

Royal Cornwall Hospitals NHS Trust

Quality Report

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

Ratings

Overall rating for this trust

Inadequate 

Are services at this trust safe?

Inadequate 

Are services at this trust effective?

Requires improvement 

Are services at this trust caring?

Good 

Are services at this trust responsive?

Inadequate 

Are services at this trust well-led?

Inadequate 

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Cornwall Hospitals NHS Trust is the principal provider of acute care services in the county of Cornwall. The trust is not a Foundation Trust and performance is monitored by NHS Improvement (NHSI). The trust serves a population of around 532,273 people, a figure that can be doubled by holidaymakers during the busiest times of the year.

CQC has previously carried out two comprehensive inspections at Royal Cornwall Hospital NHS Trust. The first being in January 2014 when the Trust was rated as requires improvement. In June 2015 we carried out a follow up to the first inspection and found the trust had not made sufficient progress in all areas and a second comprehensive inspection was initiated, which we carried out in January 2016. At that time, the trust was rated as requires improvement overall. We rated safe, effective, responsive and well led as requires improvement and caring as good.

A further unannounced focused inspection was conducted on 4 and 5 January 2017. We reviewed end of life and urgent care services to review progress against the inadequate ratings for those core services as identified on the previous inspection in January 2016. We reviewed medicine services as continued intelligence had raised concerns with regards to quality and safety of the service. We also looked at the governance and risk management support for the services we inspected. We rated urgent care services as requires improvement, end of life care services and medicine services as inadequate. We did not rate the trust overall as a result of this inspection.

This inspection took place between 4 and 7 July 2017, and was a focused announced inspection. We undertook a further unannounced inspection on 17 and 18 July 2017. We revisited those core services that we had not inspected in January 2017, with the exception of sexual health. We did not revisit medicine or urgent care services, but we did revisit the safe and well led domains in end of life care. We also inspected governance and risk management support for those services we inspected.

This inspection also covered the following sites:

- St Michael's Hospital (for surgery and outpatients and diagnostic imaging)
- West Cornwall Hospital (for surgery and outpatients and diagnostic imaging)
- Penrice Birthing Centre (for maternity)

We had serious concerns that systems to assess, monitor, and mitigate risks to patients receiving care and treatment were not operating effectively. We also had concerns that governance systems and processes were not operating effectively. We served the trust with a Section 29A warning notice on 29 August 2017. The notice required the trust to make significant improvements by 30 November 2017. There were, however, a number of areas where the trust were required to give evidence of immediate action to ensure risks were being identified and managed in the interim. These included processes being in place for identifying and managing deteriorating women in maternity and systems and processes being in place to monitor and manage non-admitted cardiology and ophthalmology patients. Additionally the trust were required to provide evidence that there were two paediatric trained staff on duty at all times in the paediatric emergency department and that a risk assessment had been completed for paediatric staffing in the emergency department and obstetric theatres.

We rated Royal Cornwall Hospitals NHS Trust as inadequate overall. Surgery, maternity and gynaecology, end of life and outpatient services were rated as inadequate and critical care and children and young people's services were rated as good. These ratings have been aggregated with the findings from the core services we inspected in January 2017.

There are separate location reports for each of the above sites, although any overarching findings from those location reports are included in this report as relevant.

Key findings:

Summary of findings

Safe:

- We rated safety as inadequate overall. Surgery, maternity and gynaecology and outpatients and diagnostic imaging were rated as inadequate, services for children and young people and end of life care were rated as requires improvement, and critical care and St Michael's Hospital were rated as good. Safety at West Cornwall Hospital and Penrice Birthing Centre were rated as requires improvement.
- When concerns were raised in surgery or things went wrong, the approach to reviewing and investigating causes was unsatisfactory or too slow. There was little evidence of learning from events or action taken to improve safety. When something went wrong, patients or those close to them were not always told and did not always receive an apology.
- The systems and processes for identifying, grading and managing incidents were not effective and were not conducted in a timely manner.
- The threshold for incident reporting was high so not all incidents were reported. This was true in both maternity and gynaecology.
- There was no evidence of oversight or scrutiny of incidents that related to end of life care at the trust. Therefore, there was no evidence of learning or changes in practice that had resulted from such incidents.
- There was not a clear incident reporting process for staff to follow in the event of a delayed fast track discharge in end of life care. There was also no evidence of executive oversight of the problem caused by inconsistent reporting, and a lack of anyone with clear responsibility for the issue.
- Incidents were not always reported promptly for outpatients. This impacted investigation timeliness and delayed potential learning opportunities.
- Safety was not a sufficient priority. There was limited measurement and monitoring of safety performance. There were significant numbers of serious incidents or never events in surgery.
- Staff did not always assess, monitor or manage risks to patients. Some opportunities to prevent or minimise harm were missed in surgery.
- Changes were made to surgical services without due regard for the impact on patient safety. There were inadequate plans to assess and manage risks associated with anticipated future events or emergencies in both surgery and maternity.
- Not all patients with severe sepsis had timely access to intravenous antibiotics.
- Guidance for midwives in critical areas such as escalation of deteriorating women was sometimes conflicting. For example, the escalation instructions on maternal early warning score (MEOWS) charts did not align with the guidance on the policy on managing the severely ill obstetric woman.
- There was no dedicated high dependency area for deteriorating women and no process to ensure that that there was always a nurse or midwife on duty with the necessary competencies to manage high dependency women. The service did not monitor the number of women needing this level of care.
- One theatre on the delivery suite had dedicated staffing. The contingency plans for using the second theatre in an adjoining room were not clearly understood and an additional theatre team was not readily available, which could result in delays and potentially a risk to women and babies. The process for opening and staffing the second theatre were not well communicated and practiced.
- Risk assessment was poor at all levels. We saw inconsistent use of maternal early warning score (MEOWS) charts and partograms (a composite graphical record of key maternal and foetal data during labour) meant there was a risk that staff might miss signs of deterioration in a woman; on the postnatal ward emergency medicines had been taken off the ward because of the heat, without assessing the risk of doing this, should there be an emergency. Some risks such as staffing were not on the corporate risk register.
- Other risks had not been identified or monitored, for example skills required of community midwives lone working in remote locations, suitability of the second obstetric theatre and staffing levels in the emergency paediatric department.
- The delivery suite capacity was insufficient for the number of women giving birth with the result that women laboured on the antenatal ward several times a month, often without one-to-one care from a midwife for the whole of their established labour.

Summary of findings

- More women than the agreed number were being induced on some days, and these inductions were not planned to take into account activity or capacity on the delivery suite to ensure that induction was safe.
- Ophthalmology and cardiology follow up appointment waiting lists were too long and patients were coming to harm through delays in treatment. The process for risk assessment was not sufficient to adequately protect patients from harm and there were no clear action plans to manage and reduce the backlogs.
- There was a significant backlog in reviewing some cardiology 24 hour tapes which put patients at risk.
- Patient identifiable information, including the results of pregnancy tests, was found in two unlocked sluice rooms on a surgical ward. Other patient identifiable information was found unattended and accessible to the public.
- The different records about women in the maternity service were not linked. Women's hand held records and hospital records, and safeguarding information were held on a separate database which made it difficult for midwives to have an overview of women's health and social history.
- There was not sufficient information or audit for the trust to be assured of the effective use of end of life care documentation. Audits did not address the quality or completeness with which the documentation was completed or understood, and did not contain any follow up action plans to address the issues raised.
- Paper based patient records, including test results in outpatients were not stored securely.
- Due to a different system in operation, the critical care unit did not use the electronic prescription charts used throughout the rest of the hospital. There had been some safety issues for patients discharged from the unit due to staff not always following the correct handover processes for medicines for the patient prior to their discharge.
- Not all staff in the surgery division had received effective mandatory training in the safety systems, processes and practices.
- Multiple mandatory training modules had not been completed by medical staff and therefore did not meet trust targets.
- We could not be assured that community midwives had up to date skills. They did not have training to cannulate women, and not all were up to date with neonatal life support training. We could not be assured that community midwives had the necessary equipment to manage obstetric or neonatal emergencies in the community in the event that the ambulance was delayed.
- Midwives required training and competency assessments in providing epidural top ups, in and in care of high dependency women. The overall 85% target set for training completion in maternity was lower than the trust target for training completion of 95%.
- Completion of some mandatory training was also below trust target for staff in children and young people's services and required improvement.
- Although safeguarding training compliance had improved in services for children and young people it remained a challenge and required continued improvement.
- At West Cornwall Hospital, we were unable to evidence the completion of simulation scenarios to respond to patient emergencies.
- We could not be assured that community midwives had up-to-date skills. They did not have training to cannulate women and did not have the necessary equipment to manage obstetric or neonatal emergencies in the community in the event that the ambulance was delayed.
- The emergency resuscitation team did not always have immediate access to a member of staff who was able to deal with difficult airway intubation in surgery.
- The service did not always ensure there was adherence to the World Health Organisation (WHO) surgical safety checklist and audits of the checklist did not provide assurance of compliance.
- Some equipment in surgery and at West Cornwall Hospital was not serviced, maintained, tested or calibrated.
- During our inspection, we noticed the critical care unit was not completely free of dust.
- Checks were carried out on the difficult airway trolley in critical care but were not permanently recorded.
- There were insufficient waste bins on the critical care unit which increased the risk of contamination.
- The antenatal ward was not secure. Open access to the Day Assessment Unit (DAU) which was combined

Summary of findings

with the antenatal ward was a safeguarding risk to women on the ward. There was also a risk to women's privacy and dignity. These risks were not on the risk register.

- There were environmental risks on the hospital site: the delivery suite had cracked flooring and worn baths which presented an infection risk and the postnatal ward was uncomfortably hot in summer, with trip risks from fans in corridors, and reported problems with drainage and insects. The ambient temperature of rooms where medicines were stored was not always measured.
- There was no clear nursing observation area on the high dependency unit of the children's ward and this represented a risk to children who were not visible to nursing staff at all times.
- The fracture clinic was a risk to patients due its design, unregulated clinic temperature and poorly maintained furnishings. Arrangements to ensure children were safeguarded whilst in the department were not adequate.
- Staffing levels in surgery were consistently under plan on most wards during the day.
- Safety briefings did not always take place prior to the start of an operation or theatre list.
- There were not enough midwives to provide a safe service in all areas at all times. Staff had to activate the escalation policy frequently to achieve safe staffing in the delivery unit. Staffing concerns were not on the risk register.
- Safe skill mix in maternity was not always achieved. There was no system to ensure that there was always a midwife or nurse on the delivery suite with skills in caring for a woman needing high dependency care.
- The handovers on the delivery suite were not multidisciplinary; there were multiple handovers several times a day, midwives to midwives and doctors to doctors at different times which were inefficient. Handovers did not clearly highlight risks. There were no safety briefs occurring in the maternity service.
- There had been gaps in gynaecology on call cover which was a risk to women.
- There were insufficient numbers of suitably qualified nursing staff in the paediatric emergency department to provide safe care at all times. There were also no

formal processes in place to ensure appropriate cover was in place in the department at all times, particularly during periods when the qualified nurse was temporarily absent from the department.

- The specialist palliative care team was too small to meet the demands of the trust as per national guidance. It was only able to provide a five day a week service, and even this stretched capacity of the team with limited cover arrangements to accommodate annual leave and sickness. This issue was reported upon following both the January 2017 and January 2016 inspections.
- Treatment escalation plans were audited and consistently shown not to be completed fully, often missing essential information about whether patients had mental capacity to consent to the plan. Incomplete treatment escalation plans were reported on following both the January 2017, and January 2016 inspections.

However:

- Staff were aware of their responsibility to report incidents in critical care and services for children and young people. The electronic reporting system had been improved since our previous inspection. Individual reporting of incidents specific to end of life care had improved since our last inspection and the ability of staff to identify such events was good in many of the areas we visited.
- There was good engagement in morbidity and mortality meetings in surgery, which led to service improvement.
- Surgery ward safety briefings held every morning were well attended, with good communication where safety concerns were aired openly.
- There was an improvement month on month in the number of patients with an end of life care plan based on the five priorities of care.
- Safeguarding was well-managed in maternity as part of an integrated hospital safeguarding team. New safeguarding paperwork had been introduced to improve the quality of safeguarding records and a database enabled midwives to check safeguarding referrals.
- Staff we spoke with in services for children and young people were knowledgeable about the trust safeguarding process and were clear about their responsibilities.

Summary of findings

- Safeguarding policies and procedures were available to staff in outpatients who knew how to access and follow these.
- A new electronic maternity information system due in October was planned which would enable more comprehensive records to be kept and improve the accessibility of information.
- Nursing and medical records had been completed appropriately and in line with each individual child's needs.
- Medicines, including controlled drugs were stored safely in critical care, and accurate records of use were maintained.
- Systems were in place in children and young person's services for the safe storage and administration of medicines and appropriate audit trails were in place for controlled drugs.
- There were effective arrangements in place around the prescription of anticipatory medications to ensure that end of life patients' symptoms could be managed in a timely way.
- Audit compliance scores for the cleanliness of the critical care unit environment were high, which reduced the risk of patients developing unit acquired infections.
- Accommodation in maternity was visibly clean and equipment was well-maintained. There had been no incidents with a contributing factor relating to maintenance in the twelve months to June 2017.
- The children and young people's units were clean and well organised. Staff adhered to infection prevention and control policies and protocols.
- Cleanliness and infection control were found to be well audited and compliant in outpatients. Staff adhered to infection control procedures.
- World Health Organisation (WHO) surgical safety checklists were used in the obstetric theatre and gynaecology theatres and we saw evidence of good compliance.
- Equipment, such as syringe drivers and specialist mattresses were readily available for end of life patients who needed it.
- Staff in maternity reported the quality of training was high. Funds had been secured and dedicated for enhanced training over the coming year
- Nurse staffing levels on the critical care unit had improved and agency use had reduced since our last inspection. Further recruitment of nurses had taken place and was ongoing to ensure the critical care unit was compliant with the Faculty of Intensive Care Medicine Core Standards for nurse staffing levels.
- Medical staffing levels had also improved and further recruitment was taking place at the time of our inspection.
- There was 60 hours consultant cover on the delivery suite which met the recommendations of the Royal College of Obstetricians and Gynaecologists for a maternity unit of this size.
- We found the time taken for diagnostic images to be reported was maintained by increasing staffing levels to meet demand.
- Areas we visited were proactively managing risks, both in and out of hours to meet the needs of patients who were at the end of life.

