments. These included: the onward care team, the cancer centre, the mortuary, chaplaincy service and bereavement office. We spoke with 10 patients and those close to them. We reviewed nine sets of patient care records and looked at six combined patient treatment escalation plans and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms. We spoke with 26 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 executive lead, administrators, the mortuary manager, volunteer staff and junior doctors.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

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

Nursing staff received and kept up-to-date with their mandatory training. Nursing staff in the specialist end of life team were 100% compliant with all mandatory training modules they were required to complete. This was an improvement on the previous inspection which showed compliance with four of ten mandatory training modules.

A breakdown of data provided by the trust for nursing staff in the SPEOL team on 11 November 2019 is shown below:
Medical staff received and kept up-to-date with their mandatory training.

The trust provided us with a breakdown of compliance for mandatory training courses from April 2019 to July 2019 at trust level for medical staff in end of life care, which is shown below:

<table>
<thead>
<tr>
<th>Training module 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>Conflict resolution</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness (inc privacy &amp; dignity standards)</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people - level 2</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling - level 1</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

These figures were for the period before the additional consultant provision was in place. In end of life care, the 95% target was met for 11 of the 12 mandatory training modules for which medical staff were eligible. In all 11 of these training modules 100% of staff had completed the training which equated to two members of staff, both were located at Royal Cornwall Hospital.

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

This was an improved figure when compared with data from our last inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training. Any due training was booked for staff to attend and staff informed us of the dates in November when they were booked. Staff told us they knew how and when to access training. Mandatory training was comprehensive and met the needs of patients and staff.
Clinical staff in end of life care completed training on recognising and responding to patients with mental health needs, learning disabilities and dementia.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. 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.

Staff received training specific for their role on how to recognise and report abuse. Nursing staff in the specialist end of life team were 100% compliant with safeguarding training modules they were required to complete. This was the same as our last inspection.

A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 at trust level for medical staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>6</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>6</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>6</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>6</td>
</tr>
</tbody>
</table>

The trust provided a breakdown of compliance for safeguarding training courses from April 2019 to July 2019 at trust level for medical staff in end of life care, which is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>2</td>
</tr>
</tbody>
</table>

In end of life care, the 95% target was met for all the four safeguarding training modules for which medical staff were eligible. This was an improvement when compared with compliance at our last inspection.

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

There were both adult and children operational groups which met bi-monthly and reported into the board's quality and assurance committee.

Staff knew how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff gave examples of how they identified adults and children at risk of, or suffering, significant harm. They described how support was offered by the trust’s safeguarding leads and how they made a referral.

**Cleanliness, infection control and hygiene**
Staff used infection control measures when visiting patients on wards and transporting patients after death.

Patients who were near to the end of their life were cared for in areas across the hospital. All the areas we visited appeared visibly clean and had suitable furnishings which were well-maintained.

The service generally performed well for cleanliness. The post mortem room managed infection control risks well. During the last inspection the mortuary post mortem room posed an infection risk to staff. However, during this inspection we saw infection risks had been removed following an extensive refurbishment of the area which included the replacement of porcelain post mortem tables with stainless steel ones, new flooring which was cleaned using a robotic cleaner, a new ventilation system and new lighting.

After death, the health and safety of everyone who came into contact with the deceased person’s body was protected. All ward areas and the mortuary were clean, well-organised, tidy and well maintained.

Cleaning records were up-to-date and demonstrated that all areas, specific to end of life care, were cleaned regularly. There were dedicated teams of cleaners who ensured the areas were clean and tidy. There were daily schedules and weekly tasks, alongside deep cleaning as and when required.

Staff followed infection control principles including the use of personal protective equipment (PPE) such as aprons and gloves. All staff were made aware of any infection risks when moving a body between ward and mortuary. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Mortuary staff were responsible for cleaning the post-mortem room and body storage areas. Staff informed us they cleaned the trolley used for transporting deceased patients after each transfer using specialist cleaning wipes.

Nursing staff adhered to aseptic non-touch techniques when setting up a syringe driver (a continuous infusion of medicines used in palliative care) in line with trust policy.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the mortuary environment followed national guidance set by the Human Tissue Authority for England, Wales and Northern Ireland. At the last inspection the mortuary service did not have suitable premises and equipment, and these were not maintained sufficiently to keep staff safe. During this inspection we saw a substantial investment had been made and a programme of works to refurbish the post mortem facilities had been completed. The premises and equipment were suitable and maintained well to keep staff safe. Post mortem tables and equipment to maintain the environment had been replaced. The mortuary had moving and handling equipment and refrigerated storage spaces. There were fridges for bariatric patients and isolation fridges for patients with known infectious diseases. The trust had access to a total of 79 fridges with a further 28 available at West Cornwall Hospital.

There was a backup generator in the event of a power failure and this ensured power was not lost to refrigeration systems in the mortuary. There was a management system for all fridges which was tested monthly. All fridge temperatures for body storage were monitored and linked to an alarm. If the storage temperature deviated from the expected range, the system automatically triggered an alarm and text alerts would be sent to the designated person who in turn would contact estates and/or mortuary staff. If this was out of hours, the on-call manager would be
contacted to investigate and take appropriate action. There was an ongoing programme to replace the fridges as part two of the refurbishment project.

The refurbishment of the area also included extensive improvements to the waiting area and quiet rooms for relatives visiting the bereavement services. There was one viewing room for family members to see the deceased. There was an adjacent room with a window to the viewing area to enable families to view their deceased relative through the window if they preferred. All areas were decorated and furnished and were both welcoming and calming. There was LED lighting to dim lights in the viewing room if required.

Entrance to the mortuary was secured through alarmed doors which were monitored by CCTV and required a swipe card for authorised personnel to gain entry.

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 carried out daily safety checks of specialist equipment. We saw these were documented when completed. Syringe drivers were maintained and used in accordance with recommendations and were stored and delivered from the equipment library, which ensured they were safe and ready to use when required.

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.

The service had suitable facilities to meet the needs of patients and maintain their safety. Side rooms were allocated to patients according to clinical need such as infection control. We saw side rooms were cleaned and made available for patients who were at the end of their life. Additional beds and reclining chairs were available for relatives to use if they wished to stay close to their loved one.

The service had enough suitable equipment to help them to safely care for patients. Wards had access to equipment to support end of life care. Syringe drivers were used and maintained and mattresses appropriate for care were supplied by the trust’s equipment library. Staff requested this equipment and stated they received it promptly often within 30 minutes of the request.

Staff disposed of clinical waste safely. Waste was segregated and stored away from public access until it was collected for final disposal.

Staff carried out daily safety checks of specialist equipment. We saw these were documented when completed. Syringe drivers were maintained and used in accordance with recommendations and were stored and delivered from the equipment library, which ensured they were safe and ready to use when required.

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 completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify patients who were in the last days of their life and escalated them appropriately. Staff from the specialist end of life team assessed referrals made to their service and provided advice to ward staff for any changes needed to the patient’s management plan. These management plans were in line with the Ambitions for Palliative and End of Life Care national guidance 2015-2020.

Staff completed risk assessments for each patient during their admission and reviewed this regularly. They used a nationally recognised tool to identify deteriorating patients and raised concerns when needed. Staff knew about and dealt with any specific risk issues for patients in their care. These included pressure ulcers, moving and handling, falls, the use of bed rails and venous thromboembolism (blood clots).

The service had access to mental health liaison and specialist mental health or psychological support (if staff were concerned about a patient’s or relative’s emotional health). Staff were able to access this support by making a telephone or electronic referral.

Staff identified and responded appropriately to the changing risks of patients. The specialist palliative care team met daily 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.

Staff shared key information to keep patients safe when handing over their care to others. Ward staff accessed specialist end of life nursing staff by calling or emailing the team. Ward staff informed us responses were prompt. Advice from specialist medical staff was also available if needed 24 hours a day and seven days a week.

Shift changes and handovers included all necessary key information to keep patients safe. The end of life nursing team met each morning to discuss and prioritise patient need. Patients who had been assessed as needing end of life care support were identified on their clinical notes and at patient handovers using a butterfly sign.

Nurses we spoke with were sensitive about managing risks for patients at end of life. Staff said that where the progression of a patient’s illness was clear, and this was towards the end of their life, the level of interventions were reduced to a minimum. For example, staff balanced the need to reposition a patient at risk of pressure area damage while acknowledging turning a patient could be uncomfortable for them. Senior nurses reminded staff that patients only needed to be repositioned gently rather than turned. Care was based on ensuring patients remained as comfortable as possible.

**Nurse staffing**

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels.

The service had enough nursing and support staff to keep patients safe. Nursing staff in the service had enough time to provide support and training for ward staff. They used ward staff to increase capacity of the service by providing additional training for end of life champions on each ward.
Specialist end of Life (SPEOL) nursing staff supported ward staff during times of high patient demand. SPEOL staff provided additional care to patients but within their skill set and only if their own workload allowed them to.

The Specialist Palliative and End of Life (SPEOL) team was made up of 6.6 whole time equivalent (WTE) registered nurses who had additional training and skills for the role. One of these nurses (0.8 WTE) had been funded by an external charity. There was a specialist palliative occupational therapist of 0.8 WTE and administration support of 0.6 WTE. The team did not use bank or agency nursing staff to cover unexpected absences. SPEOL staff absorbed the pressures on the service when team members attended training or conferences. They described how this made them busy, but they managed their workload between them.

There had been a stable workforce over the previous 12 months for SPEOL nursing staff. The sickness rate was 2.67% and below the trust target of 3.75%. The team was fully staffed and there had been no staff leaving and no bank or agency usage within the service.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels.

The trust had increased consultant funded time since our last inspection. There were 3.4 whole time equivalent (WTE) consultants for end of life care across Cornwall. In addition, there was in reach support from the local hospice service. Palliative care consultants worked alongside the SPEOL team and local hospice services. Arrangements included sharing on-call responsibilities with medical staff from local hospice services and being a ‘consultant of the day’ for patients at end of life within the trust. Although there was consultant cover for all shifts, consultants felt the rotas were unsustainable in the long term. Consultants felt this was having an impact on their wellbeing and they often completed paperwork in their own time. The clinical aspect of their work always took priority over their contributions to improvement projects for the service.

Leads for the service were reviewing consultant provision using national guidance from the Royal College of Physicians and had recently presented a case to trust leads for additional consultant cover. We were told trust executives agreed that another WTE consultant was needed for the service. Further meetings had been arranged to discuss this, but no commitment had yet been made.

Consultants shared work areas with SPEOL team staff and shared information to provide a safe service for patients.

Medical staffing information, between August 2018 and July 2019, showed a stable workforce where there was no sickness, use of bank or agency staff for the end of life service.

Information provided by the trust also showed a vacancy rate of 17% for medical staff in end of life care.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

At the time of our visit there were no consultant vacancies.

**Records**

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
Patient records were comprehensive, and staff could access them easily. Our last inspection identified concerns with patient care records. We saw records had been audited in June and August 2019 to provide a baseline of end of life care documentation. Newly revised care plans were introduced in September 2019 and had not been audited at the time of our visit. Treatment escalation plan (TEP) forms had been audited and revised to improve accurate recording of decisions made. The audit had shown 10% of TEP forms did not have patients’ mental capacity recorded on the front of the form. A palliative care consultant was responsible for leading a project to improve recording of treatment escalation plans (TEP) and repeat audits were planned to indicate any improvement. Medical staff were provided with guidance and training to encourage accurate completion of the forms. We reviewed six TEP forms had been appropriately signed by a senior clinician but two had not been fully completed. A patient’s ability to make decisions was documented but not how it had been assessed.

Improvements had been made to the process for recording assessment and care needs for patients at the end of their life. A new end of life care booklet, often referred to as the blue book, was being trialled on three wards within the trust. This booklet provided guidance for staff in how to have relevant discussions with patients at the end of their life and their relatives. It included a patient’s preferred place of death and treatment they wished to receive. Staff were positive about the new paperwork and were providing initial feedback about the use of the paperwork to the SPEOL team and an audit was planned when the pilot was completed.

We reviewed nine sets of patients’ records. Documents supported the advance care planning process. The records included treatment escalation plans, the resuscitation wishes of the patient, and their integrated care plan. Records described the patient’s needs and wishes, including spiritual preferences, if any. Discussions about advance care planning were recorded in patients’ notes.

Staff shared information about patients’ care needs when they were discharged from the hospital. When patients transferred to a new team, there were no delays in staff accessing their records. Electronic systems informed GPs and community teams, when a patient at the end of their life was discharged. GPs received this information at the time of discharge and were informed of ongoing care needs of the patient and destination of the patient discharged.

Records were stored securely and were not accessible to unauthorised individuals.

**Medicines**

_The service used systems and processes to safely prescribe, administer, record and store medicines._

Ward staff and SPEOL staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff were aware of and followed trust policy when prescribing symptom control medicines for patients who needed it. Nursing staff within the SPEOL team had attended training and were non-medical prescribers.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. SPEOL staff reviewed patients receiving end of life care as a multi-professional group. This included reviewing medicines and whether they were necessary for the patient at that stage in their care.

Nurses on the ward were able to administer medicines in line with trust policy. Staff used systems to control pain and other symptoms promptly. Anticipatory medicines, those recognised as most often used in end of life care, were prescribed in advance.
Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Staff informed us medicines were ordered and dispensed promptly and any changes to prescriptions were acted on quickly by the pharmacy service.

Staff followed current national practice to check patients had the correct medicines. SPEOL staff supported doctors and nursing staff across the trust to prescribe and administer appropriate medicines to control patient’s symptoms.

Rapid discharge medication was arranged as quickly as possible. If they were not ready on discharge, arrangements were made for relatives to collect them from the hospital or they were sent by courier within a couple of hours to ensure there was no delay to discharge. Clear guidance with advice was contained in the discharge letter. This enabled doctors or nurses from the out-of-hours team to administer medication as required.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff from the SPEOL attended trust-wide medicine management meetings and shared learning with their team and ward staff.

There were decision making processes to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Staff discussed and reviewed individual patient needs and behaviour the weekly multi-professional meeting and altered advice for prescribing medicines as a result. We saw medicines were reviewed and adjusted to suit the needs of the patient.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The trust incident reporting system identified when it involved end of life care and treatment. Staff described incidents they had reported and changes they made to practice as a result. Specialist end of life nursing staff were informed of any incidents within the trust or in hospices in Cornwall. They shared information and changed practice to reduce risks of recurrence.

Staff understood the 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. Duty of Candour (DoC) dashboards had been developed on the trust’s incident reporting system. The system had been amended to enable the tracking of verbal and written duty of candour and uploaded relevant documentation as evidence. Compliance with duty of candour was tracked centrally and bi-monthly through the Incident Review and Learning Group. A new e-learning package went live on the 1 August 2019 and every member of staff, clinical and non-clinical, was required to complete this and pass the test, every year.

**Never Events**

From October 2018 to September 2019, the trust reported zero never events for end of life care.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**
In accordance with the Serious Incident Framework 2015, the trust reported zero serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from October 2018 to September 2019.