Summary of findings

Effective

- We rated effective as requires improvement overall. Surgery and maternity and gynaecology were rated as requires improvement, and critical care and services for children and young people were rated as good. We did not rate the effectiveness of the outpatients and diagnostics service. West Cornwall and St Michael's Hospitals were rated as good, and Penrice Birthing Centre was rated as requires improvement.
- Systems and processes for identifying, sharing and implementing new or updated guidance were not operating effectively.
- Clinical audits across the trust were not always planned or carried out in a systematic or timely way to ensure compliance and identify risks or learning. Results of clinical audits were not always shared with relevant staff.
- There was a maternity audit schedule for 2017 but no effective process to ensure that cyclical improvement was established and ongoing. Audit plans did not include audit of risks rated as high on the risk register. Changes were made in response to external factors and the service did not always plan these systematically.
- Outcome data for outpatients was confused and prevented staff from measuring clinic performance.
- We were not assured that all staff were up to date with recent guideline changes, particularly community midwives who did not have remote access to the guidelines. Some guidelines, such as the use of a partogram to show the progress of labour were not followed in many women's deliveries.
- Not all staff had up to date training to use specialist equipment and the system for monitoring competence was not effective.
- Children and young people's staff working in the community did not have access to the electronic records system used by another provider of community health care in the county. Staff said it was difficult to coordinate between the two systems and this could hamper delivery of effective care and treatment.
- Post inpatient follow up reviews did not always take place, which may result in a patient being readmitted for further care and treatment.
- There was limited support from some services at weekends, including pharmacy and physiotherapy.

- There were gaps in management and support arrangements for staff in some areas, such as appraisal, supervision and professional development.

However:

- We could see evidence from audits in some areas where the results triggered change, and evidence that some treatment provided was in line with best practice and national guidance, for example in critical care, gynaecology and children and young people services.
- We saw strong relationships between most multi-disciplinary teams.
- There was good compliance with NHS England's standards for seven-day working in hospitals.
- In critical care and children and young people's services, patients had good outcomes as they received effective care and treatment which met their needs. High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes

Summary of findings

Caring:

- Caring was rated as good overall and good for each core service. At St Michael's Hospital, caring was rated as outstanding.
- In surgery feedback from patients and relatives was positive overall. For example, the NHS Friends and Family Test scores were mostly above 90% for surgical wards between March 2016 and February 2017. However, the response rate was only 11%, compared to around 25% nationally.
- Patients and their families spoke almost entirely positively about the care they received while in the surgical division. Staff worked hard to uphold patients' dignity, individuality and human rights. We observed staff acting in a respectful, kind and compassionate way to patients and those close to them.
- Staff on the critical care unit were compassionate, kind and sensitive. Patients, relatives and visitors were complimentary about the compassion and kindness they had been shown.
- Communication with patients was effective as they were kept informed of their condition, progress and treatment. Patients' privacy and dignity was maintained throughout their treatment and staff took all steps to protect confidentiality.
- Those close to patients in critical care were involved in their care and were kept updated on any progress or deterioration in condition.
- Care delivered in maternity was kind and compassionate. Women we spoke with and their families spoke well of the care they received. Specialist midwives, helped women understand the specific needs of managing conditions such as diabetes alongside pregnancy.
- The Friends and Family test results were generally good both in maternity and gynaecology.
- Women had reasonable continuity of care before and after birth from a local team of community midwives which enabled them to establish trusting relationships.
- Staff were kind and non-judgemental in the unplanned pregnancy unit.
- Children and young people were treated as individuals and as part of a family. Feedback from children, young

people and parents had been consistently positive. They praised the way the staff really understood the needs of their children, and involved the whole family in their care.

- Parents said staff were caring and compassionate, treated them with dignity and respect, and made their children feel safe. Staff ensured children and young people experienced high quality care. Staff were skilled to be able to communicate well with children and young people to reduce their anxieties and keep them informed of what was happening and involved in their care.
- Parents, siblings and grandparents were encouraged to be involved in the care of their children as much as they wanted to be, whilst young people were encouraged to be as independent as possible. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand.
- We observed staff treating patients with kindness and warmth. The neonatal unit and the paediatric wards and the outpatient department were busy and professionally run, but staff always had time to provide individualised care.
- Staff talked about children and young people compassionately with knowledge of their circumstances and those of their families.
- Staff in outpatients adopted the "hello my name is" by way of introduction to all patients.
- We found people were supported, treated with dignity and respect and were involved as partners in their care.
- We observed outpatient receptionists talking to patients in a respectful way.
- Patients told us nursing staff and doctors explained clearly what options were available to them.
- Patients were empowered and supported to manage their own health, care and wellbeing.

However:

- Some patients we spoke with in surgery did not feel well informed about their care, particularly in terms of when their operation was to take place.
- The critical care unit was not using patient diaries but there were plans to introduce them later in the year.

Summary of findings

- There were no formal arrangements for counselling services in the critical care but the unit had developed close ties to the trust's chaplaincy service which provided patients with spiritual support.
- Although there was supportive care for women in maternity immediately around the time of bereavement, there was no follow up or counselling provided by hospital staff.
- Women were less satisfied with their experience of care on the postnatal ward, particularly during the high temperatures that prevailed during our inspection.
- Privacy and dignity was not always fully maintained as two delivery rooms on the delivery suite did not have blinds for privacy when the lights were on at night.
- The fracture clinic cubicles were small and close together. Private and confidential conversations in adjoining cubicles could be overheard.

Responsive:

- We rated responsiveness as inadequate overall. Surgery was rated as inadequate, critical care, maternity and gynaecology and outpatients and diagnostic imaging were rated as requires improvement and services for children and young people were rated as good. West Cornwall Hospital, St Michael's Hospital and Penrice Birthing Centre were also rated as good.
- Surgical services were planned to meet local needs but lack of capacity and resources meant that plans were not always delivered in a way which met patients' needs.
- The facilities and premises used did not always meet patients' needs or were inappropriate, with admission lounges used for surgical and medical patients overnight.
- Surgical patients were unable to access the care they needed at the right time, and referral to treatment times for incomplete pathways had been worse than average from March 2017.
- Pressures from non-elective admissions and delayed transfers of care led to significant levels of cancellations of elective operations. Twelve patients with cancer had their operation cancelled from January to May 2017, seven on the day of their booked operation.
- Patients were not always operated on in the correct operating theatres, and assessments to identify patient risks were not always carried out.
- Patients did not always have access to services in a timely way for an initial assessment, diagnosis or treatment. Patients experienced significant waits for some services. A high number of patients were not treated within 28 days of their operation being cancelled at short notice.
- There had been too many occasions when patients had to stay in recovery overnight because there were no available beds.
- Due to the lack of capacity within the hospital for beds, critical care patients did not always receive optimal care at the right time. There were frequent delayed admissions, delayed discharges and discharges which took place out of hours.

Summary of findings

- At times, level two patients were kept in the recovery area following surgery instead of being admitted to the critical care unit, due to the lack of bed capacity on the critical care unit.
- Patients were not always cared for in separate single sex areas due to patient flow issues.
- The critical care unit did not routinely screen for patients living with dementia when admitted onto the unit.
- In maternity there were regular delays in transferring women to the labour ward because of capacity on the delivery suite, both from limitations of accommodation and staffing.
- The service did not run a dedicated elective caesarean list. This could mean woman scheduled for elective surgery had to wait if there was an emergency underway on the day they were admitted.
- The day assessment unit only had two scanning slots a day. As a result, some women who attended for reduced foetal movements had to return for scanning on another day.
- Not all women were able to give birth in the community as planned as there was a low threshold for transferring women into the main consultant led unit.
- There was a risk to women's privacy and dignity on the antenatal ward as some women gave birth on the ward. The ward did not have closed doors and was merged with the day assessment unit.
- Few partners were able to stay overnight on the postnatal ward as space was limited.
- Some maternity services had to be closed at times because of staffing, such as the homebirth service, birth centres, early pregnancy unit and emergency gynaecology unit.
- There were long waiting times for referral to treatment for some (non-cancer) gynaecology procedures.
- There were delays in completing discharge summaries on the children's wards and performance required improvement.
- The temperature in the neonatal unit was not always at a suitable level.
- There were capacity and demand issues in ophthalmology and cardiology. These demands had led to increased waiting times and unacceptably long waits for follow up treatment.
- Action plans put in place had failed to reduce the number of people waiting for follow up appointments in cardiology and ophthalmology.
- The fracture clinic did not meet patients' needs and issues identified following our January 2016 inspection continued.
- Patients told us that directional and information signage for moving through the hospital were challenging.
- The outpatients' transformation programme had not managed to improve patient flow through the outpatient clinics.
- There were a high number of cancelled appointments for avoidable reasons.
- Not all outpatient clinics had been designed to be dementia-friendly.
- The surgery service consistently missed targets to respond to complaints within 25 working days. There was little evidence to show lessons had been learned and practice changed to demonstrate people who complained were listened to.

However:

- There were good arrangements for supporting patients with a learning difficulty going into theatre.
- The critical care unit had introduced measures to ensure patient flow in and out of the unit did not deteriorate. New systems for assessing bed capacity had been introduced which increased efficiency in the admission and discharge processes.
- Since our last inspection a critical care matron had been appointed which had increased the profile of the unit at daily bed meetings. The coordinators were now more aware of the capacity issues on the unit, which assisted in securing beds for critical care patients to be admitted to.
- The chief operating officer visited the critical care unit or had daily conversations with the critical care matron to assess the unit's bed capacity.
- Antenatal and postnatal services were provided in community locations as far as possible, reducing women's need to travel to the hospital.
- Women deemed low risk could choose to birth at home, at freestanding birth centres or at the hospital delivery suite.
- Midwives assessed women's mood during antenatal visits and were able to signpost women to sources of help for anxiety and depression.

Summary of findings

- The unplanned pregnancy service was discreet. Staff were non-judgemental and women gave very good feedback about their care and treatment. Women could access the service in both Truro and Penzance.
- There was a good range of information leaflets for women with early pregnancy problems detailing ways of managing these.
- Good use was made of Facebook to communicate with women and young people.
- Services were tailored to meet the needs of individual children and young people and were delivered in a flexible way.
- There were good facilities for babies, children, young people and their families.
- The environment for the neonatal service had improved considerably with the opening of the new unit in May 2017. Staff had been involved in the design and planning phase of the development of the unit
- There were no barriers for those making a complaint. Staff actively invited feedback from children and their parents or carers, and were very open to learning and improvement. There were, however, few complaints made to the service and those that had been made were fully investigated and responded to with compassion.
- Children and young people of all ages had timely access to care and treatment
- A new wide bore scanner was soon to be available to meet the needs of larger patients.
- We found the time taken for diagnostic images to be reported was adaptable and managed demand.
- Imaging was performing well and managing many of its key waiting times.

Well led:

- Well led was rated as inadequate overall. Maternity and gynaecology, end of life care and outpatients and diagnostic imaging were rated as inadequate, surgery was rated as requires improvement and critical care and services for children and young people were rated as good. West Cornwall and St Michael's Hospitals were rated as good, and Penrice Birthing Centre was rated as requires improvement.
- The arrangements for governance and performance management in surgery did not always operate effectively. Risks, issues and poor performance were not always dealt with appropriately or in a timely way.
- Not all leaders in surgery had the necessary time to lead effectively. The need to develop leaders was not always identified or action was not always taken. Leaders were not always clear about their roles and their accountability for quality.
- The sustainable delivery of quality care was put at risk by financial challenges facing the trust.
- There was no clear vision or strategy for service development in either the maternity or gynaecology service.
- Management of the maternity service was reactive in response to external reports or adverse events. At times the service focused on solving immediate issues without risk assessing the consequences of these actions on the wider service.
- The governance processes in maternity did not ensure quality, performance and risk were managed. The maternity dashboard held predominantly clinical information with no staffing information included.
- There was an absence of comprehensive performance and quality audit plan. Several significant risks were identified which were not on the register and risk assessments had not been undertaken.
- There was very little evidence of improvements by self-examination or benchmarking with other similar maternity services. The limited range of audits restricted the scope of quality monitoring and meant there could be little assurance that practices followed guidelines.
- There was some uncertainty concerning the flow of data about the maternity unit's performance to the hospital's executive team. The unit was not holding regular nursing meetings.

Summary of findings

- There was poor communication at executive level about the future plans for the end of life service at the trust and a lack of consultation on the business plan that lay behind these plans.
 - We saw a business plan for the development of end of life care at the trust going forward. However we saw little evidence that there had been any tangible improvements in end of life care with the exception of the increase in use of the end of life care documentation.
 - There was a lack of any systematic audit programme relating to end of life care, and few measures that addressed risk and quality. This issue had been reported following the inspection in January 2017.
 - There was no evidence that the end of life care strategy was being monitored or taken forward since the departure in May 2017 of the end of life facilitator. Key tasks such as training needs analysis within the strategy had not been completed.
 - There was no scrutiny or interrogation of, delayed fast track discharges, or the achievement of preferred place of care, for end of life patients and so no learning could be taken from these.
 - In outpatients governance procedures to monitor waiting lists, waiting times, frequency of cancelled clinics, and referral to treatment timelines for patients were not robust enough which meant the impact on patients was not fully known.
 - A programme of rolling improvements in the outpatient service was not delivering sufficient results in a timely manner and significant challenges remained.
 - Accountability for decision making was unclear in several speciality clinics. Leaders, including the board and divisional management, were not visible within the outpatients department.
 - In the surgical division the culture was dictated by senior and executive management. It was not one of fairness, openness, transparency, honesty, challenge and candour. We found there was a disconnect between the executive team and frontline staff.
 - Decisions in the maternity service were traditionally made at the top and then communicated to staff. Staff had become accustomed to a top down leadership style, however, efforts were being made to effect a change in this.
 - Some staff continued to feel the culture of the maternity services was punitive despite actions to involve more staff in open discussions about the service culture.
 - Bullying and undermining behaviour towards other staff, peers or juniors appeared to have been insufficiently challenged in the maternity service. This meant that there was not a clear reporting line of key clinical issues affecting the maternity service. The operational decision-making group for midwifery did not feed into either the obstetrics and gynaecology meeting or the maternity forum.
 - A significantly high number of outpatients staff at all levels felt the culture within the trust was one of intimidation, bullying and discrimination and several staff had left or been signed off with stress.
 - The critical care unit risk register did not highlight all risks identified by the service and some ongoing risks had been closed. There were also issues with the way in which risks were added and removed from the register.
 - We were not assured of sufficient oversight and management of the risk register relating to end of life care.
 - Staff and public engagement was not given sufficient priority in most of the core services. There was a limited approach to obtaining the views of patients who used services and other stakeholders. Feedback was not always reported or acted upon in a timely way. We saw few mechanisms for capturing feedback from patients, their families and carers, or from staff. There had therefore been no input from these groups into the end of life service. This issue had been reported following both the January 2017 and January 2016 inspections.
 - There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported and appreciated. Staff did not always raise concerns or they were not always taken seriously or treated with respect when they did.
- However:
- We found nursing, theatre and medical staff to be committed to the hospital and dedicated and caring to deliver care and treatment to patients.