(Source: Strategic Executive Information System (STEIS))

Although there had been no serious reportable incidents for the service staff knew how to raise concerns and near misses in line with trust policy. Incidents from across the trust were discussed at team meetings and we saw learning was shared across the team and with ward staff using newsletters and through end of life champions on each ward. There had been some incidents involving how deceased patients were moved from ward to mortuary. Incidents had been reviewed and learning packages delivered to staff to improve understanding of end of life care. In addition, practice had been refined to provide a more sensitive approach to relatives.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The most recent three-year strategy for the service was strongly based on the national framework “Ambitions for Palliative and End of Life Care”. This framework was developed by a partnership of national organisations to improve end of life care throughout England.

Documentation used for end of life care met recommendations in line with the National Leadership Alliance for the Care of Dying People: One chance to get it right (2014) and the National Institute for Health and Care Excellence (NICE): Care of dying adults in the last days of life (2015). This guidance included five priorities to ensure high quality and consistent care for patients in their last few days and hours of life.

Recording of patient needs had continued to improve. Care plans, specific to end of life care, gave staff guidance and followed the nationally recognised “Five Priorities for Care of the Dying Person”. The priorities recognised the dying person and those important to them, should be involved in decisions about treatment and care. This had been a concern at the last inspection and processes for using end of life care plans had since been revised. We found care plans and documentation to be individualised and promoted discussion with relatives. Staff across the trust received training on the needs of the dying person. This had been incorporated into induction training for staff new to the trust and the mandatory training for all clinical staff. Compliance data for the whole trust in December 2018 was 84.9%. We requested but were not provided with the current data for trust wide training but staff we spoke with told us they had completed this training.

Our previous inspection identified that patients who may be in their last 12 months of life were not being identified. Since this time advanced care planning resources had been developed. A ‘priorities of care integrated record’ document supported the process of advance care planning. It recorded all the required information of an advance care plan in one place. Through training and improved documentation, the service encouraged staff to identify patients who may be within their last 12 months of life. This practice was not yet embedded. Staff were beginning to monitor the number of patients referred at this stage in their pathway to develop a baseline to measure improvement.
There were sessions to prepare staff to have difficult conversations with patients. To enhance this work further, staff who had already undertaken advance communication skills training were being trained as trainers.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. They demonstrated in-depth knowledge of how care, including mental health care, could be improved for their patients. We saw how staff were sensitive to the emotional needs of patients. Some patients were resistant to therapeutic care and we heard how staff kindly persuaded patients to receive care to enhance their experience.

The trust had appointed a Medical Examiner. This was part of the programme of continual improvements in governance, and to continue the organisational focus on learning and improving services. The introduction of the Medical Examiner function was to focus on how the trust supported carers and families following bereavement and how well the trust effectively learned any lessons in how it cared for patients and supported bereaved families. The appointment to this post was ahead of the nationally expected timeframe.

The bereavement service used processes to ensure all procedures after a patient’s death were completed in a timely manner to enable relatives to make funeral arrangements. Staff used systems for the completion of required documents and actions in line with NHS England guidance to ensure the needs of bereaved people were met. The bereavement team was the main point of contact at the hospital throughout and contacted relatives regularly after their loved one’s death and facilitated the statutory paperwork after death.

The team told us about the challenges in getting doctors to sign death certificates with 24 hours and often had to chase individuals with a follow-up email after three days and would then raise an incident on the electronic reporting system after five days. The team were working with medical teams to improve the response.

At handover meetings, we saw how staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their health needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.**

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Nutrition and hydration needs were included in patients’ individual care plans.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. End of life documentation guided staff to discuss the continuation of food and fluid. We were told of many occasions when staff provided specially requested food and drink for patients.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. We saw patient records included input from speech and language therapists about a patient’s swallowing ability.

Staff were aware of the option of clinically assisted hydration in patients approaching the end of their life, in line with guidance from the General Medical Council (2010) and the National Institute for Health and Care Excellence: Care of dying adults in the last days of life (2015). Medical staff
described an individual approach for the provision of clinical assisted hydration, which they discussed with patients’ next of kin.

Nursing staff provided regular mouthcare for patients nearing the end of their life, to alleviate discomfort associated with a dry mouth. This was recorded in care plans.

**Pain relief**

*Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.*

Patients received pain relief soon after requesting it. Staff, who were trained in setting up syringe drivers were available across the trust and set up this method of pain relief for patients when needed and prescribed.

Anticipatory pain relief was prescribed and used by staff when needed and followed national guidance. A specialist pain team was also available to support patients with more complex pain needs. Visitors told us nursing staff kept their relative comfortable.

Staff prescribed, administered and recorded pain relief accurately. The trust used an electronic system for prescribing medicines which was set up to provide accurate guidance and reduce errors. A note was placed on this system to guide staff to any paper prescriptions they needed to review. Paper prescriptions we saw were accurately documented.

**Patient outcomes**

*Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.*

The service participated in national clinical audits. They took part in the National Audit of Care at the End of Life (NACEL) audit for 2018. This was a comprehensive audit which focused on patient experience of care in the last admission to acute, community or mental health hospital throughout England and Wales. Information was presented thematically in nine sections, covering the five priorities for care and other key issues.

Findings were shown as a comparison against national averages and indicated areas where the trust performed similar to or better than national figures. These included: Families’ and others’ experience of care (national figure 6.6 RCHT 5.0), individual plan of care, involvement (of family) in decision making (National 8.4 RCHT 8.0) and recognising the possibility of imminent death (national 9.1, RCHT 8.9).

Managers and staff used the results to improve patients’ outcomes. The SPEOL team had developed actions for improvement based on each of the nine sections with dates for completion and a professional responsible for each action. This included a review of the end of life care plan which was amended to reflect national guidance. Guidance and training were provided for staff across the trust regarding these changes. The team was introducing a scheme of care called Butterfly Cornwall. Butterfly Cornwall was a scheme to improve the way patients and their loved ones spent their last days together and a member of the SPEOL team was leading this project. A baseline audit had been undertaken to show what actions were needed to successfully provide the scheme.

Improvement was checked and monitored. The SPEOL team carried out a comprehensive programme of repeated audits to check improvement over time. These were reported on a dashboard specific to end of life care. The team were working with data analysts to develop a set...
of measures to demonstrate patient outcomes in a meaningful way. Managers and the team used the results to improve patients’ care, treatment and outcomes. We saw the use of syringe drivers was audited and action plan developed to improve areas of lower compliance. October 2019 showed good staff compliance with checking syringe drivers in use. However, staff did not always check each syringe driver within the prescribed four hours. There was an action for end of life care staff to disseminate the information to ward staff. A repeat audit was planned for six months after this completed audit.

Patients in the last days of life could be assured that staff followed processes to decide at which point treatments or interventions were withdrawn. The specialist palliative care team were involved and worked with clinicians to make decisions in partnership with patients’ relatives. Nursing staff told us they felt supported to challenge clinicians about when to withdraw treatment, and this was managed sensitively, ensuring patients had a dignified death.

Accurate completion of patient’s decisions on treatment escalation plans (TEP) had been a cause for concern at our previous inspection. These were now part of the audit programme to measure compliance. A clinical lead for TEP forms was taking the improvement forward. Key actions being taken forward included establishing a TEP working group; completing audit of TEP completion, including capacity assessment and results being reviewed at the end of life group. Other actions included delivering communication training for junior doctors, TEP training as part of senior doctor mandatory training and a review of the TEP policy.

Managers shared and made sure staff understood information from the audits.

Our last inspection identified that people within the last year of their life may not be supported to make choices about their preferred care pathways. The service was monitoring this outcome and from November 2018 to October 2019 the percentage of patients achieving their preferred place of death ranged from 30% to 66%.

**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 development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

All staff joining the trust received end of life training at their induction and further training modules were available for staff to attend and increase their knowledge and skills. Each ward had a link nurse for end of life care. They were invited to attend end of life care link meetings and share developments and learning across their area of work.

The mortuary manager had a comprehensive training programme for porters. Porters were unable to have unsupervised access to the mortuary until they had assessed as competent in training modules specific to end of life care. The mortuary manager supported porters in completing these modules.

Specialist End of Life (SPEOL) staff, trained and supported volunteers to support patients in the service. They used their close links with managers of the volunteer service to provide suitable awareness and training.
Staff were enabled to provide advanced communication skills training across the trust. SPEOL staff, who had undertaken advance communication skills training were being trained as trainers on the subject.

**Appraisal rates**
Managers supported staff to develop through yearly, constructive appraisals of their work.

From August 2018 to July 2019, 89.5% of staff within the end of life care department at the trust received an appraisal compared to a trust target of 95%. Only one staff group out of three met the trust target for appraisal completion. However, actual numbers of staff were small, and one person made a large percentage difference. Ten out of 12 staff had received timely appraisals.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Staff we spoke with had received appraisals from their managers or had a date booked for the next appraisal.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
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<tr>
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<td>66.7%</td>
<td>95%</td>
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</tr>
<tr>
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<td>7</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

End of life care staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Clinical educators supported the learning and development needs of staff. Staff told us they had development needs identified and were able to access support to attend end of life conferences and training. Managers made sure staff received any specialist training for their role.

Managers made sure staff attended team meetings or had access to full notes of the meetings when they could not attend.

Systems supported staff to identify poor staff performance promptly and support staff to improve. Senior staff knew how to use their managers and trust protocols to manage performance issues within the team.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was a weekly multi-professionals meeting which was well attended by staff involved in the care of patients who were at the end of their life. This included specialist palliative care consultant and nurses, occupational therapists, physiotherapists, the chaplains and an administrator. The aim of the meeting was to review patients and provide support and advice about the management of patients nearing the end of their life and who had complex needs. Discussions followed a standard agenda which included the patient’s diagnosis and forward planning. Each patient was given a palliative performance status score to quantify the patient’s wellbeing and ability to carry out daily activities. The scores run from 100 to 0 where 100 is perfect health and 0 is death. A phasing score was also provided from one being stable to four being dying. Details were recorded electronically.
Staff worked across health care disciplines and with other agencies when required to care for patients. Close links had been developed with hospice services across Cornwall. These links were being developed with other services across Cornwall to develop systems of care from acute to community. An end of life care group met every two months to develop these systems.

There was clear documentation for end of life care which helped staff identify and provide care for patients at end of life.

There were clear processes for staff to use when a patient was discharged to their preferred place of care. Medical staff were advised to speak with the relevant GP before the discharge to ensure they were aware of the patients’ needs. This was followed up with a written communication.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We saw how mental health professionals were present at strategic meetings and were able to offer advice and support. The trust had processes in place to support patients with mental health issues and the SPEOL team had access to further psychological support from a cancer charity.

There were good working relationships with all departments such as the emergency department, other specialist nurses and the medical services caring for older people. The service continued to work hard to improve communications with other staff and services involved in patient care.

Seven-day services

Key services were available seven days a week to support timely patient care.

The service provided end of life support seven days a week and out of normal working hours. Specialist End of Life (SPEOL) Team members worked during day time hours Monday to Friday and at weekends. The weekend service had been provided since October 2018 and was an improvement since the last inspection. Outside of these hours, advice was available from a consultant help line. This service provided by a palliative care consultant, in conjunction with a nearby hospice, Consultants were available to attend clinical areas if this was needed.

The pharmacy was open from 7am to 7pm on Monday to Friday and from 8.30am to 5pm on Saturdays, Sundays and Bank Holidays. Outside of these hours, the on-call pharmacist was available for urgent advice and supplies.

Bereavement services were available between 9am and 4.30pm Monday to Friday.

Mortuary staff worked Monday to Friday and viewings could be arranged in the mortuary between 9am and 4pm. Staff told us they would come in to provide a viewing at weekends if this was required.

The chaplaincy service was available seven days a week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day and seven days a week.

Health promotion

Staff gave patients practical support to help them live well until they died.

The service provided relevant information to support patients to stay as healthy as they could. Leaflets were available for patients and relatives. A cancer charity was on the hospital site and had further information and a website had been produced for the local population about decision making in the event of a life limiting illness.
Staff assessed each patient's health when admitted and provided support for any individual needs to live as healthy a life as possible.

Staff understood their role in recognising patients towards the end of life and the importance of talking to patients and their families about advanced care planning and maximising their wellbeing and independence. Records showed conversations had taken place.

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. This included when and how to involve relatives in decision making.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. However, paperwork documenting these decisions were not always fully completed. Staff completed forms about whether a patient had the capacity to make a decision but did not always document how they had assessed patient capacity. This had been an issue at the previous inspection and the service had taken actions to improve the documentation by medical staff. However, these were not embedded at the time of the most recent inspection.

When patients could not give consent, staff made decisions in their best interest, considering patients’ wishes, culture and traditions. Staff promoted patient choice and acted on decisions made making sure all relevant information was communicated to patients and their relatives.

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

The trust set a target of 95% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from April 2019 to July 2019 at trust level for nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
</tr>
</tbody>
</table>

The trust provided a breakdown of compliance for MCA/DoLS training courses from April to July 2019 at trust level for medical staff in end of life care, which is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
<th></th>
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<tbody>
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<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
</tr>
</tbody>
</table>

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

In end of life care the target was met for the MCA training module for which medical staff were eligible.
Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

We saw staff had implemented Deprivation of Liberty Safeguards in line with approved documentation for patients near the end of their life.

**Is the service caring?**

**Compassionate care**

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff used quiet spaces to hold sensitive conversation with patients and relatives.

All patients and their relatives said staff treated them well and with kindness. We heard how they had been supported by staff with compassion and stated, “staff could not have done any more for them” and “nothing was too much trouble [for staff]”. Relatives were able to spend time with their loved one and visit outside of usual visiting hours. Other comments from relatives were that their loved one was well looked after and, “I can't fault the service and commend them enough.” There was high praise for all staff, including doctors, nurses and physiotherapists. They said, “staff were amazing and gave outstanding care.” “We all felt HELD by the team.”

Staff told us of examples of when they had gone the extra mile to provide compassionate care. This had previously included arranging weddings and visits from pets. One occasion involved making the room child friendly using pink cushions, with books and toys.

We observed staff treating patients with compassion and kindness and offering physical support if appropriate, for example, holding a patient’s hand or offering a hug to families.

Relatives were treated with kindness by being provided with comfort packs for those who wanted to stay overnight and had no personal hygiene provision with them.

Staff followed policy to keep patient care and treatment confidential. Porters we spoke with described how they moved patients after death and maintained their privacy and dignity.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs, additional learning or communication needs.

The Specialist End of Life (SPEOL) team rewarded staff across the trust for displaying small acts of kindness at the end of a patient’s life and was recognised with a certificate.

Staff protected emotional needs of patients and visitors when they transferred deceased patients to the mortuary. A code word was used between ward staff and porters when this was needed, and a concealment trolley was used to move the patient. They tried to maintain the patient’s and relative’s dignity during the journey to the mortuary as much as possible by avoiding areas where visitors would be.

Staff recognised the emotional impact of collecting belongings after a patient had died. They provided simple, fabric carrier bags with a butterfly logo for relatives to use. These were an
alternative to previously used, black plastic bags and protected their privacy and emotional impact of collecting personal effects.

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.**

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The chaplaincy offered support to those of all faiths and those of none. Trained volunteers supported patients and relatives who were at the end of their life and needed a person to talk with or just to be with.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The bereavement service supported families through the arrangements following a death. The mortuary environment had been sympathetically refurbished to provide a calm and restful environment. Staff in the mortuary supported families who visited to pay their respects to their deceased relative.

A charity on the hospital site offered services for patients at end of life and those close to them. They could attend social sessions, information sessions and access emotional and psychological support.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Screens were used to protect privacy if no side rooms were available. Patients were moved to the most private space on the ward area and kept relatives informed of side room availability.

SPEOL staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. All staff we spoke with demonstrated an understanding of the emotional impact of a life limiting diagnosis. We heard about actions they had taken to reduce the impact and how improving patient experience at end of life was a central part of their care.

**Understanding and involvement of patients and those close to them**

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Relatives we spoke with felt fully informed and included in decision making of care options.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. This included helping patients to make advanced decisions about their care. There was information on the hospital web site to inform patients and those close to them about making decisions within the last 12 months of their life. In addition to this there were leaflets available with clear information about choices people could make near to the end of their life.

Patients and relatives were offered choices in their care and conversations were honest and caring.
Families were always able to stay with their relatives in hospital during their last hours or days and staff offered emotional and practical support when needed. For example, meal vouchers were available for families to buy food during their stay on the ward and free parking permits.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service and the SPEOL team were developing additional methods to encourage greater numbers of relatives feeding back on their experience.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. For the 12 months of 2018/2019 there had been a total of 970 inpatient referrals to the end of life team which indicated a 13% increase on the previous year. The Specialist End of Life (SPEOL) team worked collaboratively with health systems across Cornwall and outside of the trust such as hospice services, community and mental health services. They attended meetings every two months to discuss end of life services. This included discussions about nursing and medical staff requirements across the county and how they made the care pathways between services as smooth as possible. The team recognised this was work in progress and much more work was needed to provide a seamless service.

Facilities and premises were appropriate for the services being delivered. There was a programme of work ongoing to refurbish one side room on each ward within the trust to accommodate patients at end of life and their relatives. These were decorated in a sympathetic way and had private bathroom facilities. Portable beds and reclining chairs were available for relatives to stay overnight.

The previous inspection identified a lack of side rooms within the trust. Although there were no additional side rooms available, we saw and heard how staff prioritised the needs of patients at end of life. Staff identified available side rooms across the trust and any due to become available. Cleaning of these rooms was prioritised by housekeeping staff and rooms patients were moved into these rooms if this was their choice. The National Audit for Care at End of Life (NACEL) audit (2018) showed the number of patients who were in a side room at time of death was slightly better than the national average.

The service had systems to help care for patients in need of additional support or specialist intervention. The SPEOL team provided support and training for staff across the trust to improve knowledge, skills and care delivered for all patients at end of life. All staff we spoke with were positive about the service the team provided and commented how responsive and supportive the team were.

The service was working with organisations across the community to identify patients who may be in their last 12 months of life and have conversations about preferred care. The service was trialling methods of capturing this information and had started using a national tool to identify its effectiveness.
The SPEOL team were also raising awareness with professionals in community services to promote knowledge and skills in end of life care across the county. A recent launch event resulted in more than 140 people registering for the training passport.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff had attended training in meeting needs of patients living with dementia. An electronic system flagged patients with a learning disability and/or autism. This flag notified the learning disabilities team of the person’s admission within approximately four minutes of their arrival. Other staff could see the flag and identify the possibility the patient may have additional needs and required reasonable adjustments.

Care plans contained prompts for staff to discuss individual patient needs and preferences. This included discussions about religious and spiritual preferences and guidance on how to access the chaplaincy service.

The service monitored whether patients were having their needs met by collecting data and acting on the results to improve individual care. For example, the number of admitted patients who were identified as receiving palliative care and the number of end of life care plans that were in place at the time of death. Completed care plans at end of life care had been an issue in previous reports and still did not provide assurance that patients near to the end of their lives received suitable, individualised care. From September 2018 to August 2019 there was a fluctuating trend of between 15% and 35% completion of end of life care plans. The SPEOL team had recognised this showed poor compliance with end of life record keeping and it had instigated actions to improve assurance. The team had redesigned end of life care plans and provided training for staff. The revised care plans were being trialled on medical wards within the trust and were to be re-audited.

The service had information leaflets available in languages spoken by the patients and local community. Interpreter services were available if they were needed. Staff, patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

The spiritual and pastoral care team offered a 24-hour, 365 day a year service. There were ablution facilities in the multi faith area of the hospital and the chaplaincy visited each ward regularly. The chaplaincy team adhered to the code of conduct for best practice as set out by the UK Board of Healthcare Chaplains (UKBHC) and was represented nationally on the Organising Professional Committee for the College of Healthcare Chaplains (CHCC). Staff supported people close to the patient to stay with the patient if they wished. Beds and reclining chairs were readily available, and staff supported the use of this provision.

Staff were informed of patients near to the end of their life and offered personalised support to relatives and visitors. A butterfly logo was used on patient records and displayed on handovers boards. This helped all staff to be aware and provide sensitive care. Relatives were offered additional drinks and meals if they wished to stay with the patient.

Our last inspection reported a lack of side rooms available for patients who were at the end of their life. Although there was no greater provision of side rooms at this inspection, staff were mindful of the needs of patients near to the end of their life. We heard how staff prioritised patients’ choices
wherever it was possible and prioritised cleaning of side rooms for the use of patients who were near to the end of their life.

Patients with complex needs who were at the end of their life were supported to receive the care they needed. End of life guidance encouraged staff to refer patients with complex end of life needs to the SPEOL team who could offer additional support and guidance to meet patient needs.

Discharge processes supported patients to receive care at their preferred place. A recent change to the discharge process supported this.

The bereavement team provided families and carers with a detailed booklet about bereavement and the next steps following the death of their loved one. The team helped families to navigate through practical, religious and cultural issues. Staff said they did their very best to achieve patients’ and families’ wishes and requirements and helped to do “what [families] did not want to think about.”

**Access and flow**

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were mostly in line with good practice.

Managers and staff worked to make sure patients did not stay longer than they needed to and were able to be in their preferred place of care at end of their life. Staff discussed options with patients and arranged for discharge to the specified place where possible. There had been some delays when staff used the fast track discharge system. The delays had been identified as occurring when referral forms were rejected by continuing health care teams. A recent agreement between the SPEOL team and continuing health care team meant no further forms would be delayed due to rejection of the referral for patients at end of life.

The SPEOL team responded promptly to requests for support. All staff we spoke with stated how quickly they received the advice and support they needed. From April 2019 to September 2019, the team had responded to 100% of urgent referrals within 24 hours. Non-urgent referrals had been responded to within 48 hours in at least 89% of cases within the same time period.

The SPEOL team leads monitored that patient moves between wards were kept to a minimum for patients at end of life. In January 2019, 70 patients had three or more ward moves. This had reduced to 40 patients in October 2019. SPEOL staff used this information to identify reasons for the moves and take action to reduce them. All staff we spoke with described how they would do their best to protect patients from unplanned bed moves.

Staff followed trust escalation policy when there was particularly high demand for hospital beds such as periods of winter pressures. Staff used a flow chart, which provided advice on actions around patients at the end of their life and communicating with hospice and community services to create more speedy discharges for patients who chose these options.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

**Summary of complaints**

From August 2018 to July 2019, the trust reported no complaints in relation to end of life care at the trust.
However, following the inspection the trust informed us there had been 26 formal complaints across the trust which had involved patients near the end of their life.  

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff encouraged relatives to complain about any failures in care they had observed or experienced. Staff understood the policy on complaints and knew how to handle them. A system within the trust ensured the SPEOL team were informed of any complaint that involved an end of life patient.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes. The SPEOL team used any comments or complaints to identify how they could improve the service. There was one complaint following the reporting period from August 2018 to July 2019. We saw apologies had been provided for the complainant and where end of life care systems could be improved, actions were identified. Responses were provided for the complainant, so they could receive some resolution.

Learning from complaints was shared with staff across the trust in a newsletter from the SPEOL team.

Staff gave examples of how they used patient feedback to improve daily practice such as resources, which were suitable for young children of a parent at end of life, to help them to come to terms with their loss and using a CD player to play music and reduce the intrusion of noise on the ward.

There had been no formal compliments made to the trust, but we heard compliments from staff about the support they had received from the SPEOL team and how the service had developed since the last inspection. Relatives spoke positively about the care they and their loved ones received at the end of their life.

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They used systems to understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

There was a non-executive director for the service who was visible to staff. This person had been in post for a short time. The director of nursing, Midwifery and Allied Health Professionals was the executive lead for end of life care who retained oversight of the service and represented it at the trust board. The Deputy Director of Quality, Safety and Innovations was the current lead for the end of life service and supported the service to develop.

The mortuary and bereavement service manager used skills to support staff in providing care for people who had experienced a bereavement. We saw how the chaplaincy service and volunteer service were supported by leaders to develop skills in end of life care.

Nursing leadership for the SPEOL team was provided by two staff who shared the lead role. This had been a trial at our last inspection and the arrangement had since been made substantive. The two leads felt they could use their individual skills and interests to improve the service. The nursing leads were visible to their teams and showed leadership skills to develop the service. Our last
inspection identified their focus had been on last few days of life for a patient. We found, at the current inspections, there was an additional focus on identifying people who may be in their last 12 months of life.

Management for consultants in palliative care was provided by a consultant for the nearby hospice service. Palliative care consultants could contribute to projects but had no allocated time for service development. Their clinical workloads took priority and left little time for them to provide proactive, clinical support for improvements in the nurse led service.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The vision for end of life services was to provide a seamless, countywide service across acute and community services. The SPEOL team were aware this was an aspirational vision and would not be in place in the near future. They had developed a strategy with the aim of going some way to achieving the vision. The SPEOL leads had based the strategy on “Ambitions for Palliative and End of Life Care: A national framework for action 2015-2020”. The strategy set out clearly what the aspirations were, what they were providing and what else they needed to provide to meet the aspiration. Actions were identified to fill the gap such as linking with community partners, creating a dashboard to measure progress and providing additional training for staff across the trust and county. The SPEOL team had developed the strategy and consulted with staff across health and social care services in Cornwall.

The strategy also outlined findings of our previous inspection and the action plan reflected this. The end of life care group reviewed progress and worked together on providing end life care across Cornwall.

The strategy was available for staff to view and shared with link nurses for end of life care.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The SPEOL nursing team supported each other and were focussed on providing support for staff across the county and of all disciplines. Nursing staff felt they could raise any concerns with their managers and had been supported to develop their skills. There was an opportunity for staff to access support and debriefing when this was required. The trust also had a staff support/counselling service available to all staff.

Palliative care consultants were able to provide their input to improvement projects when they were asked to. However, clinical demands on their time did not allow them to contribute to improvements. This had led to a potential lack of speed in developing improvements. Consultants felt they worked well with the SPEOL nursing team but could support them more if there was increased consultant capacity. This had led to some of the consultant team feeling frustrated with their roles and inability to use their expertise and knowledge to further improve services.
There was a strong culture of prioritising the needs of patients at the end of their life. We saw and heard this across all areas we visited. Staff in all areas found the end of life team approachable and responsive.

There was an open and honest culture with patients and service users to promote learning and real improvement which was based on people’s experiences. Staff had access to health and wellbeing services. The team had teamed up with a clinical psychologist to provide regular reflective debrief sessions. Counselling services for staff were available through the occupational health service. There was a chapel service for staff on Wednesdays.

Staff were aware of the trust freedom to speak up 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.

All nursing staff we met said they felt valued, confident and proud of the care they provided for those approaching the end of their lives. They felt supported by the leadership team and their colleagues.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leads used processes to monitor performance of the end of life service. Some of these processes were being developed to improve their effectiveness. Staff attended a range of meetings where issues around end of life care services were discussed. The specialist palliative care team met every two months and reported to the trust wide end of life group. Meeting minutes showed good attendance from across specialties within the trust. Discussions focussed on outcomes for patients and how specialties could improve and embed care for patients who were near the end of their life. This was chaired by the Deputy Director of Quality, Safety and Innovation and reported to the trust Quality Assurance group. The SPEOL team had a dashboard which was reported monthly and showed how they were performing. This included emergency readmissions from care homes, completion of end of life care plans and bereavement survey results. An information analyst was working with the team to improve the data gathered and make it a more effective measurement tool. Minutes documented discussion and learning opportunities which included from incidents and from excellence in practice.

The service had developed a range of audits to monitor and assess performance in line with national guidance and standards. SPEOL leads monitored a set of performance measures and we saw these were reported to the end of life care group. The annual report for the service was presented to the trust board in September 2019. This included an action plan to maintain good practice and improve where there were challenges to the service. We saw minutes which documented how this action plan was monitored at end of life care group meetings.

Staff were clear about their responsibilities and what they were accountable for. Consultants’ job plans had been reviewed and amended to provide a more consistent service. Leaders told us they were reviewing how the end of life care service was being provided across Cornwall between all health and social care service providers. The discussions were still taking place and no decision had been agreed. A senior responsible clinician provided line management for palliative care consultants in the trust.
Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Risk registers highlighted most areas of risk and provided assurance regarding actions taken to mitigate the risk. We saw three risks for the service, which were escalated to the corporate level risk register. These recognised where gaps in care were for these patients. However, consultant staffing did not feature as a risk to the service. Staff we spoke with were conversant with risks for the service and mitigating actions, such as training, policy development and guidelines, were underway. These were monitored at governance meetings.

The service used the National Audit for Care at the End of Life (NACEL) to support their identification of risks. We saw clear action plans and projects in progress to mitigate these risks and improve outcomes for patients. These risks were also those that presented across the health community in Cornwall and the multi-agency groups provided forums to solve issues.

Systems within the trust were used to improve end of life care services. Mortality reviews were communicated to SPEOL nurses which helped them to identify actions they could take. The end of life dashboard was reported to the executive team and it was being developed in order that it provided the most relevant information on quality of service.

Systems supported staff to work flexibly at times of high patient demand within the trust and hospice and community services supported fast track movement of patients at these times. A trust policy set out guidance for staff to follow to prioritise patient need. SPEOL nursing staff supported wards with patient care but were empowered to prioritise patients at the end of their life if needed.

The mortuary had a clear plan on how to respond in the event of a major disaster. These arrangements had been redesigned following the refurbishment of the mortuary and identifying further mortuary capacity in another of the trust’s hospital locations.

Insufficient consultant numbers for the service remained an issue since our last inspection. The number of consultants funded by the trust was one whole time equivalent (WTE), with 2.4 WTE as an arrangement with a local hospice. This was an increase from one to 3.4 WTE. Leaders of the service had reviewed consultant provision and found this number still did not meet national guidance for consultant to population ratio. They had presented their findings to the executive team and reported a positive response with further discussion planned.