Summary of findings

- Most managers we spoke to in surgery said they were overwhelmingly proud of the teams they led. There was alignment between the recorded risks and what staff said was on their worry list.
 - Innovation and improvement was encouraged within the surgical directorate.
 - There was clear vision for the critical care unit and a realistic strategy for achieving it.
 - There was an effective governance framework to support the delivery of the strategy and good quality care within the critical care unit.
 - All staff working on the critical care unit shared values which promoted the delivery of treatment that was safe and of the highest quality.
 - There was good nursing and medical leadership on the critical care unit. Managers were visible and approachable. Staff felt they could bring any concerns to their supervisors and they would be acted upon.
 - The service was taking steps to ensure the sustainability of the critical care unit so that it continued to provide safe care and treatment to patients
 - New management appointments in maternity had the potential to change the culture and involve staff more in decision making over time. A senior leadership programme for all senior managers had taken place which was in the process of being rolled out to other staff to strengthen staff understanding of leadership and develop skills.
 - The leadership, governance and culture of the services for children and young people were used to drive and improve the delivery of high-quality care. The clinical managers were committed to the children and young people in their care, their staff and the unit. Frontline staff and managers were passionate about providing a high quality service for children and young people with a continual drive to improve the delivery of care.
 - In end of life care we saw excellent examples of leadership within the specialist palliative care team and the mortuary which meant that staff working within these services benefitted from the support and commitment of their leaders.
 - Substantial funding had been agreed which aimed to improve education and provision of end of life care at the trust. There had been some improvement in the profile of end of life services since our last inspection.
 - The specialist palliative care team were held in extremely high regard across the trust in all areas we visited.
 - In diagnostic imaging we found the leadership to be visible and supportive. The culture in imaging was open and staff felt able to raise concerns.
 - Children and young people were able to give their feedback on the services they received; this was recorded and acted upon where necessary.
 - A variety of staff engagement activities following from the cultural review in maternity had tapped into staff views about the service and opportunities for improvement, and staff were taking forward some of these.
 - There was a high level of staff satisfaction with staff saying they were proud of the children and young people's units as a place to work. They showed commitment to the children and young people, their responsibilities and to one another. All staff were treated with respect and their views and opinions heard and valued.
- We saw several areas of outstanding practice including:
- The critical care unit had arranged for an external provider to provide shiatzu massage to patients on the ward to help with muscular pain. The service was also available to staff.
 - The unit was using a local private ambulance to enable patients to go on day trips to local destinations. Nurses and doctors from the critical care unit would accompany them on these visits following a thorough risk assessment process. The patients suggested the destination and the unit endeavoured to grant their wish. Payment for the use of their services comes from the Charitable Fund.
 - Emotional support and information was provided to those close to patients. Following the participation in the Provision of Psychological Support to People in Intensive Care (POPPI), three nurses from the unit had undertaken training to enable them to deliver psychological support to improve outcomes for patients being discharged from the unit. The nurses in question were delivering this support to patients during our inspection. The nurses were also able to provide support to colleagues when required.
 - An initiative was put forward to deliver additional support to bereaved children. We saw many tools to

Summary of findings

help children to cope with their loss. For example, the unit had invested in story books surrounding death.

There were also puppets, colouring books and toys which could be used to distract and comfort children.

- The outpatient department had introduced an improved treatment option for the rapid removal of blood clots from veins and arteries following the purchase of new equipment. In some instances this prevented patients having emergency surgery and reduced length of stay.
- The development and implementation of “RADAR” by Royal Cornwall Hospitals NHS Trust improved monitoring of referral to treatment, delays and clinic cancellations. It had won several national awards for innovation.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Improve the approach to identifying, reviewing and investigating incidents and never events.
- Adopt a positive incident reporting culture where learning from surgical incidents is shared with staff and embedded to improve safe care and treatment of patients.
- Ensure there is an effective system in place to monitor and scrutinise incidents relating specifically to end of life care ensuring subsequent learning can be implemented.
- Take immediate steps to improve incident reporting timeliness, consistency, investigation, learning and sharing of learning processes.
- Review and implement the systems and processes to ensure staff follow the principles of duty of candour.
- Review the security of the antenatal ward to ensure the privacy and security of women who were inpatients.
- Take immediate steps to address the fracture clinic environmental issues that have been present since the January 2016 inspection, including adequate safeguarding systems for children.
- Ensure safety checks on surgical equipment are carried out by the planned dates.
- Provide surgical patients with sepsis with timely access to intravenous antibiotics.
- Securely and confidentially manage all patient information.
- Ensure that patient records are stored securely across the trust. Patient confidentiality must be maintained in accordance with the Data Protection Act.
- Ensure that the causes of incomplete treatment escalation plans are addressed and compliance is improved in critical care.
- Ensure patients are risk assessed and operated on in the correct theatre with the correct equipment and staff available.
- Ensure emergency resuscitation teams have immediate access at all times to a member of staff who is able to deal with difficult airway intubation.
- Ensure full compliance with the Five Step to Safer Surgery World Health Organisation (WHO) checklist to prevent or avoid serious patient harm.
- Meet expected levels of medical and nurse staffing levels on surgical wards to keep patients safe.
- Ensure there are sufficient numbers of midwives and nurses, with the right skill mix on duty at all times to deliver safe care.
- Ensure inductions of labour are safe in relation to capacity, activity and staffing on the delivery suite.
- Ensure there are sufficient numbers of suitably qualified nursing staff in the paediatric emergency department and formal processes in place to ensure appropriate cover was provided at all times.
- Improve compliance with the use of surgical patient care bundles.
- Ensure better quality data about processes and outcomes within the maternity services is available for analysis and to support improvement.
- Ensure the maternity dashboard includes sufficient information to provide a comprehensive overview of maternity performance. Proactively benchmark processes and outcomes in the maternity service against comparable trusts in rural areas.
- Ensure all surgical staff receive annual appraisals, mandatory training, appropriate supervision and professional development.
- Ensure all midwives update their training to a level where they all have the skills needed for their roles, and set targets for completion of training in line with trust targets of 95%.
- Ensure there are clearly articulated and understood processes in place for identifying and managing deteriorating women and that the processes are monitored.

Summary of findings

- Review the risks and contingency plans for opening and staffing the second theatre and ensure there is a robust process in place that is well communicated and practiced.
- Identify, analyse and manage all risks of harm to women in maternity services, ensuring local risk registers are maintained in all discrete units and feed into the divisional and corporate risk register.
- Review and improve the high dependency processes and facilities for managing high dependency care in maternity services ensuring there are adequately skilled and trained staff on duty at all times.
- Take immediate steps to ensure the privacy and dignity of patients using the fracture clinic cubicles
- Improve the incomplete referral to treatment pathway compliance for surgical patients.
- Review the arrangements on the antenatal ward to ensure one-to-one care and women's privacy and dignity when giving labouring and giving birth there in the absence of additional capacity on the delivery suite
- Ensure all patients have their operations at the right time, whether in an emergency or for a planned procedure.
- Ensure surgical facilities are appropriate to meet patients' needs.
- Improve bed management, and discharge arrangements to ensure a more effective flow of patients across the hospital to improve cancellations of patient's operations.
- Ensure access and flow into the critical care unit is improved to ensure delayed admissions, delayed discharges and discharges out of hours are reduced so patients receive the right care at the right time and in the right place.
- Take immediate steps to ensure that the backlog of patients awaiting cardiology procedures is eradicated.
- Take immediate steps to ensure that the backlog of 24 hour cardiac recordings and echocardiograms are reviewed.
- Take immediate steps to ensure that the backlog of patients awaiting WARM ophthalmology procedures and glaucoma service is eradicated.
- Improve the response times for patients' complaints.
- Ensure governance processes are embedded in practice to provide assurance that surgical services are safe and effective and provide quality care to patients.
- Ensure that systems are in place so that governance arrangements, risk management, and quality measures in maternity are effective. Ensure audits are aligned to incidents and identified risks.
- Ensure governance systems and processes are established and operated effectively to ensure the trust can assess, monitor and improve the quality and safety of the services provided to patients receiving end of life care.
- Ensure action is taken to address behaviours and performance which are inconsistent with the vision and values of the hospital, regardless of seniority.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Background to Royal Cornwall Hospitals NHS Trust

Royal Cornwall Hospitals NHS Trust provides care to around 532,273 people across Cornwall, which can increase twofold during holiday periods. This includes general and acute services at Royal Cornwall Hospital, elective surgery and outpatient services at St Michael's Hospital, day surgery, medicine, outpatient and renal services at West Cornwall Hospital and maternity services at Penrice Birthing Centre at St Austell Hospital. CQC inspected the main Royal Cornwall Hospital site during this focused inspection, as well as surgery and outpatients core services at St Michael's and West Cornwall Hospitals and maternity services at Penrice Birthing Centre.

The hospital has over the last few years, seen significant and ongoing periods of instability at board level. Since the first inspection in January 2014 there had been three chief executives in post, two of those on an interim basis.

A permanent chief executive was appointed in April 2016. A new chair was appointed in January 2017, but prior to this there had been three chairs in post since 2015. The director of nursing was newly appointed in May 2017 and in post at the time of the inspection; prior to this there had been an interim director of nursing in post since November 2015. The interim medical director was in post since October 2016, and we were told this post had recently been made substantive on an honorary contract

for a period of 12 months. The chief operating officer post was interim from October 2016, and we were told that this post had been filled by an external candidate who was due to commence in post in August 2017. The director of human resources commenced in post in December 2016, and the director of corporate affairs commenced in post in January 2017. The director of finance was the longest standing executive member of the team having been in post for six years. There had been changes to this post in recent months with the current finance director taking the lead on the Sustainability and Transformation Plan (STP), and a co-appointed (with another local hospital) finance director had been in post since May 2017. This meant that by August 2017, there would be a full complement of board directors in permanent posts for the first time in a number of years.

This inspection was carried out in order to inspect those services and locations we did not inspect in January 2017 (with the exception of sexual health), and to follow up on additional concerns we had following the January 2017 inspection, in relation to the safe and well led domains within end of life care services. The ratings from this inspection have been aggregated with those ratings from the inspection we carried out in January 2017.

Our inspection team

Our inspection team was led by:

Chair: Graham Nice, Managing Director of an Independent Healthcare Management Consultancy

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

Inspection Manager: Julie Foster, Care Quality Commission

The team included three inspection managers, 12 CQC inspectors, an assistant inspector, a planner, and a variety of specialists: two medical directors, a chief nurse and governance specialist, two surgical consultants, three senior surgical nurses, a CCU nurse specialist, an anaesthetist, a paediatrician and a senior paediatric nurse, a senior midwife and an end of life nurse specialist. We also had a CQC IRMER inspector present for part of the inspection.

Summary of findings

How we carried out this inspection

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

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

The inspection team inspected six core services:

- Surgery
- Critical care unit
- Maternity and gynaecology
- Children and young people
- End of life care (safe and well led only)
- Outpatients and diagnostic imaging

We also looked at the governance and risk management arrangements supporting those core services.

Before, during and after visiting, we reviewed a range of information we held about the trust and asked other organisations to share what they knew about Royal Cornwall Hospital. These included the local commissioning group, NHS Improvement (NHSI), NHS England, the local council and we reviewed information from Cornwall Healthwatch.

We carried out an announced inspection of the main hospital site, West Cornwall and St Michael's Hospitals and Penrice Birthing Centre, and we held 28 staff drop in

sessions for a range of staff with various roles and levels of seniority across the hospital. These included clinical and non-clinical staff including nurses at all levels, consultants and junior doctors, health care assistants, allied health professionals, chaplains, administrative staff, volunteers, managers and senior leaders. We held two additional drop in sessions for staff working at West Cornwall and St Michael's sites. These sessions were generally very well attended and staff were able to share their experiences with us. People also contacted us via our website and contact centre to share their experience.

We talked with 74 patients and over 225 members of staff from across the hospital, including nurses at all levels, consultants and junior doctors, health care assistants, allied health professionals, chaplains, administrative staff, volunteers, managers and senior leaders. We observed how people were being cared for, talked with carers and family members, and reviewed over 93 patient records, including individual patient care records, patient treatment escalation plans, do not attempt cardio pulmonary resuscitation (DNACPR) forms, medical notes, observation charts and pharmacy records.

Overall the trust was rated as inadequate, with Royal Cornwall Hospital rated as inadequate, West Cornwall Hospital rated as good and St Michaels Hospital rated as good. Penrice Birthing Centre was rated as requires improvement. We rated caring as good overall across all locations and services.

What people who use the trust's services say

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the service they have received to friends and family. The trust's Friends and Family Test performance (% recommended) was generally about the same as the England average between April 2016 and March 2017. In the latest period, March 2017 trust performance was 95% compared to an England average of 96%.

In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for 13 of the 34 questions, in the middle 60% for 20 questions and in the bottom 20% for one question.