The trust end of life services used national and local systems to understand and manage their priorities. The team networked with both the South West Specialist Palliative Care and the South West End of Life Clinical Network in addition to the new NHSI/E end of life network.

Multi-professional groups within the trust met every two months to review and agree actions for improvement of the service. We saw meeting notes showing these were well attended by professionals of all levels and specialties across the trust.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
Personal and sensitive Information was stored securely in electronic or paper form. The SPEOL leads analysed information about the service and shared relevant information with the SPEOL team, consultants and staff across the trust. This information was shared at team meetings, with ward link nurses and in newsletters. Quality and performance measures were reported to the end of life care group each month on a rolling programme and highlighted trends for the service.

Link nurses on the wards printed end of life newsletters and displayed these for all staff to see.

Staff always had access to 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 across the trust were kept informed of additional needs patients may have. Flagging systems were used across the trust’s electronic systems which highlighted patients’ needs such as learning difficulties, dementia and end of life care.

The SPEOL team had produced a set of policies and guidance which was readily available for staff across the trust. These included flow charts for specific stages in a patient’s care pathway, processes for fast track discharges and guidance on care planning.

Staff used electronic systems to manage patient information such as referrals to the specialist care teams and to gain access to information about results of investigations such as blood tests. Electronic systems were secure, and password protected.

There was a comprehensive electronic bereavement and mortuary data base which had been devised by mortuary staff and the IT development team. The system included details about the patient, their status, infections, length of stay and coroner’s decision if applicable. This was displayed on electronic boards and was available to all bereavement and mortuary staff and the coroner’s office.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

Specialist End of Life (SPEOL) nursing staff attended a range of meetings within the trust and across the county to gather views and engagement from staff, service partners, patients and bereaved relatives. Notes from these meetings showed how they had discussed methods of gathering this information and actions taken in response to feedback. For example, for end of life care, the team had launched a new, public facing, web page to promote advance care planning, information leaflets and posters had been placed around trust buildings. We heard how butterfly bunting had been crocheted by volunteers and displayed in premises across the county to promote discussion.

A bereavement questionnaire had been developed to gather views of bereaved relatives. However there had been a poor number of responses. The team had designed a paper copy to be issued to families at the time of collecting the death certificate.

The bereavement team met with relatives of deceased patients when they collected the medical certificate cause of death, which was required to register the death with the Registrar of Births and Deaths. During this meeting, relatives were handed a bereavement booklet which contained practical advice and information about additional support such as the chaplaincy service. Bereavement staff offered the opportunity for relatives to raise any questions or issues connected to the care of their loved one.
A recent awareness raising event had included staff from other health providers across Cornwall. The event offered education opportunities for community staff and had resulted in 140 expressing a wish to complete the end of life modules offered.

There were effective systems to engage with staff. There were regular staff newsletters on the wards and across the care group where information was shared. There were link nurses for end of life care on each ward. These were members of staff with a specialist interest in end of life care and who had been provided with additional support and access to training. Staff on the wards we visited confirmed they had end of life care link nurses and knew who they were.

Mortuary and bereavement staff had held open days to raise staff awareness of their work. These had been well attended with 50 staff attending during ‘dying matters’ awareness week.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Since our last inspection leadership had been strengthened. Over the preceding year the service had made many improvements. These included governance procedures, developing a clear strategy using national guidelines, creating an action plan which was regularly reviewed, improving end of life care documentation and providing education opportunities across the trust and Cornish community. Not all these actions were embedded in practice, but the team had plans for further actions needed to implement improvements. Mortuary facilities had received major investment and met national standards. The bereavement services were improved and monitored.

Butterfly Cornwall was a scheme to improve the way patients and their loved ones spent their last days together. Side rooms had been upgraded on some wards to be less clinical and there were plans for all wards to have a Butterfly room.

The SPEOL team had been nominated and were finalists for a PENNA (patient experience national network) Award for the 2018 awards. This was for their work around the butterfly scheme in the section Support for Caregivers, Friends and Family. It included actions they had taken to improve knowledge and skills across the trust to improve and enhance care staff provided for patients and families in end of life care. Increasing the knowledge of staff across the trust improved the quality of care and sustainability of end of life care.
Outpatients

Facts and data about this service

The outpatient service at the Royal Cornwall Hospital is part of a much wider service provision. The trust delivers outpatient services across 47 different sites that are managed directly by the trust or by the local community trust, private providers and GP practices.

At the Royal Cornwall Hospital, the outpatient service is devolved and managed within all seven of the care groups. The hospital outpatient clinics are delivered through advice and guidance, nurse led clinics, one-stop clinics and open access clinics. There was a central booking team that managed 66% of the booking of new and follow up appointments. The booking team received outpatient referrals through the electronic referral system. Some specialities, such as ophthalmology and cardiology managed the process of booking appointments within their teams.

Total number of first and follow up appointments compared to England

The trust had 538,377 first and follow up outpatient appointments from March 2018 to February 2019. The graph below represents how this compares to other trusts. The trust had a similar number of first and follow up appointments to the England average.

(Source: Hospital Episode Statistics - HES Outpatients)

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 2018 to February 2019.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Cornwall Hospital</td>
<td>536,431</td>
</tr>
<tr>
<td>West Cornwall Hospital</td>
<td>54,848</td>
</tr>
<tr>
<td>St Michael's Hospital</td>
<td>45,362</td>
</tr>
<tr>
<td>St Austell Hospital - Penrice Birthing Unit</td>
<td>26,986</td>
</tr>
<tr>
<td>Bodmin Hospital</td>
<td>24,924</td>
</tr>
<tr>
<td>This Trust</td>
<td>754,650</td>
</tr>
<tr>
<td>England</td>
<td>109,324,322</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 2018 to February 2019.

Number of appointments at Royal Cornwall Hospitals NHS Trust from March 2018 to February 2019 by site and type of appointment.

(Source: Hospital Episode Statistics)

Our inspection team consisted of two inspectors and one specialist advisor. This inspection was focussed only on the Royal Cornwall Hospital site, known as ‘Treliske’. During our inspection we visited outpatient clinics and departments indifferent specialties. We spoke with 109 staff including administrative staff, technical staff, managers, nursing staff, allied health professionals, doctors. We looked at eight patient records and spoke with 13 patients. We checked records of cleaning and equipment and looked at a range of documents including risk assessments, minutes of meetings, policies and procedure.

Is the service safe?

Mandatory training
The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.

The mandatory training was comprehensive and met the needs of patients and staff.

Nursing staff received and kept up-to-date with their mandatory training. The trust set a target of 95% for completion of mandatory training. At Royal Cornwall Hospital outpatient’s department, the 95% target was met for eight of the 13 mandatory training modules for which qualified nursing staff were eligible. A breakdown of compliance for mandatory training courses from April 2019 to July 2019 for qualified nursing staff in the outpatient’s department at Royal Cornwall Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Dementia awareness (ink privacy &amp; dignity standards)</td>
<td>66</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>48</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>63</td>
</tr>
</tbody>
</table>
Registered allied health professionals who worked in outpatient clinics did not achieve the trust target with a 92.1% compliance rate for mandatory training. Unregistered support staff to allied health professionals achieved the trust target with a compliance rate of 97.2%.

Managers did not make sure that all staff completed their mandatory training. Not all medical staff trust-wide received and kept up-to-date with their mandatory training. The medical staffing data provided by the trust referred only to the pain management service as these were the only doctors employed solely for outpatient service provision. In the pain management outpatients clinics, the 95% target was met for 10 of the 12 mandatory training modules for which medical staff were eligible with 100% of staff having completed the training for these 10 modules. A breakdown of compliance for mandatory training courses from April 2019 to July 2019 for medical staff in the pain management outpatient’s department at Royal Cornwall Hospital is shown below:

(\textbf{Source: Routine Provider Information Request (RPIR) – Training tab})

Medical staff from specialties other than pain management were part of teams in outpatient clinics. We asked the trust to provide additional data relating to the medical staff who worked in inpatients and outpatients. The trust did not provide this exact data set, they provided data covering all medical staff in the trust. This meant we were unable to draw conclusions specifically related to the outpatient’s core service.
The trust supplied us with their medical staffing training data across the trust as a whole for 14 modules. The trust met the 95% target for two training modules, dementia awareness and medicines management awareness. However, overall there was a 71% compliance rate for training across medical staff at the trust. Compliance for paediatric basic life support was 22%, infection prevention and control level 2 was 55%, health and safety was 72.8%, adult basic life support was 74.4%, conflict resolution was 76.6% and fire safety was 77.2%.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. This training was included within the safeguarding training. Nursing staff completed additional bespoke training in supporting patients who show aggressive behaviour. Trainers used scenarios based on incidents that had occurred in the main outpatient department.

Managers monitored mandatory training and alerted staff when they needed to update their training. Matrons discussed staff compliance with mandatory training at the weekly performance ‘huddle’.

**Safeguarding**

*Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.*

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of their responsibilities to safeguard children and adults from abuse and could clearly describe the escalation process to ensure action was taken to safeguard patients. In the main outpatient clinic, staff told us they contacted the safeguarding team for advice. Staff gave an example of a safeguarding referral they had made when they became concerned about the safety of a vulnerable adult who attended the clinic.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff across the service were provided with training in female genital mutilation (FGM) to support them in recognising such cases. In gynaecology outpatients, staff had additional resources and further teaching around this topic.

The fracture clinic had recently introduced a new process to ensure safeguarding referrals for children were raised at the earliest opportunity. The fracture clinic ran a clinic for children for the first hour of the working day. If a child was not brought to an appointment, the team would contact the trust safeguarding team and a safeguarding alert was made to ensure the safety of the child.

Staff followed safe procedures for children visiting the clinics. In the cardiology clinic, staff escorted children and their parents directly to the clinical area and made sure children did not enter the curtained changing cubicles. In the main outpatient area, children were placed in a separate waiting area away from adult patients. In the fracture clinic, children were booked into the first appointments of each clinic.

Staff received training specific for their role on how to recognise and report abuse. Roles and competencies for child safeguarding training are outlined in ‘Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document Third edition: March 2014. The trust used a decision tree to identify which staff were required to have level three safeguarding, this was based upon current national guidance. The national guidance states that all
non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should complete level two safeguarding children training.

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training. This target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible. A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 for qualified nursing staff is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</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></td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td></td>
<td>65</td>
<td>66</td>
<td>98.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td></td>
<td>64</td>
<td>66</td>
<td>97.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td></td>
<td>63</td>
<td>66</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td></td>
<td>62</td>
<td>66</td>
<td>93.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The medical staffing data provided by the trust referred only to the pain management service as these were the only doctors employed solely for outpatient service provision. In the pain management clinics, the 95% target was met for all the four safeguarding training modules for which medical staff were eligible with 100% of staff having completed each module. A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 for medical staff is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</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></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></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></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></td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

Medical staff from specialties other than pain management were part of teams in outpatient clinics. We asked the trust to provide additional data relating to the medical staff who worked in inpatients and outpatients. The trust did not provide this exact data set, they provided data covering all medical staff in the trust. This meant we were unable to draw conclusions specifically related to the outpatient’s core service. The trust supplied us with their trust-wide medical staffing safeguarding training data, of the five safeguarding modules medical staff did not meet the 95% target for any.

**Cleanliness, infection control and hygiene**

Staff used equipment and control measures to protect patients, themselves and others from infection. They kept the premises visibly clean. The service did not always control infection risks well and did not always keep equipment visibly clean.

Staff did not control all risks of infection as records showed toys in waiting areas were not always cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand washing facilities and hand sanitiser gel were available throughout the clinics and we
observed staff using these regularly. All staff were bare below the elbow in clinical areas, in line with national guidance. PPE was readily available across the outpatient department which staff used when required.

Staff took precautions when patients attended the outpatient department with a known or suspected communicable diseases like infectious diarrhoea, tuberculosis or seasonal flu. Staff treated these patients in side rooms when available or placed them last on the clinic list, so staff could deep clean the area after use.

Outpatient clinics were visibly clean and had suitable furnishings which were clean and well-maintained. In all clinics we visited, chairs had wipe-clean seating to prevent the spread of infection. Clinical areas across the department met the Department of Health, Health Building Note 00-10, Part- A, flooring and Part- B walls and ceilings requirements.

The cleaning of the fracture clinic was subcontracted to an external cleaning provider. Under the terms of the contract with the Trust, the provider was required to following the National Cleaning Standards. These standards did not require a cleaning record to be completed but required robust auditing. We checked a sample of audits and saw these were completed thoroughly. The results of these audits were reported through the Hospital Cleaning Operations Group, Hospital Infection Control Committee and the Monthly Management meeting with the Contractor. We checked a sample of these audits and they showed a consistently high percentage of compliance (above 97%).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. In all clinics staff attached ‘I am clean’ stickers on equipment to show when the equipment had been cleaned.

However, not all cleaning records were up-to-date. Records did not demonstrate that all areas were cleaned regularly. Not all toys in waiting rooms were visibly clean. Staff did not follow the trust policy for care of play equipment. This policy identified procedures for the storage, weekly checking and cleaning of toys, and for the recording of these procedures. Staff in the main outpatient department and the fracture clinic, staff did not complete a record when they cleaned toys. Staff in both clinics told us told us they did not always have time to clean them. In the diabetes clinic, the record showed that toys had been cleaned on only five occasions during the six months before our inspection.

**Environment and equipment**

**The design and use of facilities and premises kept people safe. Staff managed clinical waste facilities well. The maintenance and use of equipment did not always keep people safe.**

Daily checks on emergency equipment were not always completed and were not always thorough.

Safety of equipment was variable. Staff did not always carry out daily safety checks of specialist equipment. Equipment designed for single use was well stocked and in date in all clinics we visited. Resuscitation equipment trollies all had tamper evident seals. We checked a sample of records of daily and weekly checks of resuscitation equipment. In five of these clinics, staff had completed these consistently.

However, in the cardiology clinic, there was a risk that resuscitation equipment was not ready for use. Daily checks of the resuscitation trolley had not been recorded on 18 occasions during the five months preceding our inspection. Weekly checks had not been recorded on five occasions during the five months preceding our inspection. Staff told us they were not sure if the checks had
taken place. Patients attending this clinic were more likely to need emergency equipment due to the nature of their condition and the high-risk activities such as exercise tolerance tests and tilt table tests that were carried out in this department.

Checks on emergency equipment were not always thorough. In most clinics, staff stored medical gases appropriately and cannisters were in date. However, in the diabetes clinic, the oxygen cylinder on the resuscitation trolley was five weeks past it’s expiry date. This had not been noted during routine daily and weekly checks on this equipment.