The trust performed similar to the England average in the patient-led assessments of the care environment (PLACE) 2016 for assessments in relation to Food, Privacy/dignity/wellbeing and Facilities. The trusts performance for the facilities improved from 2015 to 2016.

Summary of findings

The CQC Inpatient Survey looked at the experiences of people who received care at Royal Cornwall Hospitals in July 2016. Between August 2016 and January 2017, a questionnaire was sent to 1,250 recent inpatients and responses were received from 605 patients. The trust performed about the same as other trusts for all the questions asked.

For end of life care, there was a lack of survey or other evidence to show patients' needs were being consistently met.

Facts and data about this trust

Key figures for the Royal Cornwall Hospital:

This trust has four locations:

- Royal Cornwall Hospital
- St Michael's Hospital
- West Cornwall Hospital
- Penrice Birthing Centre (at St Austell Hospital)

Local Population:

- Around 532,273 people (according to 2011 census report release published in February 2013) are served by the trust, although this figure can double during busy holiday seasons
- According to the 2011 Census, Cornwall's population was 98.2% white, 52% are women, 56.7% are between the ages of 20 and 64 and 18.7% are over the age of 65
- In the 2015 Indices of Multiple Deprivation, Cornwall was in the second-to-worse quintile for deprivation. The proportion of children aged 16 and under in low-income families was slightly lower than the England average.
- Cornwall performed better than the England averages for 25 of the 32 indicators in the Area Health Profile 2015. Areas where the county performed worse than average included excess weight in adults and incidence of malignant melanoma

Bed occupancy:

- The trust's bed occupancy was consistently lower than the England average between quarter 3 of 2015/16 and quarter 4 of 2016/17. Occupancy varied between a low of 81.2% in quarter 1 2016/17 and a high of 84.7% in quarter 3 2016/17. In quarter 4 of 2016/17 occupancy was 83.0% compared to the England aggregate figure of 89.0%.

The trust has a total of 777 beds spread across various core services:

- 706 General and acute beds
- 45 Maternity beds
- 26 Critical care beds

Between February 2016 and January 2017 the trust had:

- 90,885 A&E attendances
- 110,270 Inpatient admissions
- 754,277 Outpatient appointments

Between January 2016 and December 2016 the trust had:

- 3,955 deliveries

Between February 2016 and January 2017 the trust had:

- 1,641 deaths
- 275,815 bed days

Staffing:

- As of April 2017, the trust employed 4,984.3 whole time equivalent (WTE) staff out of an establishment of 5,311.1 WTEs, meaning the overall vacancy rate at the trust was 14.7% for registered nursing and midwifery staff and 6.8% for medical staff.
- These comprised 793 medical staff (6.8% vacancy rate), 1,467 nursing and midwifery staff (14.7% vacancy rate), 260 allied health care professionals (6.1% vacancy rate), 1,489 categorised as other clinical staff (4.2% vacancy rate) and 1,293 categorised as other non-clinical staff (7% vacancy rate).

Revenue (between April 2016 and March 2017) :

- In the latest financial year, 2016/17, the trust had an income of £379.5 million, and costs of £380.4 million, meaning that it had a deficit of £929,000 for the year. The trust predicts that it will have a surplus of £1.3 million in 2017/18.

Commissioning:

Summary of findings

- Services are commissioned by NHS Kernow Clinical Commissioning Group.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>Overall, we rated safety of the services in the trust as inadequate. For specific information, please refer to the reports for Royal Cornwall, St Michaels and West Cornwall Hospitals, and Penrice Birthing Centre.</p> <p>Summary of key findings for safe:</p> <ul style="list-style-type: none">• The systems and processes for identifying, grading and managing incidents were not effective and reporting and investigations were not conducted in a timely manner. The threshold for incident reporting was high so not all incidents were reported. The trust was an outlier for never events between December 2016 and June 2017.• There was no evidence of oversight or scrutiny of incidents that related to end of life care at the trust. Therefore, there was no evidence of learning or changes in practice that had resulted from such incidents.• There was not a clear incident reporting process for staff to follow in the event of a delayed fast track discharge in end of life care. There was also no evidence of executive oversight of the problem caused by inconsistent reporting, and a lack of anyone with clear responsibility for the issue.• The trust' systems and processes in place to fulfil its obligations in relation to the duty of candour regulations were not operating effectively.• We found people were at risk of unsafe care and avoidable harm in some areas we visited. Comprehensive risk assessments were not carried out for some patients and not all risk management plans were developed in line with national guidance. Risks were not managed positively.• Women in maternity were not consistently monitored for signs of deterioration and guidance for staff when managing deterioration in women was conflicting.• The decision to divert triage calls from the hospital to the penrice birthing centre between 5pm and 8pm did not have a clear contingency arrangement if the midwives at Penrice were with labouring women.• Safety was not a sufficient priority. There was limited measurement and monitoring of safety performance. There were significant numbers of serious incidents or never events in surgery.	<p>Inadequate </p>

Summary of findings

- Staff did not always assess, monitor or manage risks to patients. Some opportunities to prevent or minimise harm were missed.
- Safety briefings did not always take place prior to the start of an operation or theatre list.
- The handovers on the delivery suite were not multidisciplinary; there were multiple handovers several times a day, midwives to midwives and doctors to doctors at different times which were inefficient. Handovers did not clearly highlight risks. There were no safety briefs occurring in the maternity service.
- There had been some safety issues for patients discharged from the unit due to staff not always following the correct handover processes for medicines for the patient prior to their discharge.
- Changes were made to surgical services without due regard for the impact on patient safety. There were inadequate plans to assess and manage risks associated with anticipated future events or emergencies in both surgery and maternity.
- Staffing levels in surgery were consistently under plan on most wards during the day.
- The lack of medical staffing for the surgical unit at West Cornwall Hospital, following completion of theatre lists, posed a risk if a patient deteriorated. Although processes were in place staff were not always able to access fast advice. Staff told us not all consultants visited patients following completion of their theatre lists. This left staff feeling vulnerable and was not consistent with the local flow chart.
- There were not enough midwives to provide a safe service in all areas at all times. Staff had to activate the escalation policy frequently to achieve safe staffing in the delivery unit. Safe skill mix in maternity was not always achieved.
- There were insufficient numbers of suitably qualified nursing staff in the paediatric emergency department to provide safe care at all times.
- The specialist palliative care team was too small to meet the demands of the trust as per national guidance.
- Not all patients with severe sepsis had timely access to intravenous antibiotics.
- There was no dedicated high dependency area for deteriorating women and no process to ensure that there was always a nurse or midwife on duty with the necessary competencies to manage high dependency women. The service did not monitor the number of women needing this level of care.
- The contingency plans for using the second theatre in an adjoining room were not clearly understood and an additional theatre team was not readily available, which could result in delays and potentially a risk to women and babies.

Summary of findings

- The delivery suite capacity was insufficient for the number of women giving birth with the result that women laboured on the antenatal ward several times a month, often without one-to-one care from a midwife for the whole of their established labour.
- More women than the agreed number were being induced on some days, and these inductions were not planned to take into account activity or capacity on the delivery suite to ensure that induction was safe.
- There was no clear nursing observation area on the high dependency unit of the children's ward and this represented a risk to children who were not visible to nursing staff at all times.
- Ophthalmology and cardiology follow up appointment waiting lists were too long and patients were coming to harm through delays in treatment. The process for risk assessment was not sufficient to adequately protect patients from harm and there were no clear action plans to manage and reduce the backlogs.
- There was a significant backlog in reviewing some cardiology 24 hour tapes which put patients at risk.
- The emergency resuscitation team did not always have immediate access to a member of staff who was able to deal with difficult airway intubation in surgery.
- Staff were not clear on the arrangements with the ambulance service to transport deteriorating patients to Royal Cornwall Hospital. Staff reported delays in transfer from West Cornwall Hospital because it was seen as a place of safety and therefore not prioritised.
- The service did not always ensure there was adherence to the World Health Organisation (WHO) surgical safety checklist and audits of the checklist did not provide assurance of compliance. However at West Cornwall Hospital and in gynaecology there was good evidence of compliance.
- The trust did not have effective systems and processes in place to ensure that patient confidentiality was maintained at all times.
- The antenatal ward was not secure. Open access to the Day Assessment Unit (DAU) which was combined with the antenatal ward was a safeguarding risk to women on the ward.
- The design, maintenance and use of facilities and premises meant there were risks to patients. Some equipment in surgery and at West Cornwall Hospital was not serviced, maintained, tested or calibrated and there were environmental risks on the hospital site.

Summary of findings

- Arrangements for managing medicines, medical gases and contrast media did not always keep patients safe. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of medicines.
- There were systems and processes in place at the trust to ensure all staff completed mandatory training, however, for some staff groups and mandatory training topics, these were not operating effectively.
- At West Cornwall Hospital, we were unable to evidence the completion of simulation scenarios to respond to patient emergencies.
- We could not be assured that community midwives had up to date skills. They did not have training to cannulate women and did not have the necessary equipment to manage obstetric or neonatal emergencies in the community in the event that the ambulance was delayed.

However:

- Staff were aware of their responsibility to report incidents in critical care and services for children and young people. The electronic reporting system had been improved since our previous inspection. Individual reporting of incidents specific to end of life care had improved since our last inspection and the ability of staff to identify such events was good in many of the areas we visited.
- There were established safeguarding systems and processes in place at the trust to ensure patients were protected from abuse. Some safeguarding training had not met targets but the trust was actively improving those.
- There were mostly reliable systems and processes in place to prevent and protect patients from healthcare associated infections. Improvements were noted in antibiotic prescribing.
- There was good engagement in morbidity and mortality meetings in surgery, which led to service improvement.
- Surgery ward safety briefings held every morning were well attended, with good communication where safety concerns were aired openly.
- Systems were in place in children and young person's services for the safe storage and administration of medicines and appropriate audit trails were in place for controlled drugs.
- There were effective arrangements in place around the prescription of anticipatory medications to ensure that end of life patients' symptoms could be managed in a timely way.
- Most areas we visited were visibly clean and tidy and staff were seen mostly to adhere to the principles of infection control.

Summary of findings

- World Health Organisation (WHO) surgical safety checklists were used in the obstetric theatre and gynaecology theatres and we saw evidence of good compliance.
- Equipment, such as syringe drivers and specialist mattresses were readily available for end of life patients who needed it.
- Staff in maternity reported the quality of training was high. Funds had been secured and dedicated for enhanced training over the coming year
- Nurse staffing levels on the critical care unit had improved and agency use had reduced since our last inspection. Further recruitment of nurses had taken place and was ongoing to ensure the critical care unit was compliant with the Faculty of Intensive Care Medicine Core Standards for nurse staffing levels. Medical staffing levels had also improved and further recruitment was taking place at the time of our inspection.

Detailed findings

Incidents

- The systems and processes at the trust for managing incidents were not operating effectively.
- There were processes in place for the reporting, investigation, identification and management of incidents within the trust. However, these were not applied consistently throughout the trust and were not effective.
- Staff throughout the trust understood these processes and their obligation to report incidents. They felt able to report incidents. However, there was evidence of a high threshold for staff reporting incidents in surgical services and maternity and gynaecology, where staff did not report some types of incidents, this included incidents relating to: grade 3 and 4 pressure ulcers; delays in patient discharges; and where a parent was walking a new-born around the ward without a cot when the ward was busy and there were trip hazards.
- Between October 2016 and July 2017 there had been nine reported never events at the trust and one reported near miss never event. This was a significantly higher rate than for other similar trusts. Two never events were identified and highlighted by us and had not been picked up as never events by the trust's internal systems. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Five of the nine never events related to surgery. The other four, whilst coming under the medical division (for example in

Summary of findings

cardiology or endoscopy), all involved the use of pre-operative checking systems which had failed. Two of the surgical never events were 'wrong site surgery' and three were 'retained foreign objects post-procedure'. In cardiology the never event was related to an incorrect pacemaker being inserted.

- There were examples of where significant incidents had not been evaluated and categorised correctly by the trust. This included a never event at St Michael's Hospital. Some senior staff were not using up to date criteria for reporting never events. There was not sufficient overall oversight and scrutiny in terms of the decision making committee for serious incidents and never events; the minutes from these meetings were not reflective of discussions in many cases and there was little evidence of robust challenge or follow up of outstanding actions. There was very little evidence of holding staff to account where serious incident investigations were delayed, or review of the reasons why they were delayed.
- Senior managers could not provide assurance that all staff had read and understood the briefings regarding incidents. They told us about, and we saw, briefings for staff regarding the never events in theatres in 2017. We were told this was emailed out to staff and a briefing placed in the 'hot topic' folder in theatres, but they could not provide assurance that the briefings had been read, understood, and actions implemented.
- In accordance with the Serious Incident Framework 2015, the trust reported 106 serious incidents (SIs) which met the reporting criteria set by NHS England between June 2016 and May 2017. Of these, the most common type of incident reported was "Slips/trips/falls" (34), followed by "Treatment delay" (21), "Surgical/invasive procedure incident" (nine) and "Medication incident" (nine).
- During our January 2017 inspection we found there were significant gaps in assurance around incident reporting; there was a high proportion of incidents categorised as 'no harm' when some of these were a 'near miss', or could have resulted in some harm, or where the level of harm to the patient could not have been determined. This meant that not all incidents triggered appropriate investigations or were escalated appropriately. It also meant that the data recording the numbers of harm incidents was not accurate or a true reflection of the situation. We saw several examples of incidents that should have been categorised as serious incidents, but had not been, and some involved patient death. We issued the trust with a requirement notice to improve systems and processes for managing incidents, and the trust placed this on the

Summary of findings

corporate risk register. The trust had nominated a lead for serious incidents and had appointed a director of governance to lead on the improvements. Plans were in place to ensure twice daily reviews by a governance administrator and daily reviews by divisional leads of all incident forms.

- However, when we inspected in July 2017, we found similar issues and did not find that significant improvements had been made. For example, across all areas and sites inspected we found that incidents were not always identified or reported correctly, and in many cases they were not reviewed or investigated in a timely manner. We found one example of a serious incident where a patient had died, that had not been detected or reported at the time it occurred; this had been identified as part of another investigation.
- There was a significant average delay for example between a serious incident occurring and it being reported on the Strategic Executive Information System (STEIS) of approximately 70 days; the expected timescales for reporting to STEIS are within two days. 72 hour reports were not completed within 72 hours in most cases, and 60 day reports were severely delayed by several weeks in many cases, and in the period between February 2017 and June 2017, none of the 34 we were expecting to see completed had been. We were told that the 60 day period did not start 'on the clock' until after it had been reported on STEIS, which was already very delayed. This meant that crucial opportunities for learning from serious incidents were potentially missed or at best, very delayed. Actions resulting from incidents were very poor in many cases, and it was not apparent how actions were being monitored or followed up to ensure they had been closed down.
- The board meeting minutes from April 2017 recorded receipt of an improved overview of the detail of serious incidents and any relevant learning, which was set out in the serious incident assurance report; however, the assurance report did not include timeliness of investigations nor address the wider concerns around ineffective systems and processes.
- Throughout the trust there were meetings where incidents were discussed, but in some areas, for example, maternity and gynaecology, end of life care and surgery, there was little evidence of the discussion or oversight.
- There was no evidence of oversight or scrutiny of incidents that related to end of life care at the trust. Therefore, there was no evidence of learning or changes in practice that had resulted from such incidents.

Summary of findings

- There was not a clear incident reporting process for staff to follow in the event of a delayed fast track discharge in end of life care. There was also no evidence of executive oversight of the problem caused by inconsistent reporting, and a lack of anyone with clear responsibility for the issue.
- Community midwives at Penrice Birthing Centre were not able to tell us with confidence which incidents should be reported. There was confusion around what was on the maternity incident trigger list.
- Opportunities to learn lessons from incidents were not always taken. Some staff reported that they did not get feedback from incidents that they reported, this was particularly within surgery, where there was no assurance that staff in the theatre at Royal Cornwall Hospitals had read and understood briefings about learning from incidents including the five reported never events that had occurred within the trust. There was evidence that this learning had been shared with St Michael's Hospital and West Cornwall Hospital and action taken as a result.

Duty of Candour

- The trust had a process in place to fulfil its obligations in relation to the duty of candour regulations but this was not operating effectively. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The trust told us it ensured compliance with the duty of candour regulation via two routes: Significant/major harm/death - through the serious incident process, where each serious incident was tracked with regards to duty of candour and assurance was received at the fortnightly executive-led Serious Incident Review Panel (ESIP). Minor harm was tracked by the record of each qualifying incident, overseen by the respective specialty/division and recorded on the electronic reporting system.
- The lead person that had responsibility for compliance was the medical director, supported by the head of clinical governance. In reality this was a delegated responsibility to a senior member of the administration team, who had not undertaken any specific training for duty of candour. There was no system in place to ensure there was backfill for this responsibility during times of annual leave or other absence.
- There was evidence that the trust was open and honest with patients in some of the serious incidents we reviewed. Records showed that a formal apology had been given as required,

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along with an explanation of the actions that would be taken to prevent the issue happening again. In September 2016 a separate field was added to the serious incident template to ensure duty of candour was considered and documented for all serious incidents.

- However, opportunities to implement the duty of candour may have been missed through the incorrect classification of incidents as 'no harm' where they may have been moderate, major or catastrophic. In addition, some of the serious incidents we reviewed had a 'yes' in the free text box where the detailed explanation should be written to indicate that duty of candour had been carried out. The serious incident form also required the reporter to document their discussion and rationale; however a number of reports we reviewed did not have anything documented, and in some cases, where duty of candour had not been applied, the rationale for this was not clear. There were also examples noted where duty of candour had been delayed due to the condition of the patient.
- We found some examples where an apology had been given and recorded in the patient notes, but this had not been followed up with a written apology.
- The majority of staff we spoke to were aware of the need to be open and transparent under the duty of candour regulation. The trust had produced staff guidance setting out legal requirements upon them when things went wrong, however we found this was not consistently applied.

Safety thermometer

- Safety thermometer information was displayed clearly on all surgical wards, which informed patients and relatives of how the ward was performing in these areas of patient safety.
- We reviewed data relating to surgical areas from the Patient Safety Thermometer between April 2016 and April 2017. Surgery reported 40 new pressure ulcers, 15 falls with harm and 12 new urinary tract infections in patients with a catheter. There were no new urinary tract infections in patients with a catheter in March or April 2017. We saw in meeting minutes the wards were working toward reducing hospital acquired pressure ulcers.
- Not all surgical patients, on admission, received an assessment of venous thromboembolism (VTE) or blood clots, and their bleeding risk. The service had met its local target of 90% from June to December 2016. However, from January to May 2017 it consistently missed this target.
- As required, patients were reassessed within 24 hours of admission for risk of VTE and bleeding, and we saw this was documented in all 19 patient records we looked at.

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- The maternity service had made monthly trust-wide data returns to the NHS maternity safety thermometer since October 2016. However, we found ward staff had little understanding of the purpose of this, how this data was collected and presented, or of the national standards for definitions. They had not used the data to benchmark against other services or make improvement plans.
- The results of the safety thermometer were on display in Wheal Fortune ward and showed that 68% of patients were receiving harm free care in July 2017 compared to an average national score of 70%. When the first monthly national return was made in November 2016 the ward had achieved 85%. However, the rate had declined since then and since March 2017 had fallen below the national average for each month.
- The gynaecology ward submitted data monthly to the NHS safety thermometer and results were displayed on the trust's 'Know how you are doing' boards. Falls were the main patient harm and pressure ulcers acquired in the hospital showed a variable trend during 2016/2017. The 35% harm free care information for May was displayed. This was discussed at the clinical governance meeting where a higher number of patient falls were identified as the reason for a lower level of harm free care that month. We did not see results of the safety thermometer reviewed at divisional level meetings in either maternity or gynaecology.
- Data provided to us by the trust showed the critical care unit had reported 100% harm-free care throughout the period from May 2016 to March 2017. The critical care unit displayed their safety thermometer data so that all staff, patients, relatives and carers could see it.
- There was a good safety performance on the paediatric units. The service participated in a paediatric specific safety thermometer in the form of paediatric and neonatal early warning scores as well as the national safety thermometer performance. The trust reported data on patient harm each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. It covered incidences of hospital-acquired (new) pressure ulcers; patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis). From April 2016 and April 2017 harm free care was consistently maintained across the service.

Cleanliness, infection control and hygiene

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- The director of infection prevention and control (DIPC) role was shared by the nurse consultant for infection prevention and control and a consultant paediatrician. The role of DIPC was to oversee infection prevention and control policies and their implementation. The DIPC reported directly to the chief executive and the board, via the director of nursing.
- There were mostly reliable systems and processes in place to prevent and protect patients from healthcare associated infections.
- Across the trust there were good audit results for hand hygiene practice, which in most areas we observed in practice. NICE guidance QS61 Statement 3 (2014) states patients receive care from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. The service undertook monthly audits of the 'five moments of hand hygiene'. Audits showed between 96% and 100% compliance for hand hygiene each month between November 2016 and June 2017 in surgical wards and theatres.
- The audit practice was not consistent with our observed care. We saw a number of nursing staff, occupational therapists, a bed manager, and a cleaner who did not cleanse their hands when entering or leaving the ward areas on St Mawes ward and the trauma unit. There were also no hand washing facilities or hand gels available on the entrance to bays on the trauma unit. The hand gel on admission to St Mawes ward was blocked by three wheelchairs. We also noted hand gel was not available outside the three bays in the surgical admissions lounge.
- Staff in surgery at Royal Cornwall Hospital told us standards of cleanliness were not always maintained at night. Although wards had regular cleaning staff, ward staff told us domestic staff finished either at 1.30pm or at 5pm. We reviewed the high-risk service level agreement, which outlined wards areas would be cleaned between 5pm and 9am, but staff told us domestic cleaning staff did not always turn up. This meant by the evening some bins could be overflowing and toilets could need cleaning. If cubicles required deep cleaning, nursing staff would request a cleaning team but would sometimes have to escalate this to a site manager to get the work undertaken. Staff on the surgical admissions lounge told us due to a shortage of cleaners they sometimes cleaned the toilets, emptied bins or deep cleaned cubicles themselves.
- The environment in the fracture clinic did not promote cleanliness, infection control and hygiene. Fabric armchairs were used in patient waiting areas, some of which contained rips and had exposed fillings. This presented an increased risk

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to bacterial contamination. Wooden furnishings along the walls were deeply chipped and unsealed; the porous nature of this surface further increased the risk of bacterial harbourage. The floor was deeply ingrained with passing foot traffic and in need of replacing. There were issues with air flow and high temperatures. A fault in the ventilation system within the clinic made the environment extremely hot and staff had deployed fans to move the air around the clinic to improve the environment for patients and staff. However, this increased the risk of airborne pathogens being carried through the clinic. We were told at our last inspection in January 2016 that this was a temporary location for the clinic, however the clinic had not been relocated and works to improve the environment had not been undertaken. All these concerns were raised following our inspection in 2016, but had not been addressed.

- There were variable results in the audit of patient screening for MRSA. The concerns were with screening of elective patients on Newlyn ward with 16% of patients not screened for MRSA between April 2016 and March 2017. In the surgical admissions lounge, 20% of patients were not screened (with data collected from January to March 2017). For emergency patients, data was collected from October 2016 to March 2017. This showed 37% were not screened on Wheal Coates ward, 16% on the trauma ward, and 33% on both the surgical admissions lounge and Theatre Direct. On Pendennis ward, 79% of patients were not screened, although this was for a low number of patients (eight out of 11). We saw no evidence of this issue being reported as part of patient safety in the governance meeting minutes.
- There was one case of methicillin-resistant *Staphylococcus aureus* (MRSA) reported between April 2016 and March 2017. Trusts have a target of preventing all MRSA infections, so the trust failed to meet this target within this period. Additionally, the trust reported 25 methicillin-sensitive *Staphylococcus aureus* (MSSA) infections and 26 *Clostridium difficile* infections over the same period, which was above their target of 14. The trust did not meet its *Clostridium difficile* objective of no more than 23 trust apportioned cases in 2016/2017. However, this is the lowest number of cases the trust has seen since 2012/2013. Of the 26 cases, 11 were deemed to have been avoidable. Where contributory issues had been identified, for example processes around the management of cannulation, these had not been fully risk assessed, addressed, or added to the risk register.
- We requested environmental infection control audits and we were provided with some results of these (10 areas), but we were not provided with results for all relevant areas, or an

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overarching summary report. Many of the areas were hovering around or below the compliance level set at 85%, for example, Dolphin House and gynaecology outpatients were 83% compliant. The audit reports did not contain any actions, or any review dates.

- Improvements were noted in antibiotic prescribing. The trust was the best performing trust in the South West for the second year running.
- In cardiology we did not see any cleaning checklists. When we asked staff about this we were told the rooms were cleaned but this was not recorded. We could therefore not be assured regular cleaning was taking place.
- Within imaging and X-ray we found good precautions were taken if a patient posed a risk of infection. They were seen at the end of the day and then a deep clean was undertaken of the room and equipment used.

Environment and equipment

- The design, maintenance and use of facilities and premises in a number of areas of the trust meant there were risks to patients. For example, the Newlyn day unit was often used as an admissions ward for patients directly from the emergency department, and medical patients being admitted to the unit. Consequently, operating theatre lists were frequently under-booked, less productive and efficient, while waiting lists were increasing. Staff had raised this as an issue with management. They had been advised to continue to under-book theatre lists due to the expectation of continuing to use wards for medical patients.
- At West Cornwall Hospital, the use of fabric, reusable curtains, rather than disposable on the surgical unit posed an infection control risk. This is not best practice for infection prevention and control. Curtains appeared clean but there was no easily visible date on them showing when they were last cleaned, or when they needed to be cleaned again. We asked a cleaner the regularity of these being cleaned and were told these were inspected weekly to check for spillages and changed when needed. We were told they should be cleaned in June and December each year however there was no record of this and we were told this was not always achieved.
- We saw signed cleaning checklists for specific rooms, however we were informed the completion of day to day checklists had stopped the week before and those still in use were wiped at the end of each week or month so there was no historical record of cleaning being carried out. Therefore we could not be assured that cleaning was consistently being done.

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- There were unresolved maintenance issues, which were a risk to the spread of infection. On Pendennis ward, staff told us sewage regularly backed up through a toilet in one of the patient bays. This had been ongoing for three years, and nurses reported this had been getting worse over the last three months. The impact was a bay of four beds was regularly closed, and also meant there was only one available shower for female patients, leading to queues for washing.
- Within maternity the second obstetric theatre was sparsely equipped, although we were subsequently told that there was an anaesthetic machine and diathermy machine for this theatre. It was also not clear whether there was an adequate air-handling system in place and the doors were propped open. The trust carried out a risk assessment following our request for this, and it was found that the positive air flow system had failed. Wider potential risks within this theatre had not been assessed.
- The antenatal ward was not secure. Open access to the Day Assessment Unit (DAU) which was combined with the antenatal ward was a safeguarding risk to women on the ward.
- Equipment within the trust was not always serviced and maintained in line with manufacturers' guidance. The systems and processes for ensuring equipment was serviced, maintained, tested or calibrated were not effectively managed. Equipment on some wards and in some departments had not been safety tested within the required length of time. This included: anaesthetic machines; syringe pumps; blood pressure cuffs and bladder scanners. At West Cornwall Hospital the asset register showed that 74% of the equipment in the operating theatre had no date of last service and no date to indicate when servicing was next required. This included the operating table, scopes and patient monitors. It was not clear if these required a service or when they would require servicing.
- Not all of the resuscitation equipment was stored in tamper evident resuscitation trolleys this was particularly in critical care. This was not in line with guidance from the Resuscitation Council (UK). The trust told us this practice had been risk assessed since our last inspection (in January 2017) and that it was felt that staff could respond more promptly in the event of an emergency. In mitigation of the risk of tampering, trolleys were in highly visible locations. Checks on trolleys were to be done daily to ensure that the requisite equipment was available and in date. The equipment in critical care was all available and in date, but not in all other areas, including some surgical wards.