Staff did not always take timely action to address risks related to environment and equipment. We reviewed a selection of fire risk assessments. These risk assessments identified required actions that in some cases were outstanding from the previous assessment and were not complete at the time of our inspection. For example, in addition to sound alarms, visual notifiers were required in some clinics such as audiology, main outpatients, dermatology, urology and the Mermaid Centre (cancer care outpatients clinic). In some clinics, emergency equipment had not been installed. For example, in the pain clinic smoke detectors were missing. In several clinics, additional emergency lighting was needed in bathrooms.

Most equipment in the outpatient clinics was well maintained. Portable electrical safety testing was in date for all appliances across the outpatient department. The service log showed that all high-risk equipment was compliant with the service requirements for this safety check and 83% of medium risk equipment was compliant. Low risk equipment was 97% compliant. This met the trust targets. However, we saw that fire extinguishers were out of date for service in the Mermaid centre, the diabetes clinic and the gynaecology clinic.

Staff disposed of clinical waste safely. Staff separated clinical and non-clinical waste and disposed of this in colour coded waste bin bags. Sharps boxes were dated and closed to reduce the risk of accidental needle stick injury when not in use.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff identified deteriorating patients and escalated them appropriately. Staff were aware of procedures for the care of patients who became unwell or deteriorated while waiting at the clinic. Staff in the fracture clinic provided an example of how the team had taken action to manage a deteriorating patient in their department. The right action was taken, and the patient received the correct care for their condition.

Staff completed risk assessments for each patient on arrival when required. For example, staff in the dermatology clinic completed a World Health Organisation (WHO) Surgical Safety Checklist specifically designed for dermatological procedures. We observed the checklist being correctly completed at the beginning of a procedure.

The WHO surgical safety checklist was electronically audited at the time of the surgical procedure in all areas apart from Endoscopy and the Cardiac Catheter Laboratory. This audit included an observational check of the quality of the process. In dermatology, the team compliance with the checklist was 100% between June and September 2019.

In radiotherapy, staff worked in pairs to check the details of each patient before starting treatment. This included confirming they were treating the right patient, for the right part of the body, and on the correct side of the body.
Staff knew about and dealt with any specific risk issues. Staff in the main outpatient department completed moving and handling risk assessments for patients with mobility issues. This meant staff could safely assist patients to move and transfer onto equipment such as treatment beds.

Staff in fracture clinic completed risk assessments for venous thromboembolism (VTE) when this had not been previously completed. This identified whether action needed to be taken to ensure the safety of the patient during a period of immobilisation.

Staff in outpatient clinics were regularly confronted with patients who showed aggressive behaviour. Staff felt confident to call security to assist them and gave examples of good collaboration with the security team to prevent escalation of fractious situations.

The service had access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. For example, if staff in the main outpatient department became concerned for a patient’s mental health whilst visiting the department. Staff sought help from the mental health teams to ensure the safety of the patient and others in the department.

All clinical teams completed harm reviews to monitor and mitigate the risk of patients deteriorating while on the waiting list for an appointment. The harm review process was introduced following our previous inspection. When staff identified a potential for a patient to come to harm, they escalated this immediately to expedite an appointment for the patient. These risks were also raised at weekly governance huddles, referral to treatment time meetings and governance meetings.

Staff shared key information to keep patients safe when handing over their care to others. Staff attended a ‘safety huddle’ every day. This was a brief meeting to highlight any pertinent risks relevant to the patient care for that shift. This included, for example, staffing shortages, learning from incidents and patient safety alerts.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff and support staff to keep patients safe. Nurse staffing rates within outpatients were analysed for the past 12 months and there was not enough variation in the turnover rates to comment on the performance of this metric over time. The table below shows a summary of the nursing staffing metrics in outpatients compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate (Jul-18 – Jun-19)</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>189.8</td>
<td>9%</td>
<td>8%</td>
<td>4.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>44.1</td>
<td>9%</td>
<td>7%</td>
<td>3.0%</td>
<td>6,411 (10%)</td>
<td>5,104 (8%)</td>
<td>529 (1%)</td>
</tr>
</tbody>
</table>
The data for sickness rates was provided for a different time-period (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

The outpatient clinics were staffed by registered nurses and health care assistants. Clinical nurse specialists and allied health professionals also attended different speciality clinics to see patients. There was a good range of staffing skill mix across the clinics. During our inspection, staff told us that nursing vacancies did not impact upon current service provision. In some clinics, teams had benefitted from an increase in their staffing establishment to facilitate future development of the service, and vacancies reflected a need to recruit into these opportunities.

Vacancy rates

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from October 2018 to March 2019.

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

Sickness rates

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from January 2019 to June 2019.

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

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. There was no requirement for a specific acuity or dependency tool to be used to determine staffing levels in the outpatient department. Matrons attended a daily safer staffing briefing to identify and mitigate
any staffing risks within outpatients. In some specialties such as gynaecology, dermatology, oral surgery and rheumatology, matrons were in the process of reviewing the staffing requirements for the outpatient clinics.

The ward manager could adjust staffing levels daily according to the needs of patients. Matrons were increasing their staffing resource by training inpatient nurses to cover outpatient clinics when necessary. In response to recruitment challenges, managers offered flexible working hours contracts. This meant there was more flexibility to manage the needs of the service over the working day and created a greater chance of recruiting and retaining staff in the department.

The service had reducing rates of bank and agency nurses used.

**Bank and agency staff usage**

![Bank hours - qualified nurses, health visitors and midwives](image)

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from March 2019 to July 2019.

![Agency hours - qualified nurses, health visitors and midwives](image)

Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from February 2019 to July 2019.

*(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)*

Managers made sure all bank and agency staff had a full induction and understood the service. Managers limited their use of bank and agency staff and requested staff familiar with the service.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
The service had enough medical staff to keep patients safe. The medical staffing data provided by the trust referred only to the pain management service as these were the only doctors employed solely for outpatient service provision. This data was analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy. This data showed there is not enough variation in the turnover rates, sickness rates, bank use and locum use over the last 12 months for medical staff to comment on the performance of this metric over time.

The table below shows a summary of the medical staffing metrics in the pain management outpatients service compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate (Jul-18 – Jun-19)</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>3.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>205.5</td>
<td>9%</td>
<td>8%</td>
<td>4.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>4.4</td>
<td>20%</td>
<td>0%</td>
<td>0.2%</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The data for sickness rates was provided for a different time period (July 2018 to June 2019) to all other staffing data (August 2018 to June 2019).

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staff from specialties other than pain management were part of teams in outpatient clinics. We asked the trust to provide additional data relating to the medical staff who worked in inpatients and outpatients. The trust did not provide this exact data set, they provided data covering all medical staff in the trust. This meant we were unable to draw conclusions specifically related to the outpatients core service.

At the time of our inspection, there were medical staffing vacancies in some specialties. For example, the following specialties all had a vacancy for one consultant: hepatology, gastroenterology, dermatology, ophthalmology, maxilla-facial, rheumatology, ear, nose and throat, respiratory, endocrinology. Neurology had a vacancy for two consultants and cardiology had a vacancy for 0.45 consultant.

Teams ensured that medical staffing vacancies did not impact on existing outpatient service provision. Where medical staffing vacancies existed, teams prioritised coverage of outpatient clinics. Medical staff worked additional hours and locums were employed. In some specialties, for example, cardiology, managers were looking to source additional capacity from independent healthcare providers.

Where possible, experienced non-medical staff took on specialist roles in clinics. For example, in the gynaecology and outpatient service, specialist nursing roles were under development to facilitate hysteroscopy and colposcopy clinics. In dermatology, the team was developing a nurse consultant role and nurses had undertaken additional training to lead drug monitoring follow up.
clinics for the service. In the fracture clinic, the advanced physiotherapist practitioner reviewed x-rays and planned onward care for patients.

Teams endeavoured to ensure that all specialties were staffed by at least two consultants, thereby reducing the risk of disruption to the service through absence. This collaborative working extended to the wider system, for example, the consultant for sarcoma was the lead for the regional network in this specialty.

Teams used innovative approaches to ensure there were enough competent staff to meet the needs of patients across the wider healthcare system. For example, in cancer services, GP’s with a special interest were working in the outpatient clinic one day a week. In this way, the teams were encouraging primary care colleagues to become confident advocates for the needs of their patients. The collaborative working provided some sustainability of the staffing in the clinic and promoted opportunities for shared learning.

**Records**

**Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. Not all records were stored securely.**

Patient notes were comprehensive, and all staff could access them easily. We looked at eight sets of patient records. These records contained all expected documentation. In every clinic, several systems of recording patient information were used, including paper records and a variety of electronic systems. In some clinics, staff told us they wasted time recording the same information on different systems.

Records ensured continuity of care. Teams completed discharge summaries, and these were made available to GP’s. Staff told us these were completed in a timely way, however there were no audits of this process.

When patients attended outpatient clinics, there were sometimes delays in staff accessing their records. Staff in outpatient clinics could usually access all information needed to provide care. However, staff told us medical records were not always available for the start of clinics. This was mostly mitigated by staff accessing information on the electronic record system to make a temporary folder. However, the electronic record did not contain record of appointments recently attended that had not yet been scanned onto the system.

Records were not always stored securely. Staff followed protocols for storage of patient records. However, the system for storing patient records in cardiology did not provide assurance of security. Records of cardiac pacing tests were stored in cardboard folders on shelves in a walk-in store cupboard accessed via key pad. There was no system to log when records were added or taken away. There was no system to monitor who had access to these records. The medical records department were not aware of these files and this meant the information they contained might not have been included within disclosure requests. The cupboard was untidy, and staff told us it was often difficult to find records. In the past, staff had audited these records on an annual basis and found that patients had been missed for follow up. This audit had not occurred in the two years before our inspection.

Immediately following our inspection, managers completed a risk assessment of this area and made three recommendations: to write a standard operating procedure, to inform the medical records team, to implement a tracker system and to establish an electronic pacemaker database system to remove the need for paper device files in the future.

**Medicines**
The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff in the pharmacy department completed audits of controlled drugs in outpatient clinics every six months. These audits followed the guidance set out in the Department of Health 2007 guidance for good controlled drug management in secondary care. We checked these audits and they highlighted no issues of concern in outpatient clinics.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. We checked a sample of medicines and these were stored safely and securely. Pharmacy staff monitored all refrigerators in the trust including those in outpatients via a Wi-Fi temperature monitoring system. Staff had access to the standard operating procedure if a refrigerator was to stop working and they spoke to pharmacy if the temperatures were outside the permitted range. Appropriate action was taken to rectify anomalies.

Prescribing documents were issued electronically. The pharmacy department reviewed prescribing document (FP10) data monthly to identify any unusual prescribing.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines. ‘Patient Group Directives’ (PGD) were used in the dermatology department. PGD’s are written instructions to allow non-medical registered staff 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.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff discussed safety alerts during daily safety huddles and weekly governance huddles.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured actions from patient safety alerts were implemented and monitored.

Shared learning was not always embedded. Not all staff demonstrated a working knowledge of how learning from incidents was applied to their own working practice.

Staff knew what incidents to report and how to report them. During our previous inspection, staff did not always feel empowered to report all incidents. However, all staff we spoke with during this inspection understood their responsibilities to raise concerns and felt confident to do so.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff gave examples of incidents they had reported, and appropriate action had been taken. For example, in the renal outpatient clinic, staff had reported an incident of a patient who had fallen at the clinic. This had resulted in installation of handrails along the corridor at this clinic.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The senior management team responded promptly to incident reports. For example, during our inspection, the clinical director
attended the hand clinic to discuss and investigate an incident that had been reported the same day. We checked the incident reports of three serious incidents and these were comprehensive and inclusive.

The Medication Safety Officer reviewed all reported incidents related to medicines. The controlled drugs accountable officer (CDAO) deputies reviewed all reported incidents related to controlled drugs. Where themes of incidents were picked up, the CDAO and deputies referred these to the Medication Safety Group or other relevant groups for wider discussion, investigation and recommendations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Leaders used mechanisms to share learning from serious incidents. For example, the gynaecology service shared learning from serious incidents via several methods. This included the care board report, exception reports at the specialist governance meetings, at specialty mortality and morbidity meetings. Managers emailed newsletters related to trust-wide learning from serious incidents to all staff working every three months.

The Head of Patient Safety produced a shared learning bulletin. For example, one of these included recommendations from an incident occurring in ophthalmology plus more generalised learning about the dangers of using acronyms and abbreviations when communicating about patients.

Not all learning from incidents was embedded. Staff we spoke with during our inspection demonstrated awareness of learning from incidents that had occurred in the specific clinic where they worked. However, a sample of staff in cardiology and in gynaecology were not aware of learning that had occurred in other clinics within their specialty area. This included situations where patients had experienced harm because of the incident.

Staff met to discuss the feedback and look at improvements to patient care. All incidents were discussed at the Incident review and Learning Group meetings and learning was disseminated to team meetings and specialty governance meetings. In some clinics, there was evidence that changes had been made because of feedback. For example, the respiratory service had introduced a pathway for interstitial lung disease for patients who were suspected to have pulmonary fibrosis. Staff made improvements following medicines incident investigations. For example, to reduce unaccounted for losses of liquid medicines, staff used syringes with bungs to measure rather than measuring cups.

Never Events

From October 2018 to September 2019, the trust reported no never events for outpatients. The service had no never events in the outpatient’s clinics. 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

Trust level

The outpatients service reported serious incidents in accordance with the requirements of the Serious Incident Framework 2015. However, this process did not identify outpatients as separately quantifiable data, Therefore, this dataset showed, the trust reported no serious incidents (SIs) in
outpatients which met the reporting criteria set by NHS England from October 2018 to September 2019.

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Clinical teams utilised a range of best practice guidance from the National Institute of Health and Care Excellence (NICE), Royal Colleges and other national evidence based best practice sources. For example, staff used the British Orthopaedic Association guidelines for trauma and orthopaedics to review the clinical pathway for patients attending the virtual fracture clinic. As part of this process, leaders had developed new referral systems and clear exclusion criteria for referrers. This ensured patients were being seen within the recommended 72 hours if they were to receive non-operative management of their fracture.

Teams audited their compliance with best practice. For example, in the Mermaid Centre, the team treating patients with cancer were audited annually as part of a recognised external quality management certification process.

Managers checked to make sure staff followed guidance. For example, in response to a high wound infection rate in the dermatology clinic, managers audited procedure against the National Institute for Health and Care Excellence (NICE) guidance NG125 Surgical site infections: prevention and treatment. As a result, the team made improvements to the protocol for skin cleaning preparation prior to a procedure. The speech and language therapy service had audited their compliance with the national guidelines. Recommendations from this audit included the need for more consistent documentation and a policy review.

Where clinical guidelines were not met, the service implemented plans to address this. Managers in the specialist services and surgery outpatient team were recruiting for a band six nurse to provide an increase in nursing care in accordance with NICE Clinical Guideline 152 Crohn’s Disease: Management.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients could access water fountains in outpatient waiting areas. Patients could also access the cafes and shops located at the hospital to purchase food and drink. Staff offered food and drinks to patients who were delayed in clinics.