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- The environment and equipment in the fracture clinic did not always keep patients safe. Staff within the fracture clinic told us the environment was not fit for purpose and they felt patients were being put at risk. Patients who had to keep a leg elevated due to the nature of their fracture were at risk of having their leg knocked into because there was no provision to protect them. Chairs were not movable and in a busy clinic there were lots of people passing by who could accidentally knock into the raised leg. Additionally, no dedicated children's waiting area was available and this meant children were not separated from adults. These issues were highlighted in our January 2016 inspection report, but no action had been taken to improve the situation.
- Equipment, such as syringe drivers and specialist mattresses were readily available for end of life patients who needed it.

Medicines

- Arrangements for managing medicines, medical gases and contrast media did not always keep patients safe. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of medicines.
- In most areas medicines were stored securely. However, on some surgical wards and in maternity not all medicines were stored securely or in line with manufacturer's guidance. There were medicines which were not stored within the designated temperature range. Storage rooms were found to be above the recommended room temperature in some surgery wards, and in maternity at Royal Cornwall Hospital. In maternity we found a medicine which should have been stored at room temperature, stored in the fridge. Also, not all fridge temperatures were checked in maternity because there was a lack of clarity about whose responsibility it was to do so. On the postnatal ward the emergency drugs for use in post-partum haemorrhage had been removed to an adjoining ward because of the high ambient temperature in the treatment room. This meant that should they been needed in an emergency situation, staff would need to leave the ward to collect them, which could leave too few staff on the ward. This had not been risk assessed.
- There was a lack of security around the disposal of some medicines. On our unannounced inspection, we found four bins filled with large number of nearly empty medicine bottles and broken glass vials in the unlocked sluice room on the Theatre Direct unit. Some bottles contained droplets of oromorph, paracetamol, and flucloxacillin. Staff and senior managers told us these bins, which did not have lids, had been introduced

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across the hospital. They recognised this was a risk to patients and visitors to the hospital. This incident was not subsequently reported on the hospital's incident reporting system or on the surgery risk register.

- Controlled drugs were stored securely across the trust and managed in line with standard operating procedures.

Records

- The trust did not have effective systems and processes in place to ensure that patient confidentiality was maintained at all times. Records were not always stored securely. For example, pregnancy test results with patient identifiable information were found in two sluice rooms (12 tests results on Theatre Direct and 17 on St. Mawes).
- In January 2017 following our unannounced inspection we raised concerns about zip bags left at the entrance to the wards containing patient notes; we found these again across several areas of the trust during our inspection in July 2017. On one occasion, we found a portering trolley unattended in the main corridor holding a large amount of zip lock bags containing patient records.
- During our unannounced visit we found lists of patients on wards which contained patient identifiable information, including names, addresses and dates patients were due to come to the hospital for their operation. These were placed on a shelf in a corridor at the main entrance to Theatre Direct ward, which could not be viewed from the nurse's station and was unmanned out of hours. This meant that members of the public had open access to view or remove these folders. There were several unlocked consulting rooms in this area which contained filing cabinets that were open, containing patient notes. In one consulting area, we found patient results left on a desk. Outside the consulting rooms was a wall mounted box which contained letters to patients and further test results.
- Care records were not stored securely in the outpatient service. In several of the clinics we visited we found notes were stored insecurely and were not always observed by staff. This meant unauthorised people could access these confidential records. In the cardiology outpatient's clinic, we saw that approximately 150 patient identifiable records of 24 hour cardiac tapes were stored in a letter tray in an unlocked staff room within a publicly accessible area.
- In the same clinic we saw open records trolleys with records accessible behind reception and on one occasion reception was left unattended.

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- Care records were accurate, complete, legible and up to date. We inspected 18 records from a selection of different outpatient clinics. All of the notes we read contained a copy of the referral, a treatment plan, and a discharge summary, which had been shared with the patients GP. Alert stickers highlighting allergies were visible on records and details contained within the inside cover.
- In most areas of the trust a complete record of patients care was maintained. However, within maternity, only a quarter of the records we reviewed were complete and there were omissions in confirmation by the midwife of checks that were done. There was no routine audit of maternity notes to monitor whether key elements were included. A few sets of notes were reviewed within the clinical incident review group where documentation was noted as an issue in a few of the cases discussed.

Safeguarding

- There were established safeguarding systems and processes in place at the trust to ensure patients were protected from abuse, however despite considerable efforts by the safeguarding team, compliance with mandatory training remained a challenge.
- There was comprehensive staff guidance to assist with reporting safeguarding concerns, including flow charts, contact details for internal and external advice and support and tools such as body maps were available for staff to use. Many of the policies and procedures had been revised in February 2017. Most staff we spoke with were confident about what to do if they had any safeguarding concerns and were able to articulate the referral process when asked.
- The director of nursing had delegated authority and was the named lead on the board for safeguarding, providing a strategic steer. As per statutory requirements the trust had three Named Professionals for safeguarding children, and two for safeguarding adults, along with 15 hours of dedicated secretarial time per week to support the service.
- Other safeguarding team members included: part time mental health and well-being nurse for children and adults, who was also the mental capacity lead for the trust; three full time liaison nurses for adults and children's learning disabilities and autism (commissioned externally); full time admiral nurse for dementia (co-funded by the trust and an external body); full time safeguarding administrator; full time homeless advisor funded

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by an external body; part time independent mental capacity advocate (IMCA) funded by adult social care. From June 2017 the team also had two full time workers to support patients with substance misuse funded by an external body.

- The safeguarding agenda at the trust is supported and monitored through the Safeguarding children's operational group (SCOG) and safeguarding adult operational group (SAOG).
- The quality and assurance committee (QAC) reviewed and monitored quarterly reports as regards safeguarding activity within the trust. These groups met bi-monthly and were chaired by the director of nursing. There was senior representation from the trust on both county safeguarding boards.
- Since May 2016, the children and adult safeguarding services had been integrated and were co-located in Pendragon House. In February 2017 the safeguarding midwives joined the team; the safeguarding midwifery agenda was addressed at the SCOG.
- Following publication of the Lampard Report 2015 (written in response to the Jimmy Saville Enquiry) the trust's policies and processes with regards to volunteers, celebrity visits and charitable organisations within NHS organisations were reviewed; actions were identified and the trust told us they were being addressed. We did not review progress against those actions identified.
- The safeguarding adults and children's integrated annual report dated April 2017 provided a summary and overview of safeguarding activity within the trust over the past year, outlining key achievements and challenges.
- In 2015/2016 there were six allegations of safeguarding adults made against the trust and in 2016/2017 there were 12. Five of the allegations did not meet the threshold and were closed immediately and a further five were still under investigation. One allegation had been substantiated and the action plan accepted by the safeguarding adult's case conference.
- Children and adult safeguarding training was mandatory for all health staff regardless of role. A target of 85% compliance was required. The level of training required was role dependant and set out in the Intercollegiate Document: Safeguarding Children and Young People (2015) and the Intercollegiate Document for Adults (April 2016).
- Compliance with safeguarding training at the trust had been a challenge; figures for safeguarding children level one training overall had improved from 76% in 2016 to 84% in 2017 but still remained lower than the target of 95%. For level two training overall, figures had decreased from 72% in 2016 to 66% in 2017;

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this was despite considerable efforts by the safeguarding team to increase the number of training courses available, as well as the offer of bespoke training sessions for individual teams. For level three, figures had improved overall from 58% in 2016 to 83% in 2017, but still remained lower than the target of 85%. As of May 2017, the trust's training target was not met for medical staff for any of the five safeguarding modules. Completion was lowest in this staff group for level two (54.8%) and level three (75%).

- Compliance with adult safeguarding training was achieved with 96% of staff trained at level 1, and at level two, figures had improved from 68% in 2016 to 88% in 2017.
- We saw evidence that additional training had been offered and were confident that the safeguarding team were working very hard to increase the rate of compliance and continually raise awareness of the need to increase safeguarding training compliance as a high profile item. For example, the team had put on an in house safeguarding conference (including external speakers) for staff to attend and update with level three training. Compliance figures were presented and discussed at divisional governance meetings; however it was not clear what, if any action was taken to close the gaps by individual departments. For example, in the annual safeguarding report (April 2017), it was reported that individuals who were not compliant with level one training were sent the level one safeguarding children leaflet on a monthly basis; this did not ensure that staff attended the training. It was not apparent what support the safeguarding team were given by the divisions in ensuring departments or staff were held to account for not attending this mandatory training.

Mandatory training

- There were systems and processes in place at the trust to ensure all staff completed mandatory training, however, for some staff groups and mandatory training topics, these were not operating effectively.
- The trust set a target of 95% completion for nearly all mandatory training courses. The only exceptions were medicines management awareness, resuscitation and advanced life support (four years) and incident commander training, for which there were no targets.
- Excluding the three courses above, the overall completion rate for mandatory and statutory training across the trust as of 31 May 2017 was 88.1%. Therefore the trust target of 95% was on track.

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- The trust training target of 95% completion was met for nursing and midwifery staff for equality diversity and human rights (99.8%) and the Mental Capacity Act 2005 training (100.0%). However the target was not met for infection control training (86.1%), duty of candour training (92.2%) or resuscitation and basic life support (84.9%). However, the trust 95% training completion target was not met for any of these five training modules for medical staff. In particular fewer than half of the required staff (43.5%) were up to date with duty of candour training. Only 58.8% were up to date with infection control training. However, managers and the human resources business partner confirmed the electronic staff record reports did not accurately reflect completion of training.
- The corporate risk register included the risk that some 'staff had inadequate annual mandatory training and did not receive an annual performance development review'. This was caused by the inability to release staff to undertake training due to operational pressures and the need to prioritise patient care. As of June 2017, the trust wide mandatory training was recorded as 84.5% and annual appraisal rate was 80.1%. The actions set out on the risk register comprised a list of expectations for staff and managers to ensure these tasks were completed, along with a review of the appraisal policy; these were not mapped to the stated issue of staff not being able to be released.
- Some staff told us that they had tried to book onto mandatory training before the expiry date, but courses were often full and no more courses were scheduled within timescales to ensure compliance.
- The learning committee meeting minutes from April 2017 recorded that the clinical mandatory training day had been reduced from a full day to a half day for the remainder of 2017. Staff were asked to attend training in uniform so that they could return to their clinical areas in the afternoon. It was not clear from the minutes of this meeting which mandatory subjects were being dropped or if any risks were associated with shortening the mandatory training day. This information was not included in the papers presented to the board.
- Some staff from smaller teams told us there was little flexibility to cover for staff who needed time off for training, and this added pressure to the team, particularly where the training was off site.
- All staff we spoke with understood the need to complete mandatory training; we were told that online training had been set up so staff could access this from home, as there often was insufficient time or space to complete this at work, however the

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system did not always operate from remote locations. Some managers told us they had experience of many calls from staff at home who had been given time to complete the training, but could not access it.

- Staff in maternity reported the quality of training was high. Funds had been secured and dedicated for enhanced training over the coming year.

Assessing and responding to patient risk

- Comprehensive risk assessments were not carried out for some patients and not all risk management plans were developed in line with national guidance. Risks were not managed positively.
- The service did not always ensure compliance with the World Health Organisation (WHO) surgical safety checklist. This had included failure to mark the surgical site (marking on the patient where the operation will occur). The information provided by the hospital showed a number of occasions where marking of a surgical site had been completed incorrectly or with limbs not being marked. There were also changes of personnel in theatre after completion of the WHO checklist. Furthermore, there were two never events of wrong site surgery which may have been prevented by proper completion of the checklist.
- There was reason to question the validity of the audit of the WHO checklist. Audits of compliance with the WHO checklist showed completion of between 95 and 99% from May 2016 through to May 2017. Some managers cast doubt on the validity of the audits, telling us staff who carried out the audit were too close to the working environment, and there had been selection of lists and theatres where compliance was expected to be high.
- Systems and processes for ensuring patients were risk assessed prior to surgery were not adequate. The service had no current guidance available for staff to set standards as to which patient should be allocated to which list, in which theatre. This meant that at times, patients were operated on in an inappropriate operating theatre, without the required level of skilled staff or equipment. Coupled with that, we found that safety briefings were not always undertaken prior to the start of an operation or theatre list.
- The emergency resuscitation team did not always have immediate access to a member of staff who had experience to deal with difficult airway intubation. Anaesthetists told us the emergency resuscitation team should call for a member of the

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intensive care team if a patient required airway management. A consultant anaesthetist said that although all anaesthetists had training in difficult airway intubation, they had not all had experience of dealing with these situations.

- 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. The trust's monthly clinical dashboard showed in surgery and theatres there were good levels of compliance in noting NEWS scores in patient records.
- Within maternity there was a lack of clarity and regular use of the Modified Early Warning System (MEOWS) for all women. This meant that the early detection of the deterioration in women receiving care and treatment was not always possible. There was confusion among the staff we spoke to as to who should have a MEOWS and when. Guidance within key policies in terms of escalating high MEOWS scores was also conflicting.
- In addition there was not system to ensure that there was an identified high dependency trained member of staff on duty at all times on the delivery suite. Not all midwives were aware of the guidance on managing women requiring high dependency care and there was a lack of clarity from senior managers about the arrangements in the delivery suite for a high dependency unit. There was no up to date competency record for the midwives on the unit in respect of high dependency care. Information provided showed that the last training recorded was in 2010. The trust did not collate data on the number of women who required high dependency care, in order that they could review the staffing needs to meet demand.
- The contingency plans for using the second theatre in an adjoining room were not clearly understood and an additional theatre team was not readily available, which could result in delays and potentially a risk to women and babies.
- The delivery suite capacity was insufficient for the number of women giving birth with the result that women laboured on the antenatal ward several times a month, often without one-to-one care from a midwife for the whole of their established labour.
- More women than the agreed number were being induced on some days, and these inductions were not planned to take into account activity or capacity on the delivery suite to ensure that induction was safe.
- We had concerns that, not all community midwives were trained in cannulation which would limit their ability to provide first line support to mothers and babies while waiting for an ambulance. Following our concerns being raised, the trust

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conducted a risk assessment and told us of plans to train midwives in the skill through the use of an on line training resource. It was not clear how midwives would obtain the practical skills to undertake this. Midwives were to be issued with boxes containing equipment to allow them to cannulate, however, they did not carry the necessary intravenous fluids to administer following their insertion. The risk assessment did not include means of mitigating the risk in the interim.