Specialist support from staff such as dieticians was available for patients who needed it. Dietitians provided nutritional support, advice and guidance for patients to plan their onward care. For example, dietitians were part of the multidisciplinary team in the bariatric clinic and the diabetes clinic.

Pain relief
Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. The pain management clinic provided a holistic approach to care and treatment for patients with both acute and chronic pain. The multi-disciplinary pain management service included nurses, physiotherapists, occupational therapists, clinical psychologists, pharmacy and consultants. The service used a validated self-administered questionnaire to evaluate the severity of a patient’s pain and the impact of this pain on the patient’s daily functioning.

Patients pain was managed in accordance with evidence-based guidelines. For example, the Cornwall Endometriosis Centre cared for women with a potentially long-term condition that had significant and complex needs especially around pain management. The nurses in this team ran a joint clinic in collaboration with the gynaecology team and pain consultants. In this way, patients were offered a multidisciplinary pain management service with expertise in pelvic pain in accordance with NICE NG73: Endometriosis: diagnosis and management September 2017.

Patients received pain relief soon after requesting it. Some outpatient staff completed additional training in non-medical prescribing. This meant staff could prescribe pain relief without patients having to wait for an appointment to see the consultant or their GP.

Staff prescribed, administered and recorded pain relief accurately. At the pain clinic, staff prescribed medicines and patients collected these at the pharmacy to take home as required. Staff at the clinic completed daily checks and associated recording of the medicines held at the clinic.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

Staff monitored the effectiveness of the consultation process in the outpatient service. For many outpatient clinics, the goal of the consultation was to determine the next steps for their treatment and to progress the patient to the most appropriate treatment pathway. Achievement of this goal was internally audited for every patient. Staff completed a form for each individual patient to record the outcome of every appointment and the next steps for the patient. These forms were inputted to an electronic system by administration staff at the end of each clinic. The information enabled leaders to track the patient journey to ensure they followed the correct pathway and their treatment was not negatively impacted by delays.

The service participated in relevant national clinical audits. In the respiratory clinic, the team contributed towards the cystic fibrosis database. The results of this measure were discussed at regional specialty events. In the renal outpatient clinic, the team contributed toward the National renal registry and the bariatric clinic contributed to the Society of Bariatric Anaesthetists registry. This enabled leads to benchmark the care they provided against regional and national parameters.

The outpatient service used healthcare evaluation data (HED) to benchmark the outpatient activity against national and south west trusts. This highlighted where the service was offering more or less procedures than the regional and national average. Any discrepancies prompted further investigation to confirm accuracy of the coding process. For example, in ophthalmology, the service was recording 25.7% of patient appointments as including a procedure, compared with 42.7% in the South West and 34.8% nationally. This process also highlighted unusual data in
vascular specialty where 1.8% of appointments included a procedure compared with 35.9% in the South West and 21.9% nationally.

In some specialties, teams provided treatment at the outpatient clinic appointment. Some of these specialties used outcome measures to monitor the effectiveness of the treatments offered. For example, staff in the pain management clinic audited individual patient outcomes at the start and end of treatment programmes using validated outcome measures, for example the EQ-5D (looking at generic health status) and the Hospital Anxiety and Depression Scale (HAD). In the respiratory service, staff used the Epworth Sleepiness Score (a sleepiness questionnaire) to measure the effectiveness of treatment at the sleep apnoea clinic.

However, not all specialties providing outpatient treatment checked outcomes for individual patients or for the effectiveness of the service as a whole. For example, staff in therapy services did not regularly monitor the success of treatment programmes. The stroke therapy team recently piloted the use of a validated outcome measure. This measure was not in routine use at the time of our inspection.

When services monitored outcomes, the results for patients were positive, consistent and met expectations, such as national standards. For example, the pain clinic had audited the chest trauma pathway. The treatment outcomes included a decrease in the number of patients who died or were admitted to the intensive care unit.

Managers and staff used the results to improve patients' outcomes. Leaders worked with other healthcare providers across the region to make improvements highlighted by national audit reports. For example, in urology, leaders were collaborating across the South West region to develop a prostate cancer diagnosis and treatment pathway as recommended in the National Prostate Cancer Audit Annual report 2018.

**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 development.

Managers gave all new staff a full induction tailored to their role before they started work. In the bookings team, staff participated in a structured induction. During this induction, staff were supported to meet specific competencies at every stage. When staff joined the dermatology service they completed a comprehensive set of competencies which covered the required procedures for their work in the clinic. These new staff were supervised by experienced members of the team. Staff were only deemed competent when they had been signed off by a consultant working at the clinic.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers ensured that staff received specialised training to meet the specific requirements of their role. For example, service managers and staff in the booking team participated in demand and capacity training. This included refresher training around referral to treatment times and ensured all staff had a shared understanding of terminology, data and reporting mechanisms.

Staff participated in conflict resolution and customer care training to enable staff to recognise and respond effectively to patients and relatives who may become stressed or agitated.
Staff participated in training to develop their role. For example, some specialist nurses had completed the non-medical prescribing course. This allowed them to carry out additional roles reviewing and prescribing medicine for patients.

Managers supported staff to develop through supervision of their work. However, the regularity and structure of this supervision varied across the outpatient service. Managers did not audit the quality or quantity of supervision provided to outpatient staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We checked the minutes of meetings and saw these were thorough. Meetings were well attended. Team information was also communicated by newsletter. For example, in ophthalmology a weekly newsletter kept staff up to date with governance and training opportunities and praised staff for their hard work.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. When therapy staff attended courses or learning events, they shared learning with their teams and submitted a 400-word summary to the clinical school. These snapshots of learning were then showcased at internal learning events.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Line managers encouraged staff to participate in external training and gave them opportunities to develop skills through varied on the job experience. For example, in fracture clinic, staff developed their skills by working in specific clinics of their choice. In the pre-operative clinics, trainee anaesthetists held weekly clinics to develop their skills as well as adding capacity for the clinic.

Managers made sure staff received any specialist training for their role. Bespoke training had been provided to the nurses working at the virtual fracture clinic. The training looked at different injuries and fractures which came through in referrals to the clinic to ensure the nurses had a thorough understanding, to give advice to patients referred into the virtual clinic. In February 2020, the service planned to provide a bespoke training course for a range of clinical staff across the system in Cornwall, who encountered or referred patients into fracture clinic.

Managers did not support all staff to develop through yearly, constructive appraisals of their work. Not all staff had received an appraisal during the 12 months preceding our inspection.

From August 2018 to July 2019 81.0% of staff within the outpatients’ service received an appraisal compared to a trust target of 95%. The staff appraisal completion rate was met for three out of the seven staff groups in the outpatients’ service. Appraisal completion rate was low for the allied health professionals staff group with 62.5% of staff having received an appraisal. However, at the time of our inspection this had improved to 87.9%. Therapy managers had viable plans to sustain this improvement.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>August 2018 to July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>2</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>14</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>5</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>49</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>33</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>25</td>
</tr>
</tbody>
</table>
Medical staff from specialties other than pain management were part of teams in outpatient clinics. We asked the trust to provide additional data relating to the medical staff who worked in inpatients and outpatients. The trust did not provide this exact data set, they provided data covering all medical staff in the trust. This meant we were unable to draw conclusions specifically related to the outpatient’s core service. Across the whole trust, the compliance rate for all medical staff was lower than the trust target at 85.6. Some specialties demonstrated 100% compliance, for example, cardiology and endocrinology. Some specialties scored lower than the trust target, for example 81% in ophthalmology and 83% in vascular services.

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

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. In all clinics, staff referred patients to be discussed at multidisciplinary meetings to determine the optimal treatment pathway. For example, the pain clinic held a regular multi-disciplinary team meeting for patients with spinal problems to discuss their care and treatment and ensure their pain was effectively managed. This meeting was attended by spinal consultants, pain consultants, psychologists and physiotherapists.

Staff worked across health care disciplines and with other agencies when required to care for patients. Doctors in fracture clinic worked with physiotherapists, occupational therapists and the advanced physiotherapy practitioner to make sure care and treatment was optimised for patients. Physiotherapists provided care for patients with cystic fibrosis. The ophthalmology and endocrinology teams were working together to provide a joint thyroid clinic.

The outpatient service provided ‘advice and guidance’ for GPs in several specialties, including hepatology, ear nose and throat and urology. This function aimed to reduce the demand for face to face appointments by suggesting management and treatment options for GP’s to consider before referring the patient to the acute hospital.

Staff referred patients for mental health assessments when they showed signs of mental ill health, for example depression. Staff in the main outpatient department gave an example of a patient they had referred for input from the mental health liaison team. However, not all assessment documentation used by staff in outpatient clinics referred to the mental health needs of patients.

The psychology team provided input to several outpatient clinics, including pain management, cystic fibrosis, intensive care follow-up, bariatric surgery, neuropsychology, patients at high risk of breast cancer and patients who had been fitted with an implantable cardioverter-defibrillator (ICD). An ICD is a device placed under the skin that tracks heart rate and rhythm and sends out a shock to get the heart back into rhythm if it beats too fast or out of rhythm.

Patients could see all the health professionals involved in their care in one-stop clinics. Several teams provided clinics where patients could see a number of clinicians related to their problem at one time. For example, in the ear nose and throat service, patients attending the neck lump clinic could have an assessment, scan and treatment all on the same day. This team were also trialling the use of a portable audiology machine allowing tests to be undertaken while in clinic rather than waiting for an audiology appointment.
Seven-day services

Key services were not available seven days a week to support timely patient care.

Most outpatient services were not available seven days per week. Main outpatient clinics ran from 8.30am until 5.30pm Monday to Friday. However, the virtual fracture clinic provided a seven-day service.

Several specialties offered additional clinics on weekends to reduce outpatient backlogs. For example, the dermatology service provided day clinics on Saturday to help manage demand when required. The endocrine service ran additional evening clinics when needed.

Staff tried to be flexible, where possible, with appointment timings. For example, in the respiratory clinic, staff occasionally opened the clinic 30 minutes early to specifically support patients who needed to start their working day.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. For example, in cardiology, physiologists and specialist nurses could call the ‘Cardiologist of the Week’ who was rostered to provide timely advice and support when needed.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles. Leaflets were available in the outpatient areas and clinics providing support and advice for patients. For example, this information included advice on smoking cessation, mental health problems or support for carers.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Dieticians at the bariatric clinic supported patients with their diet and nutritional needs to support ongoing treatment at the clinic. This ensured the patient would be able to manage their diet independently in future to maintain good overall health. Staff in the diabetes clinic invited patients to attend groups where staff explained the importance of healthy lifestyles in managing diabetes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including Mental Capacity Act 2005 and they knew who to contact for advice. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity. If they had concerns about a patient, they would raise these with the lead clinician for the clinic. The lead clinician completed an assessment of mental capacity if appropriate.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed the formal consenting process. Written consent was gained for complex treatments carried out at clinics. For example, for procedures carried out at the dermatology clinic, specific consent form identifying the risks of the proposed treatment, including what the treatment was, why it was required and alternative treatments which the patient could have. This ensured
patients were fully informed about the procedure before they gave their consent. In the ear nose and throat clinic, doctors gained patient consent for all procedures undertaken.

Staff clearly recorded consent in the patients’ records. Patients gave verbal consent for care and treatment in the outpatient departments. We saw examples where verbal consent had been documented in the patient records for an acupuncture treatment session carried out at the pain clinic.

Staff made sure patients consented to treatment based on all the information available. For example, in gynaecology, staff made sure they gave full explanations of treatment options to patients to ensure patients were aware of the risks involved with any procedure.

All staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust set a target of 95% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA training courses from April 2019 to July 2019 at Royal Cornwall Hospital for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
<th></th>
<th></th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>66</td>
<td>66</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Royal Cornwall Hospital outpatient’s department, the target was met for the MCA level 1 training module with 100% of qualified nursing staff completing the training.

A breakdown of compliance for safeguarding training courses from April 2019 to July 2019 at Royal Cornwall Hospital for medical staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to July 2019</th>
<th></th>
<th></th>
<th>Trust target</th>
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<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Capacity Act level 1</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The medical staffing data provided by the trust referred only to the pain management service as these were the only doctors employed solely for outpatient service provision. Medical staff from specialties other than pain management were part of teams in outpatient clinics. We asked the trust to provide additional data relating to the medical staff who worked in inpatients and outpatients. The trust did not provide this exact data set, they provided data covering all medical staff in the trust. This meant we were unable to draw conclusions specifically related to the outpatient’s core service. The trust supplied us with their medical staffing training data across the trust as a whole for 14 modules. At Royal Cornwall Hospital outpatient’s department, the target was met for the MCA level 1 training module with 100% of medical staff completing the training.

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

Managers monitored how well the service followed the Mental Capacity Act. There were regular trust-wide audits of mental capacity assessments, not specific to outpatients.

Managers made changes to practice when necessary. The outpatients service recognised a need to improve the quality of the consent process. Managers planned to audit consent and to raise awareness in the monthly newsletter of the need to evidence consent and to provide specialty level standard operating procedures for taking consent.

Is the service caring?
Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs. Staff did not always treat patients in a way which respected their privacy and dignity.

Care and treatment did not always maintain patient confidentiality.

Staff were discreet and responsive when caring for patients. Patients said staff treated them well and with kindness. Staff identified patients in clinics who needed additional support during their appointment. We saw staff supported patients with mobility impairments to be comfortable in the waiting room. In the diabetes clinic, staff recognised some patients with obesity experienced embarrassment using public transport to attend clinic. Staff arranged a taxi to help them to overcome this.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Patients were given the opportunity to be accompanied by a friend or relative for their outpatient appointment. Staff acted as chaperones in accordance with the trust chaperoning policy. Chaperone posters were on view around the department for patients to see. The electronic record included a prompt to check if patients wanted a chaperone.

Patients with anxiety were supported by staff. Staff provided an example of a recent patient with agoraphobia who had attended the department. The staff asked the doctor to review the patient immediately in a quiet room ensuring they were seen promptly to ensure effective management of the patient's anxiety.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, the specialist nurse for teenagers and young adults with cancer completed a holistic assessment that included sexual health, spirituality, finances, and drug taking behaviours.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw a range of staff groups took the time to communicate with patients to make them feel at ease when attending clinics. Reception desk staff lowered their voices to speak to patients and relatives, so they could not be overheard.

However, care and treatment did not always maintain patient confidentiality. In the fracture clinic, staff did not always fully close the curtains to treatment cubicles during patient appointments. In the cardiology clinic, we noticed that staff voices from the open treatment area could be easily heard from the waiting room.

Care and treatment did not always maintain patient dignity. In cardiology, staff did not always fully close curtains to the changing rooms that were situated in a corridor. Gowns were available for patients, however one patient told us he felt uncomfortable because he was asked to walk from the changing cubicle to the treatment area with his upper body exposed.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. For example, patients accessing the pain clinic had access to a clinical psychologist to support their chronic pain conditions.
Clinicians were supportive and empathetic toward patients during their clinic appointments. For example, staff gave support to cancer patients when they felt anxious having radiotherapy. During the treatment sessions, radiotherapists played music, verbally reassured patients and even sang to them.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. For example, the specialist nurse for teenagers and young people with cancer understood the cultural perspective of this age group. Every six weeks, the nurse arranged a peer support evening at a local restaurant for young people to meet others who were receiving treatment for cancer.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff recognised that patients who had received treatment for cancer often experienced emotional distress immediately after being told they no longer required treatment. The health psychology team provided support to all teenagers and young adults living with cancer. This was offered as six appointments, that could be accessed anytime up to two years after the patient discharge.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff helped patients to prepare for difficult news. For example, staff in the genetic clinic offered patients the choice of how they wanted to hear the results of tests. The team texted patients to let them know that the letter with the result of their test was on its way to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff at fracture clinic showing patients their x-rays and explaining what this meant for the patient. Staff used anatomical models of various joints to provide a clear visual representation for patients of their fracture.

In the Mermaid centre, patients scheduled for radiotherapy attended a review consultation. At this appointment, clinicians carefully explained what treatments could be offered. Review consultations occurred throughout the treatment programme and after radiotherapy had finished. This ensured that patients and staff were fully informed of the treatment plan and knew what to expect at each stage of treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. For example, we observed a consultant at the bariatric clinic used a visual representation to show the patient what to expect when they had their surgery. The patient said this had helped to relieve some of their anxieties about their pending surgery.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients were given a specific outpatients friends and family questionnaire on leaving the department. This has just been introduced one month before our inspection. The service planned to review the data to identify areas which needed to improve.

Staff supported patients to make informed decisions about their care. Patients from several clinics spoke positively of the lines of communication with clinicians. Patients felt they had the opportunity to ask questions and staff gave them time to process information.
Patients gave positive feedback about the service. We saw displayed in the outpatient department comments from patients regarding their experience at the outpatient department. These included, ‘good communication,’ ‘excellent service,’ and ‘efficient, friendly staff.’

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. All outpatient teams were implementing strategies to increase capacity in their hospital clinics and focus resources on more complex patients. For example, in ophthalmology, leaders had opened a minor eye casualty service had been opened two months before our inspection. The service was working with community healthcare providers to develop patient pathways for care and treatment. This included nurses triaging patients to see opticians closer to their home. This had freed up an additional two clinics in the department to review more complex patients.

The outpatient transformation plan developed by the trust in collaboration with external stakeholders was looking at digital alternatives to create a more sustainable outpatient model. Some outpatient teams were introducing telephone and virtual clinics. For example, there was a telephone clinic for the thyroid specialty within cancer outpatients. This model meant increasingly frail patients did not need to leave their home to engage with specialist staff.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. These clinics optimised care and treatment for patients. For example, in the bariatric clinic, patients saw the anaesthetist, the consultant, the dietician, whilst also having their bloods taken and physical observations monitored by healthcare assistants. Health psychologists were also available at this clinic.

In the diabetes clinic, staff arranged for the retinal screening team to be available once per month. Vascular surgeons joined the diabetes specialists for regular joint clinics to meet the needs of patients who might require foot amputation. Patients told us it was helpful to see all clinicians in one clinic to avoid having to make multiple trips to the hospital.

The outpatient service tried where possible to meet the needs of patients who lived far from the acute hospital site. To accommodate patients across Cornwall and the Isle of Scilly, outpatient services provided from Royal Cornwall Hospital were also provided at the trust’s peripheral sites such as West Cornwall Hospital, and St Michaels hospital.

Facilities and premises were appropriate for the services being delivered. For example, in the main outpatient clinic, there was space in patient waiting area to ensure the accessibility of wheelchairs and patients had access to disabled facilities such as toilets. There was equipment designed to meet the needs of bariatric patients. For example, in the diabetic clinic this included walk on scales, toilet seats, plinths and armchairs. This clinic could accommodate patients on stretchers. In the ear nose and throat clinic, there was a separate waiting area for children and a garden. The outpatient clinics participated in patient led assessments of the care environment (PLACE reviews). The 2018 inspections had not identified any actions specific to outpatients.

However, for some specialties, demand for the facilities had grown and many clinics did not have enough space for the services being delivered. Clinicians struggled to find available rooms to accommodate their clinics. For example, in the cardiology clinic, staff checked patient’s height,
weight and blood pressure and obtained swabs in an open area approximately three metres along the corridor from the waiting room. Other patients walked through this area on their way back from the treatment cubicles. Male and female patients undressed in adjacent curtained cubicles in a narrow corridor. We saw one member of staff explaining treatment to a patient in the changing cubicle because there was no clinic room available. The chronic fatigue syndrome outpatient service offered appointments only on one day a week due to clinic space restrictions. In the fracture clinic, cubicles were separated by a partition wall and curtains. Discussions between patients and doctors could be overheard between the cubicles and by people using the walkway or queueing to check in. Staff were aware of the challenged environment posed and when required could take patients to a quiet more confidential room. However, these were not always available for use.

Not all waiting rooms were large enough to meet the capacity of the clinics. In the Mermaid Centre, we saw there were times when all seats in the waiting room were occupied. Staff working in haematology outpatients told us they sometimes had to ask relatives to stand up to free up chairs for patients. Not all waiting rooms were designed to allow good visibility from reception staff. In the ophthalmology clinic, the receptionist station faced away from the waiting room. There were plans to rectify this. Not all waiting rooms had separate areas for children. For example, in the cardiology clinic, children waited in the same area as adults.

The service had systems to help care for patients in need of additional support or specialist intervention. The hepatology clinic was working in conjunction with a charity supporting people with alcohol dependency who often found it difficult to access traditional outpatient clinics. The teams supported these patients to gain diagnosis by using finger prick testing in the community. Staff discussed possible treatment options at the multidisciplinary meetings and tried wherever possible to meet the patients’ needs close to home.

Managers acted to minimise missed appointments. For example, the staff in the sleep apnoea clinic had trialled the use of patient initiated follow up appointments. The outpatient service planned to extend this initiative to haematology, respiratory, and rheumatology clinics.

Teams also implemented strategies to bring care closer to the patient’s home. For example, in the diabetes clinic, staff gave patients a blood glucose monitor. This equipment allowed patients to upload their blood glucose results using Bluetooth technology via an application on their telephone. Clinicians were then able to monitor the patient without the need for them to attend clinic, and when patients had queries, staff could refer to the online data to give informed advice.

Teams managed patients who did not attend appointments. From March 2018 to February 2019, the ‘did not attend’ rate for Royal Cornwall Hospital was consistently lower than the England average. Managers ensured that patients who did not attend appointments were contacted. When patients did not attend their appointments, staff were aware of the potential harm to patients if their treatment plan was delayed. Staff were mindful of the safeguarding implications for children and vulnerable adults who did not attend or were not brought to their appointments. In all clinics, staff contacted patients who did not attend their appointment.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with learning disabilities received the necessary care to meet all their needs. Patients with learning disabilities flagged on the electronic record system and teams
planned ahead to meet their needs. The learning disability team highlighted any reasonable adjustments that may be needed for patients to attend the hospital. For example, staff in the sleep study clinic arranged an individual rather than group appointment for patients with learning disability. In radiotherapy, patients with learning disability were paired with a specific radiographer for all their treatment sessions to encourage continuity of care. In the pre-operative assessment clinic, staff booked double appointment slots for patients with learning disability and completed telephone assessments where possible to minimise disruption to the patient’s routine.

A team of people with learning disabilities or autistic spectrum conditions carried out audits of the outpatient areas, with the support of the learning disability team. Teams made improvements because of these audits. For example, staff on all reception areas now had access to copies of the learning disability passport and copies of the easy read appointment sheet for patients to record appointment details.

Teams encouraged patients who had a learning disability to bring a hospital passport with them to outpatient appointments. This document included information for staff to help them to understand the patients’ needs. For example, the passport included essential information such as allergies and next of kin, plus supplementary information such as how the person likes to manage their anxiety or communication needs.

Staff made sure patients living with mental health problems and dementia, received the necessary care to meet all their needs. For example, in the pre-operative clinic, staff helped patients who felt anxious about attending the hospital for surgery by showing them a virtual theatre tour.

Staff could access help for patients with mental health needs or learning disability during clinic hours. When needed, staff contacted the dementia nurses and the mental health liaison team for further support. Aspects of the service provided to patients with dementia was included within the patient led assessments of the care environment (PLACE reviews).

The outpatients service did not meet all the individual needs of patients with sensory loss. Audio induction loop systems were not available in all departments to support patients with reduced ranges of hearing. However, managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. Staff across the outpatient department also had access to sign language interpreting services for deaf patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The learning disability team produced easy read feedback forms for staff to give to patients with a learning disability.

**Staff coordinated care with other services and providers.** The outpatient therapy service was part of an integrated structure combining resources of two organisations in the community and acute trust. This integrated approach aimed to ensure patients’ needs were met across the whole system. ‘First contact practitioners’ ensured patients were signposted onto the correct pathway to meet their needs at their first appointment.

A specialist nurse provided a service for teenagers and young adults aged between 16 and 24 who were living with cancer. This nurse made sure young patients received coordinated care that met their needs which were often uniquely complex. This involved liaising with GPs and other healthcare providers and charities. For example, on one occasion, this nurse had approached a charity to fund the travel and accommodation for a patient who needed treatment a long way from home.

**Access and flow**
People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment were not always in line with national standards.

A good proportion of the waiting times were within standards and the service was fully focussed on making further sustainable improvements.

Managers monitored waiting times. The bookings team provided a report to each of the care groups every week. This detailed all patients waiting for appointments. Specialties produced reports that were specific to the clinical risks in their specialty, for example, in ophthalmology, bespoke reports detailed the profile of patients with macular disease and glaucoma.

Patients with the most urgent needs had their care and treatment prioritised. Staff regularly discussed complex patients and checked to make sure these patients were receiving the right level of care. After each clinic appointment, outpatient teams completed an ‘outcome form’. This recorded the next step for the patient. This meant patients could be tracked on the treatment pathway and delays monitored.

The bookings team allocated follow up appointments based on urgency of clinical need and the length of time patients had been waiting. The outpatients service used a co-efficiency tool to determine urgency according to agreed criteria for each specialty.

Action was taken to minimise the length of time that patients had to wait for care treatment or advice. The bookings team attended the referral to treatment meeting every week and used this forum to highlight the need for additional clinics to meet demand where necessary. There were rapid access clinics for urgent patients. For example, the hepatology service offered a rapid access clinic twice a week for patients presenting with painless jaundice. The team aimed to see these patients within two weeks of referral.

Not all aspects of the booking process were efficient. At the time of our inspection, the systems for vetting referrals were not consistent. The purpose of vetting was to allocate patients to the right resource to meet their needs in an appropriate time frame. In most specialties, consultants and specialist nurses vetted referrals. One speciality accepted referral without vetting, others completed the process electronically, other specialties required booking staff to print off referrals and manually deliver these to specialty offices and then collect referrals the next day.

Not all clinics ran on time. Not all measures were taken to minimise disruption to patients during these delays. There was no visual display of expected waiting times. Managers did not monitor the time patients waited in the waiting room.

However, in the cancer outpatient clinic, staff worked flexibly to extend the working day when radiotherapy equipment breakdowns delayed the start of treatment. In the main outpatient’s clinic, a minimum of two staff remained in the department to care for patients who were waiting for transport to return home, or for patients attending clinics which had overrun.

Managers worked to keep the number of cancelled appointments to a minimum. Medical staff were required to give at least six weeks’ notice for all annual leave or study leave so clinic cancellations could be kept to a minimum. Any exceptions were required to be authorised by the General Manager and the Director of Operations.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Leaders had begun work to improve utilisation of clinic rooms in the main outpatient department. Limited space was an ongoing challenge for the service. Teams aimed to improve the process for booking clinic
rooms. This included identifying additional space which may be available when clinics were cancelled.

Not all patients could access services when needed. Not all patients received treatment within agreed timeframes and national targets. Data for referral to treatment times and cancer waiting targets showed a mixed performance picture. For example, the number of patients receiving treatment within 18 weeks of referral in ophthalmology was 5% higher than the England average, and at the time of our inspection there was no waiting list for renal outpatients. However, the number of patients receiving treatment within 18 weeks of referral in gastroenterology was almost 20% below the England average.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From July 2018 to June 2019, the trust’s referral to treatment time (RTT) for non-admitted pathways has been generally similar to the England overall performance with improved performance in the last two months (May 2019 and June 2019). The latest figures for June 2019, showed 88.1% of this group of patients were treated within 18 weeks versus the England average of 86.7%.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Royal Cornwall Hospitals NHS Trust.**

![Graph showing referral to treatment rates](image)

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

Eight specialties were above the England average for non-admitted 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>Other</td>
<td>94.2%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>93.5%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>91.2%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>88.2%</td>
<td>85.5%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>87.9%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>85.9%</td>
<td>84.1%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>82.2%</td>
<td>79.9%</td>
</tr>
</tbody>
</table>
Seven specialties were below the England average for non-admitted 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>Geriatric medicine</td>
<td>93.8%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>88.9%</td>
<td>90.8%</td>
</tr>
<tr>
<td>General surgery</td>
<td>83.1%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>80.9%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>70.7%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>69.9%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>60.9%</td>
<td>80.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – incomplete pathways**

From July 2018 to June 2019 the trust’s referral to treatment time (RTT) for incomplete pathways has been worse than the England overall performance. However, the trust’s performance has improved over the 12-month period and the latest figure for June 2019, showed 86.9% of this group of patients were treated within 18 weeks versus the England average of 85.8%.

**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**

Eight 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>General medicine</td>
<td>100.0%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>97.2%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>91.7%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Neurology</td>
<td>90.0%</td>
<td>86.2%</td>
</tr>
</tbody>
</table>
Eight specialties were below 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>Other</td>
<td>88.1%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>87.5%</td>
<td>90.8%</td>
</tr>
<tr>
<td>General surgery</td>
<td>83.1%</td>
<td>83.9%</td>
</tr>
<tr>
<td>Urology</td>
<td>81.3%</td>
<td>84.6%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>81.2%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>80.9%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>74.5%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>69.3%</td>
<td>81.3%</td>
</tr>
</tbody>
</table>

(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 performed better than the 93% operational standard for people being seen within two weeks of an urgent GP referral for the first two quarters of the reported period (July 2018 to December 2018). Performance deteriorated below the 93% standard from January 2019 to June 2019.

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 performed 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
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing below 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.

Not all patients could access therapy services when needed. Patients did not always receive treatment within agreed timeframes and targets. The trust set a referral to treatment target of 92% for therapy teams. Staff in the physiotherapy outpatient service had met this target with 93.1% of patients being seen within 18 weeks of their referral. The outpatient occupational therapy service had not met the target with 80.5% of patients being seen within 18 weeks of their referral. The dietetics service had also not met the target with 89.5% of patients being seen within 18 weeks of their referral. Data for follow up appointments showed 100% of all patients seen in all the therapies were seen for follow up within 18 weeks.