- Safety briefings did not always take place prior to the start of an operation or theatre list. However, surgery ward safety briefings held every morning were well attended, with good communication where safety concerns were aired openly.
- The handovers on the delivery suite were not multidisciplinary; there were multiple handovers several times a day, midwives to midwives and doctors to doctors at different times which were inefficient. Handovers did not clearly highlight risks. There were no safety briefs occurring in the maternity service.
- There had been some safety issues for patients discharged from the unit due to staff not always following the correct handover processes for medicines for the patient prior to their discharge.
- The surgical service at Royal Cornwall Hospital did not always ensure compliance with the World Health Organisation (WHO) surgical safety checklist. This had included failure to mark the surgical site (marking on the patient where the operation will occur). The information provided by the hospital showed a number of occasions where marking of a surgical site had been completed incorrectly or with limbs not being marked. There were also changes of personnel in theatre after completion of the WHO checklist. Furthermore, there were two never events of wrong site surgery which may have been prevented by proper completion of the checklist.
- There was evidence of good compliance with the WHO checklist in gynaecology, paediatrics, St Michael's and West Cornwall Hospitals.
- The Royal Cornwall hospital was poorly compliant with care bundles in surgery, but these were being implemented well in critical care.
- Not all patients with severe sepsis had timely access to intravenous antibiotics.
- The emergency resuscitation team did not always have immediate access to a member of staff who was able to deal with difficult airway intubation.
- There was no clear nursing observation area on the high dependency unit of the children's ward and this represented a risk to children who were not visible to nursing staff at all times.

Summary of findings

- In outpatients, the reception staff were unable to see much of the waiting room due to the layout of the clinic, which meant if a patient deteriorated while in the waiting room they may not be identified by staff. This issue was highlighted in our January 2016 inspection report, but no action had been taken to improve the situation.
- In cardiology we found a back log of approximately 150, 24 hour cardiac recording tapes reaching back to March 2017. When we asked staff how many tapes they thought were backlogged they were unable to tell us. This was of particular risk because if any cardiac anomalies were present in the tapes, the patient would remain unaware of this. Without the records being checked frequently, the lifestyle or medical condition of that patient could be placing them at an increased risk if left untreated. Staff informed us that they had initially worked extra hours on weekends earlier in the year to reduce the back log but were told to stop because the trust used an external analytic company for the work. Since then the backlog had been growing and it had left the staff frustrated and concerned.
- In cardiology, from December 2016 to June 2017, 554 patients had been delayed past their agreed date for follow up appointment. A backlog had developed due to a change in model that removed an outpatient consultant. Cardiology had yet to appoint a speciality lead and therefore the Consultant Cardiologist had to multirole. We were informed of two patients who had died of cardiac related causes while delayed on the waiting list. While it was not possible to say the deaths were directly linked to the delay, the trust reported it was highly likely.
- Although risks associated with delays were being assessed, we were not assured this process was sufficient or that there was an effective plan in place to reduce the backlog. In cardiology we found delayed follow up appointments were reviewed by the administration teams. All patients whose follow up appointment was more than two months overdue were reviewed by the service lead and risk assessed using the 'wait-risk' coefficient method. This did not take account of the patient's current condition and was therefore not sufficiently managing the risk.
- In ophthalmology there were 6,503 patients who had breached the time for a follow up clinic. We also found an increase in demand for the Wet Age Related Macular degeneration (WARM) clinic had not been met. This meant patients were not being reviewed within a safe timeframe. At the time of our inspection there were 1,200 patients waiting for WARM treatments. This delay to treatment had caused harm to at least four patients

Summary of findings

between July 2016 and May 2017 who had suffered partial loss of vision or complete blindness as a result. A plan had been submitted to train more associated health professionals and machine trained staff to manage waiting lists.

- In critical care we found comprehensive risk assessments were carried out for patients and risk management plans developed in line with national guidance.
- Patient risk assessments were completed and evaluated for children and young people. There were clear processes to deal with children where their medical condition was deteriorating. There were paediatric early warning scores (PEWS) and neonatal early warning scores (NEWS) completed within 15 minutes of arrival. Each chart recorded the necessary clinical observations such as pulse, temperature and respirations. Staff were knowledgeable in responding to any changes in the observations which necessitated the need to escalate the child to be seen by medical staff.
- There was good engagement in morbidity and mortality meetings in surgery, which led to service improvement.

Staffing

- The trust did not have sufficient clinical staff (medical, nursing and other) with the right skills and experience to deliver consistently high quality, patient-centred care as a result of recruitment and retention challenges, inability to deliver new staffing models and high agency usage with the potential for sub-optimal care and harm and poor clinical outcomes for patients. This was on the risk register as a specific risk, and there was evidence of ongoing and proactive recruitment drives.
- Throughout the trust there were often times where the actual number of nurses and midwives on wards did not meet the planned numbers. These planned numbers had been identified using recognised staffing dependency tools.
- The trust was asked to supply data for their staff vacancy rates; we were provided with two contradictory sets of data for the same period. We have taken the data that is most favourable to the trust with the caveat that we were unable to accurately identify the numbers. The trust told us the vacancy rate as of May 2017 was 14.7% for registered nursing and midwifery staff and 6.8% for medical staff.
- The nursing and midwifery staff turnover rate between June 2016 and May 2017 was 7.5%. This was below the trust target range of between 10 and 14%. For medical staff, the turnover rate between June 2016 and May 2017 was 16.2%. This breached the trust target range of between 10 and 14%.

Summary of findings

- Between May 2016 and April 2017, the trust reported a sickness rate of 4.9% for nursing and midwifery staff. This breached the trust target of 3.75%. For medical staff between May 2016 and April 2017, the trust reported a sickness rate of 1.8% for medical staff. This was within the trust target of 3.75%. The trust's sickness rate between January 2016 and December 2016 was mainly higher than the England average. However the sickness rate improved in November and December 2016 and was below the England aggregate figure in both months.
- As of January 2017, the proportions of consultant and junior (foundation year 1-2) staff reported to be working at the trust were both higher than the England averages. There was a vacancy rate for medical staff of 6.8%. This was within the trust target of having a vacancy rate of below 8%.
- The training data supplied by the trust did not include information on major incident awareness training. We asked the trust whether this was included in their Health and Safety training and again asked the trust to specify if it was included within another training module. However the trust misunderstood the question and supplied other information. The training data did include a module called "Incident commander training"; however the data supplied was invalid. The trust had entered figures in the "number trained" column but did not tell us how many staff were eligible for this module.
- Staffing levels in surgery were consistently under plan on most wards during the day.
- There were not enough midwives to provide a safe service in all areas at all times. Staff had to activate the escalation policy frequently to achieve safe staffing in the delivery unit. Safe skill mix in maternity was not always achieved.
- There were insufficient numbers of suitably qualified nursing staff in the paediatric emergency department to provide safe care at all times.
- The specialist palliative care team was too small to meet the demands of the trust as per national guidance.
- Nurse staffing levels on the critical care unit had improved and agency use had reduced since our last inspection. Further recruitment of nurses had taken place and was ongoing to ensure the critical care unit was compliant with the Faculty of Intensive Care Medicine Core Standards for nurse staffing levels. Medical staffing levels had also improved and further recruitment was taking place at the time of our inspection.

Summary of findings

Are services at this trust effective?

Overall, we rated effectiveness of the services in the trust as requires improvement. For specific information, please refer to the reports for Royal Cornwall, St Michaels and West Cornwall Hospitals, and Penrice Birthing Centre.

Summary of key findings for effective:

- Implementation of evidence-based guidance was variable and care and treatment did not always reflect current evidence based standards or best practice.
- Systems and processes for identifying, sharing and implementing new or updated guidance were not operating effectively.
- Clinical audits across the trust were not always planned or carried out in a systematic or timely way to ensure compliance and identify risks or learning. Results of clinical audits were not always shared with relevant staff.
- Patient outcomes were variable; however, mortality data was within expected ranges.
- Not all staff had the right skills, knowledge and experience to do their job and in some areas of the trust the learning needs of staff were not fully understood.
- There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development.

However:

- We could see evidence from audits in some areas where the results triggered change, and evidence that some treatment provided was in line with best practice and national guidance, for example in critical care, gynaecology and children and young people services.
- We saw strong relationships between most multi-disciplinary teams.
- There was good compliance with NHS England's standards for seven-day working in hospitals.
- In critical care and children and young people's services, patients had good outcomes as they received effective care and treatment which met their needs.

Detailed findings

Evidence based care and treatment

- The trust system for identifying and disseminating new or updated national guidance, standards and practice was not effective in all areas. Staff told us that NICE guidance and safety

Requires improvement



Summary of findings

alerts were implemented, disseminated and monitored through the trust's guidelines and alerts steering process group. However, we did not see evidence of oversight and checks to ensure that relevant staff were aware of all new guidance.

- There was a variable impact to this across the trust. In critical care, new or updated guidance and best practice was discussed at and shared at clinical governance meetings. However, the wrong framework for identifying never events was used within the surgical division. A change to the framework was made in 2015 and, although this was known at the trust level, this was not known within the division and a number of significant events had been incorrectly categorised as a result of this.
- There were examples of where up to date guidance and evidence based practice had not been implemented or were not being followed. This included: screening for delirium and aspects of NICE Guidance quality standard (QS) 90 (Rehabilitation after critical illness) that were still not being delivered in critical care; the lack of a dedicated triage midwife, contrary to NICE guideline CG190; and guidelines, such as the completion of a partogram, were not always followed in the delivery suite.
- The trust supplied us with their clinical audit and outcomes programme which was updated in July 2017. This listed all clinical audits that were ongoing, due for completion and overdue for completion. The trust had rated the list (using green, amber and red to denote the status of each audit). Excluding the ongoing audits, the trust had 25 completed (green status), 61 not completed (amber status) and 45 overdue for completion (red status). Included within the programme were 115 priority divisional re-audits, including 'external must do' national audits; however no due dates were set against these nor any information indicating their status.
- The trust also supplied us with a number of audits which set out the raw data findings, but did not include any narrative in terms of interpretation. For example: outcome following geniculate nerve procedure; and opioid use. No summary of findings, actions or recommendations were included in these audit reports.
- All areas of the trust were involved in audit. However, it was not always clear how the results were shared with colleagues or used to improve the services provided. For example: Surgical teams were involved in a wide range of clinical audits including national audits, specialty audits, and audits of NICE guidelines.

Summary of findings

Clinical audits were not on the agenda for the dermatology specialty meetings or the ophthalmology audit or governance meetings, but were for other specialties where they had a standing agenda item.

- Surgical staff were engaged in National Confidential Enquiry into Patient Outcome and Death (NCEPOD) data collection and reporting. However, there was no evidence they used this to monitor their services against best practice and benchmark their outcomes. The purpose of the NCEPOD is to assist in maintaining and improving standards of care for adults and children by reviewing the management of patients, undertaking confidential surveys and research, maintaining and improving the quality of patient care and publishing results of such activities.
- The maternity service took part in national audits, including the new RCOG National Maternity and Perinatal Audit (NMPA), and the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK). They were an early adopter of the Saving Babies Lives care bundle. However, audit plans in the maternity service were not related to risks on the risk register. For example there was no audit of CTG interpretation and the use of fresh eyes, even though the risk of CTG misinterpretation was on the risk register as a high risk. Some clinical audits had been abandoned because of staff leaving, these included: two audits regarding the induction of labour; and an audit of maternal readmission with sepsis. The dates of others had slipped by several months, and a few by more than a year.
- In Children and young people's services a number of regular audits were carried out in the service to monitor performance against national patient outcomes and to maintain standards. The audit programme and work plan was monitored by the safeguarding children's operational group (SCOG) for children. Audit results were presented at the audit and guidelines group, held bi-monthly by the child health department.
- We saw audit information that demonstrated the radiology department regularly audited diagnostic reference levels in radiology and diagnostic services. These audits showed the correct amount of radiation was being used to image a particular part of the body.
- We found that outpatient clinics and associated diagnostic services participated in both local and national audits, benchmarking, accreditation, and peer review. From these, actions were put in place to improve outcomes. For example, more effective ways to inform patients of their appointments to try and reduce the number of patients that did not attend.

Patient outcomes

Summary of findings

- Information about the outcomes of patient care and treatment were routinely collected and monitored in most areas. Patient outcomes were variable across the trust.
- Performance in the national bowel cancer audit, 2016, was slightly better than or within the expected range. The national vascular registry audit, 2015, had performance within the expected range. The 2016 oesophago-gastric cancer national audit demonstrated performance within the expected range. However, the national hip fracture audit, 2016, showed performance which did not meet the national standard for the proportion of patients who had their surgery on the day or day after admission and the perioperative medical assessment rate. The national emergency laparotomy audit 2016 showed performance was at the higher end of the expected range for a number of measures.
- Information about the outcomes of patient care and treatment was routinely collected and monitored in the critical care unit. The unit participated and contributed data to the Intensive Care National Audit and Research Centre (ICNARC). By participating, the unit could benchmark itself against units of a similar size and across all units nationally. The data contributed by the unit was of a high standard, meaning it was mostly complete and could be evaluated and compared.
- Patients reported variable outcomes. In the Patient Reported Outcomes Measures (PROMS) from April 2015 to March 2016, varicose vein outcomes showed more patients' health improving, and fewer patients' health worsening, compared to the England averages. Groin hernia and varicose vein outcomes both showed fewer patients' health improving compared to the England averages. The latter also showed fewer patients reporting a worsening in their health compared to the England average. Otherwise, the indicators were in line with the England averages in terms of the proportions of patients reporting an improvement and a worsening in their condition.
- The mortality was within expected ranges. The standardised hospital-level mortality indicator (SHMI) the ratio of observed to expected deaths, had a value of 99.23. The hospital standardised mortality ratio (HSMR) the ratio of observed to expected deaths for a group of 56 diagnosis groups which represent approximately 80% of in-hospital deaths, was stable at 99.42. The crude mortality rate for March 2017 (11.5) was also stable although there was a slight upward trend.
- There was a gap between weekend and weekday mortality. However, this was narrowing and the trust was not highlighted for their weekend mortality figures and when compared with other trusts in the South West had middling performance.