Managers were taking action to improve waiting times for appointments. The high demand for services was recognised in the outpatient transformation strategy and many aspects of this work was focussed on finding alternative innovative ways to meet the needs of patients. Services such as ophthalmology, dermatology and cardiology had outsourced some clinics to independent health providers. In gastroenterology, the team were utilising an extra clinic room to increase clinic
capacity. In the main outpatient department, teams had met to discuss best use of room space and this was an ongoing project. Many specialties were finding alternative methods to meet patients’ needs, for example, providing virtual clinics and community-based clinics. In some specialties there were nurse-led clinics, for example, cardiology and respiratory. Specialties encouraged patients to self-manage their condition. For example, in the diabetic clinic patients used an online portal to upload their blood results and then discussed these on the telephone with specialist nurses. Additionally, therapies were undertaking a project to transform its outpatient pathways with the aim of improving waiting times and access to its services.

In breast care, the team had reduced their waiting list. They had achieved this by adding a new pathway for patients not requiring multiple investigations, redesigning the referral proforma to involve GP’s in the triage process, and contracting work to an independent healthcare provider to provide weekend clinics.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. From August 2018 to July 2019 the trust received 34 complaints in relation to outpatients at Royal Cornwall Hospital (7% of total complaints received by the hospital).

Staff understood the policy on complaints and knew how to handle them. For example, in the respiratory outpatient’s clinic, staff tried wherever possible to respond to patients concerns immediately and resolve these without the need for formal procedures.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed three letters responding to patients who had made a formal complaint about an outpatient service. Each of the letters clearly addressed all aspects of the complainant’s concerns, providing a clear rationale for why the issue raised had or had not been upheld. However, managers took longer than expected to complete the investigation process. From August 2018 to July 2019, managers investigated and closed 28 complaints in the outpatient’s service. This process took an average of 43.2 days, this is not in line with the trust complaints policy, which states complaints should be completed within 30 days.

Managers investigated complaints and identified themes. Clinical treatment accounted for 41%, the highest number of complaints in the outpatient service between August 2018 to July 2019. For example, following several complaints about delays in the hand therapy clinic, managers changed the timetable of the clinic to reduce the likelihood of over-running.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, the patient services team had altered the template for outpatient appointments to provide directions and clearer information about the location of clinics.

Staff could give examples of how they used patient feedback to improve daily practice. For example, following a complaint in the gynaecology outpatient’s clinic, staff made sure referral letters were signed off electronically in a timely way.

Summary of complaints

A breakdown of complaints by type is shown below:
<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>14</td>
<td>41%</td>
</tr>
<tr>
<td>Appointments</td>
<td>7</td>
<td>21%</td>
</tr>
<tr>
<td>Values and Behaviours (Staff)</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>Communications</td>
<td>3</td>
<td>9%</td>
</tr>
<tr>
<td>Trust Admin/Policies/Procedures including Patient Record Management</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Admissions and Discharges (Excluding Delayed Discharge Due to Absence of a Care Package - See Integrated Care)</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Access to Treatment or Drugs</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Note due to the rounding of percentages the total figure may not add up to 100%.

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

**Number of compliments made to the trust**

From August 2018 to July 2019 there were 1,071 compliments about outpatients at the Royal Cornwall Hospital. The highest numbers of compliments were reported for radiotherapy and the mermaid centre.

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

**Is the service well-led?**

**Leadership**

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

Leaders understood and managed the priorities and issues the service faced. Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. The senior leaders clearly explained the challenges in the outpatient department relating to specific clinics, lack of consultant cover, referral to treatment times and the need to reduce waiting lists. Managers held improvement ‘summits’ for cardiology, gastroenterology and neurology specialties. For example, an internal summit for cardiology was held in August and a working group was then set up to address the issues raised with support from the quality improvement team.

Leaders had the integrity, skills and abilities to run the service. Staff described their leaders as skilled and having integrity. Leaders were passionate about working together to deliver improvement. There were clear priorities for ensuring sustainable, inclusive and effective leadership, through the development of a leadership programme. Staff spoke positively of the internal ‘Brilliant Leaders’ course delivered by the trust. Staff who had attended the course told us they now felt the trust was ‘investing in people.’

Leaders supported staff to develop their skills and take on more senior roles. There were clear priorities for ensuring sustainable, inclusive and effective leadership. Leaders supported more staff
to gain skills and work experience to become future leaders. The senior nurse in the general outpatient department mentored a band six member of staff in taking on band seven roles and responsibilities to provide cover for the senior nurse when they were not at work. Leaders supported less experienced members of staff to develop and implement their ideas in the different clinics. For example, there were new systems and protocols in the virtual fracture clinic and the safeguarding processes had been developed.

Leaders were visible and approachable in the service for patients and staff. Staff told us leaders were visible and approachable. Other members of staff also spoke highly of their line managers and told us they were supportive and felt they could access them and raise concerns if needed.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action. developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders and staff understood and knew how to apply them and monitor progress.

Leaders were aware that the current devolved outpatient department was not always effective and there was a need to redesign the service. The outpatient transformation strategy encompassed three workstreams. The referral management workstream aimed to provide a systemic consistent approach to referrals. This included, for example, addressing variations in referrals, developing new models of referral management. The transforming delivery workstream aimed to develop innovative methods of working. This included, for example, looking at new ways to reduce patient cancellations and non-attendances, and ensuring the effectiveness of outpatient procedures. The self-management and care workstream aimed to support clinicians to enable patients to be more independent in self-care of their condition. For example, teams planned to develop a comprehensive library of patient information videos to reduce need for face to face appointments and telephone queries.

The strategy was developed with all relevant stakeholders and was aligned to local plans within the wider health economy. The trust had recently invited the Cornwall and Isles of Scilly Health and Social Care Partnership Outpatient Transformation Board to join their outpatient strategy meetings. The focus of the merged meeting would be whole system-wide transformation and development strategy.

Leaders and staff understood and knew how to apply them and monitor progress. The strategy was well defined, with clearly identified leads for every aspect of its delivery. The operational lead was tasked with providing monthly update reports to the operational board, the quality improvement delivery board and the sustainability and transformation partnership (STP) board. The trust had recently invited the Cornwall and Isles of Scilly Health and Social Care Partnership Outpatient Transformation Board to join their outpatient strategy meetings. The focus of the merged meeting would be whole system-wide transformation and development strategy.

Minutes of the outpatient transformation board showed each item on the strategy was reviewed and progress scrutinised.

Clinical leaders showed understanding of how the outpatient transformation strategy related to their specialties as well as an awareness of how the local strategy linked with regional and national plans. For example, in cancer outpatient services, the team were looking to appoint a project lead to analyse irregularities and blocks in the patient pathway. The vision was to have clear visibility of pathway options for patients, so teams could put together bespoke packages of treatment resources based on individual patient needs.
Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

One member of staff told us ‘it’s a pleasure to come to work.’ Staff appreciated being nominated for trust wide awards. The bookings team told us they had the best staff survey results in the hospital. In one team newsletter we saw that managers praised a member of staff for ‘working her socks off’.

Managers listened to their teams. For example, staff had opportunities to speak up daily at their safety huddles. Consultants told us the board was listening to them and this translated to tangible investment in their service, for example, the provision of new equipment and the recruitment of staff.

Staff were focused on the needs of patients receiving care. Staff told us they had seen a change in cultural thinking across the service and an improved sense of shared responsibility for delivering high quality care. Staff across the different outpatient clinics told us they supported each other as a team and worked hard to ensure the best experience for patients. For example, service managers spent time in the bookings office to understand how the bookings team were working to reduce delays to patient appointments.

The service promoted equality and diversity in daily work and provided opportunities for career development. Staff of all grades told us the culture was inclusive and open. In the bookings team, managers were proud of their apprentice scheme, they had employed three apprentices who were later successful in gaining more senior roles.

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff told us the culture had become more open and honest. Staff now felt empowered to report incidents and raise concerns with their line managers. Staff were aware of the Freedom to Speak-up Guardian and their role and felt confident to raise concerns. One member of staff spoke of their positive experience after raising a concern this way.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Staff at all levels were clear about their roles and accountabilities. All staff understood their role in the new governance structure. Following our previous inspection, the trust had introduced a new governance structure, moving from four divisions to seven care groups. The outpatients service was governed by all seven care groups due to the broad nature of services offered. Staff consistently spoke positively of the new set up and the improved lines of communication across the care groups with clearer lines of support.

Leaders operated effective governance processes, throughout the service and with partner organisations. There were improved structures, processes and systems of accountability to support the delivery of good quality care and implementation of the outpatient improvement strategy. All levels of governance and management functioned effectively and interacted with each other appropriately.
Specialty governance arrangements were updated. The teams ensured governance processes were compatible with the system wide patient pathway. For example, the health psychology team had undertaken a review of their governance processes to ensure the model was fit for their purpose. This had resulted in an 18-month long process of reform that included investment in continuing professional development, training new staff, embedding a new team within the acute setting and auditing patient notes.

Leaders identified areas to improve within the new governance framework. Leaders of the outpatient service were aware not all specialty governance meetings followed a standard agenda. Work was ongoing to improve consistency.

Staff had regular opportunities to meet, discuss and learn from the performance of the service. Teams held morning safety briefings. At these meetings, leaders shared relevant patient safety information and staff had opportunity to raise any concerns. Each service held weekly governance huddles to discuss pertinent risks, changes to policies or procedures, learning from incidents. Each speciality across the outpatient service had its own monthly governance meeting. This reported to the monthly specialty care board. Representatives from the care board reported to the monthly trust board meeting.

There were governance procedures to monitor waiting lists, waiting times, frequency of cancelled clinics. For example, the access and referral to treatment performance meeting was held weekly. Standard items on this agenda included referral to treatment performance and harm reviews. These meetings were effective. Referral to treatment timelines for patients were improving. In September 2019 there was only one patient who had been waiting 52 weeks for an appointment.

There was good representation of outpatient staff at governance meetings. For example, the Access and Referral to treatment performance meeting was attended by the director of operations, all care group general managers, and representatives from the bookings team, outpatient services and cancer services.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders and teams used systems to manage performance effectively. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Each service had introduced weekly performance huddles to discuss performance. This included, for example, progress with mandatory training compliance, appraisals and finance.

The outpatient service planned to introduce an internal accreditation scheme. This was part of the outpatient transformation programme and had not started at the time of our inspection.

Managers maintained oversight of the trust-wide audit process by the clinical effectiveness group and within the care group governance processes. The trust presented data that showed audits relating to outpatient care were completed. For example, audit of the management and prevention of venous thromboembolism was completed, an audit of consent was planned to start in December 2019.

Staff identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff were aware of risks relating to their clinical area. For example, there was one
specialist nurse to cover the renal anaemia clinic and no other staff were trained in this role. This nurse was informed about progress to mitigate this risk.

The trust provided outpatient risk registers for two care groups, general surgery and cancer services care group and the specialist medicine care group. However, these risk registers did not include the risks identified during our inspection. For example, the outpatient risk register did not record all the risks relating to fire safety equipment.

All specialities across the patient department carried out harm reviews of their waiting lists to ensure patient did not come to harm when waiting for an appointment. Staff understood the importance of this process and in some specialities, for example oncology, they had developed bespoke processes to ensure the harm reviews met the specific needs of their patient group. This information fed into the weekly governance safety huddles, the speciality meetings and the care board. Action was taken to expedite patient appointments if there was a risk of harm.

There was comprehensive oversight of the risks related to controlled drugs. For example, there was an electronic system that monitored inappropriate usage of controlled drugs. The system flagged where there was an increase in usage of a controlled drug and produced a report, based on previous stock issue volumes to that clinical area. Prescribing habits were also monitored. Any discrepancies were escalated to the controlled drugs accountable officer.

Leaders had plans to cope with unexpected events. For example, at the time of our inspection, the electronic referral system had not been working for four days. We saw the booking team had activated a contingency process to ensure patient referrals were not delayed or mislaid during this period.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Team managers had access to a range of information to support them with their management role.

Managers used an outpatient’s dashboard to summarise performance in this core service. This included up to date performance metrics, for example, number of referrals and patients that attended clinics, number of clinics held, percentage of patients that did not attend, cancellations with less than six weeks’ notice. This information was available for all specialties.

Managers could access data regarding referral to treatment times for each of the specialities in their care group. Relevant managers had clear visibility of waiting lists and the co-efficiency tool to quantify patient risk in an understandable and communicable way.

Staff accessed several information technology systems containing patient information to support care and treatment planning for patients. Staff accessed these systems using protected passwords.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. They did not actively and openly engage with equality groups and the public.
There were opportunities for patients to engage with the service. For example, the cancer outpatient teams liaised with the Cornwall and Isles of Scilly patient group who met every three months to discuss issues relating to patient experience.

In several clinics, specialty teams had redesigned the existing patient experience questionnaire to gather relevant feedback about patients experience in their specific outpatient setting. At the time of our inspection, data had not yet been analysed. However, teams planned to use the questionnaires to identify areas where improvements could be made to the service.

Staff asked patients for their expertise. When staff in the Mermaid Centre found cancer, patients were not following guidance related to how much they should drink before appointments, they asked patients to review and change this information leaflet. When leaders made changes to protocols, such as the introduction of video consultations, the projects included evaluation of patient and clinician experience.

The executive team engaged with outpatient staff about the redesign of the outpatient service and the outpatient transformation programme through team talks delivered by the chief executive, and recent roadshows delivered by the trust.

Leaders collaborated with partner organisations to help improve services for patients. For example, the standard operating procedure for outpatient clinic letters was being revised to incorporate suggestions from primary care providers.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Clinical leaders were proactively working with the bookings team to implement a new referral assessment system.

Staff had a good understanding of quality improvement methods and the skills to use them. For example, the outpatient clinic within the Urgent Emergency and Trauma care group were working with the trust-wide quality improvement team to implement an improvement plan.

Leaders encouraged participation in research. For example, the bariatric clinic was part of an ongoing research study in conjunction with Bristol University looking at metabolomics (substances in the body necessary for the metabolism).

Leaders encouraged innovation. In cancer outpatient services, an oncologist had developed an application for mobile phones. This ‘app’ contained information for patients on all aspects of their cancer care, including treatments, side effects, parking and travel information. The app was used across the geographical region and had won the ‘App of the Year’ and ‘Overall Winner’ at the Health Tech Newspaper Health Tech awards in 2018.

Teams in several specialties were introducing video consultations in their outpatient clinics. At the time of our inspection, this was in progress within Hepatology and Neurology Clinics.

Teams participated in recognised accreditation schemes. The purpose of accreditation is to define and monitor standards of care, organisation and quality within services. For example, the urogynaecology clinic was accredited with the British Society of Urogynaecology. The hepatology clinic was working towards accreditation as part of the Improving Quality in Liver Services Scheme.
The Cornwall Endometriosis Centre is a BSGE (British Society for Gynaecology Endoscopy) nationally accredited specialist service for the management of patients with Endometriosis. We manage women with a potentially long-term condition that have significant and complex needs especially around pain management.