Summary of findings

- The mortality rates for patients admitted to the critical care unit were lower (better) than the national average. However, there had been an increase in the mortality rate from October to December 2016, but this had decreased over subsequent months. The number of patient deaths, post-discharge from the critical care unit, was lower (better) than the national average.
- Results from the National Paediatric Diabetes Audit (NPDA) for 2015-2016, showed an improving delivery of results. The results had improved year on year to present results.
- The findings of the UK Perinatal Mortality Surveillance for 2015 showed up to a 10% lower rate for the trust than the England average for perinatal mortality.
- The maternity service clinical dashboard or scorecard did not cover all aspects of the service in order to fully monitor the outcomes as identified in the Royal College of Obstetricians and Gynaecology Good Practice guideline No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card). The maternity service maintained a primarily clinical score card. There was no information about staffing such as staff sickness, use of bank staff or vacancies. We did not see evidence of scrutiny of performance recorded on the clinical scorecard in meetings. We expected to find a review of items rated 'Red' some of the parameters, and action planned to restore parameters in this or in the amber zone to expected values.
- More babies than the trust target were readmitted to hospital within 28 days because of feeding concerns. However, there was no clinical guideline to provide information or support to staff regarding this or evidence of plans to reduce this.
- The maternity service generally achieved a lower rate of emergency caesarean section than the national average (9.6%), and a high proportion (70%) of women had unassisted births. The community birth rate was 11.4% which was much higher than the national average of 2.4%
- Outcome data was muddled between the outpatients specialities. For example, in general outpatients it was hard for staff to demonstrate how a given clinic's outcome data reflected how well the clinic was performing. Staff felt this was due to many clinics being under the surgical specialties management rather than outpatient specific clinics.

Competent staff

- We found staff to be generally competent within their roles. Staff told us the trust encouraged staff training; however it was

Summary of findings

mostly done online using e-learning packages. Many staff said they did not feel this was effective for all courses, for example mental capacity act training. Several staff felt face-to-face training was better as they could ask questions at the time.

- Not all staff in the critical care unit had up-to-date training to safely use the specialist equipment within the department. Data submitted by the trust showed there were varying levels of staff trained to use specialist equipment with high levels of staff training being out of date. For example, only 37% of staff had up to date training to use the transport ventilator. The unit had assessed the training levels as being a medium risk within the department.
- In the maternity services, some training was planned that had not been included in the training matrix. For example, midwives had no face to face training in giving epidurals but were expected to administer top ups.
- There had been no review of the skills that remote lone working midwives needed in life threatening emergencies. Clinicians told us that midwives in the hospital were not confident in cannulation. The practice development midwife had recognised the need for cannulation training for community midwives, although not for hospital midwives. This training need was also not identified in the training needs analysis matrix. We were told it would take six months to train all community midwives. This was a risk to women living in geographically distant areas as a delay in ambulance arrival would delay the patient receiving potentially lifesaving treatment.
- Community midwives were not trained to work in delivery suite so did not have the right skills to be fully part of the hospital team. Although planned, no rotation programme was in place.
- There was no overall induction programme for new consultants. We saw from minutes of meetings that consultants were considering what approach would be most helpful.
- The hospital was not meeting its target for 100% of staff to have had their annual performance review. It is a requirements of doctors' registration to have an annual performance review as part of their revalidation programme, as required by the General Medical Council in 2014. By 31 May 2017, within surgery only 74% of medical staff and 78% of nursing staff had an appraisal in the preceding 12 months. Within trauma and orthopaedics, 86% of medical staff and 78% of nursing staff had an appraisal. In oral and maxillofacial trauma and orthopaedics, appraisals had been undertaken with only 55% of medical staff and 43% of nursing staff. Parameters excluded staff on long-term leave such as maternity, career break or long-

Summary of findings

term sickness. Only two of the five senior managers in the surgery division team had an appraisal in the last 12 months. However, in other areas such as critical care, the compliance rate was 97%.

- The arrangements for supporting and managing staff included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation. However, managers in surgery told us the capacity to have annual appraisals for their teams were limited due to lack of management time.
- Staff were encouraged but had limited opportunities to develop. Most staff told us they had access to training and managers told us they had budgets to enable staff to access training. However, we were told it was difficult for staff to find time for training and development, or they could not be released from the ward because of a lack of staff.
- Some staff felt they were supported in their development and were given opportunities to attend additional training to improve their skills. Staff told us they had been funded to attend courses and some were booked to attend courses later in the year.
- Nurses were supported through their revalidation process by the trust and their colleagues.

Multidisciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing patients' care and treatment. The patient records demonstrated input from dietitians, physiotherapists, and occupational therapists. Records also showed input from pharmacists, medical teams, and diagnostic and screening services.
- Exceptional multidisciplinary working was observed at St Michael's Hospital; care and treatment was co-ordinated and necessary staff were involved in assessing, planning and delivering patient care and treatment.
- Staff in gynaecology described good working relationships and good communication. MDT meetings were held to decide on treatment for women with gynaecological cancers.
- Although we saw obstetricians, anaesthetists and midwives working together on the delivery suite, some staff reported tensions across the service. A system had been introduced to allow staff to report on their feelings after a shift and to try to understand the reasons for tensions. This system was in its early days but we saw that it had potential to identify and address problems that prevented productive team work.
- In children and young people's services, we saw evidence that staff worked professionally and cooperatively across different

Summary of findings

disciplines and organisations both in the acute hospital and in the community. This was to ensure care was co-ordinated to meet the needs of children and young people. Therapy was conducted on the children's wards, the outpatient department, and the neonatal unit. Staff reported good multidisciplinary team working with meetings to discuss children and young people's care and treatment.

- We were told relationships between the outpatient departments were good and learning was shared.

Seven-day services

- The hospital performed well against national benchmarks for weekend services. In 2016/2017, data showed 80% of patients had a consultant review within 14 hours of admission over the weekend. This performance was actually better than during the week, where 74% of patients were seen within 14 hours (with Mondays (63%) and Fridays (65%) performing the worst). A working group had plans to increase reviews within 14 hours over the weekend to 100% by 2020/2021. Analysis undertaken by the hospital of weekend patient NEWS scores were higher than weekday scores suggesting sicker patients were admitted over the weekend.
- Ward staff told us junior doctors would be responsible for the ward rounds over the weekend. This had led to times when it was difficult for staff to locate a doctor, as the doctor had a wide-range of responsibilities. However, junior doctors told us they had good support from consultants and they could access them quickly by telephone or in person both out of hours and at weekends.
- A full review of the seven-day services across all specialties in the trust in line with NHS England's 10 clinical standards for weekend working. This had been undertaken by the chief pharmacist. The review showed that against the four priority standards (time to consultant review; access to diagnostics; access to interventions; and ongoing review) the hospital had met targets set by March 2017. An action plan was signed off by the trust Management Committee. There was an executive lead and a working group to implement the action plan.

Access to information

- There was easy access to trust policies through its intranet site. Some wards kept hard copies of protocols available for staff in offices or on staff workstations. However, in some areas for example surgery, there were no processes to ensure that the policies kept in files were up-to-date and represented the latest version.

Summary of findings

- There had been a programme to update guidelines in the maternity service through a multidisciplinary group. However, we found some guidelines contradicted others and not all midwives seemed to understand the importance of adhering to guidelines. Some guidelines, such as the use of a partogram to show the progress of labour were not followed in many women's deliveries.
- Community midwives did not have remote access to maternity guidelines. Remote access would not be possible until the new maternity information system was introduced, due October 2017. Midwives had paper copies of relevant guidelines, but there was no process to ensure midwives were following guidance through audit.
- Staff working in the community children and young people's service did not have access to the electronic records system used by another provider of community health care in the county. Staff said it was difficult to coordinate between the two systems and this could hamper delivery of effective care and treatment.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The lead nurse for mental health and well-being, (who was an accredited best interest assessor) undertook capacity assessments for complex cases or second opinions.
- The Deprivation of Liberty Safeguards (DoLS) is an amendment to the Mental Capacity Act (MCA) 2005. The Mental Capacity Act allows restraint and restrictions to be used, in patients who lack mental capacity, if it is in a person's best interests. This can include preventing the person from leaving hospital. The trust had seen an increase in DoLS applications made, from 250 in 2015-2016 to 300 in 2016-2017; the trust reported this increase to be attributed to a recent change in case law which reduced the threshold for making a DoLS application, as well as improved staff awareness and understanding resulting from widespread training.
- At the beginning of 2016 the safeguarding team were successful in a bid for monies (£13,000) to review the training and application of the Mental Capacity Act (MCA). A project plan included the revision of current training and the MCA assessment tools, focus groups with staff to support the development of new tools and the filming of an MCA assessment video. The project had been completed and the new electronic MCA tool was in use across the hospital. A mandatory training package had supported the launch of the

Summary of findings

new tool in addition to staff communications. The mental capacity lead was invited to attend the national mental capacity action day at the Royal College of Physicians, London, to share the good practice.

- Training on the MCA / DoLS Policies and their application was included in corporate induction and mandatory training. Training was also delivered to senior medical staff and junior doctors. Bespoke training was available to the emergency department, maternity, paediatrics, clinical imaging and hospital volunteers. Clinical areas could also request bespoke training using a range of delivery methods including drop in sessions, toolbox training, case reviews and team meetings. An example of this set out in the annual safeguarding report April 2017 was the use of a MCA and DoLS toolkit bespoke for critical care, which also aided the amendment of their electronic records to better capture assessments of mental capacity and the need for DoLS.
- Staff were aware of all policies regarding consent, mental capacity act and deprivation of liberty safeguards and had access to them through the intranet. Most senior nurses felt competent to raise consent issues and to complete the relevant documentation. They were aware of the policy from initiation to best interest assessment and the revisiting and lifting of deprivation of liberty safeguards where appropriate.
- Staff had a good understanding and guidance to follow in relation to mental capacity assessments
- The trust's 'Policy for Consent to Examination or Treatment' expired in March 2016 and was still under review at the time of the inspection.
- Consent was audited trust wide. The latest annual consent audit was undertaken in June 2015. The survey reviewed 10 cases in each discipline and results indicated that processes were adequate. We noted that staff did not normally give patients written information to supplement the information given verbally, in line with good practice.
- We asked about the consent process for young people in relation to termination of pregnancy. Staff we spoke with had a good understanding of Gillick competence and Fraser guidelines.

Are services at this trust caring?

Overall, we rated caring of the services in the trust as good. We rated caring at St Michael's Hospital as outstanding. For specific information, please refer to the reports for Royal Cornwall, St Michaels and West Cornwall Hospitals, and Penrice Birthing Centre.

Good



Summary of findings

Summary of key findings for caring:

- We found that people were supported, treated with dignity and respect and were involved as partners in their care.
- St Michael's Hospital was rated as outstanding for caring; staff put patient care at the forefront of everything they did and went the extra mile.
- Patients and their families spoke almost entirely positively about the care they received across all services we visited. Patients and those close to them told us they were treated with respect, kindness and compassion and felt supported and cared about. We observed staff in several areas treating patients with kindness and warmth.
- Communication with patients was effective as they were kept informed of their condition, progress and treatment. Patients' privacy and dignity was maintained throughout their treatment and staff took all steps wherever possible to protect confidentiality.
- Women had reasonable continuity of care before and after birth from a local team of community midwives which enabled them to establish trusting relationships.
- Children and young people were treated as individuals and as part of a family. Feedback from children, young people and parents had been consistently positive. They praised the way the staff really understood the needs of their children, and involved the whole family in their care.
- Parents said staff were caring and compassionate, treated them with dignity and respect, and made their children feel safe. Staff ensured children and young people experienced high quality care. Staff were skilled to be able to communicate well with children and young people to reduce their anxieties and keep them informed of what was happening and involved in their care.
- Staff in outpatients adopted the "hello my name is" by way of introduction to all patients.
- Patients were empowered and supported to manage their own health, care and wellbeing.

However:

- The critical care unit was not using patient diaries but there were plans to introduce them later in the year.
- There were no formal arrangements for counselling services in the critical care but the unit had developed close ties to the trust's chaplaincy service which provided patients with spiritual support.

Summary of findings

- Although there was supportive care for women in maternity immediately around the time of bereavement, there was no follow up or counselling provided by hospital staff.
- Women were less satisfied with their experience of care on the postnatal ward, particularly during the high temperatures that prevailed during our inspection.
- Privacy and dignity was not always fully maintained as two delivery rooms on the delivery suite did not have blinds for privacy when the lights were on at night.
- The fracture clinic cubicles were small and close together. Private and confidential conversations in adjoining cubicles could be overheard.

Detailed findings

Compassionate care

- St Michael's Hospital was rated as outstanding for caring; staff put patient care at the forefront of everything they did. Patients spoken with continually gave us overwhelmingly positive feedback on the care and treatment they had received. The wards were inundated with thank you cards which sang the praises of the care staff provided in theatres and on the ward. This was also reflected in the high numbers of extremely positive comments submitted with the friends and family test.
- People felt staff went the extra mile and the care they received exceeded their expectations. Between January and June 2017 there were 342 comments from the Friends and Family test, of which 341 were extremely positive about the care and treatment received. Comments included; "everyone without exception has been extremely kind, patient and helpful", "fantastic care given at all times felt very confident about all aspects of care", "kindness and care was shown from the moment I entered the ward I cannot praise enough the care which I received", "the level of care has been exemplary. All the staff are both efficient and friendly" and "wonderful care and attention I cannot speak highly enough about the amazing people who looked after me".
- Each ward at St Michael's Hospital displayed their monthly C.A.R.E audit results. The C.A.R.E campaign looks at whether staff, C – communicate with compassion, A – assist with toileting, ensuring dignity, R – relieve pain effectively and E – encourage adequate nutrition. For the month of May both wards had achieved 100% in each area, in the month of June 100% was achieved with the exception of St Michaels Ward 98% for A and R and 96% for E.

Summary of findings

- In surgery feedback from patients and relatives was positive overall. For example, the NHS Friends and Family Test scores were mostly above 90% for surgical wards between March 2016 and February 2017. However, the response rate was only 11%, compared to around 25% nationally.
- Staff in surgery worked hard to uphold patients' dignity, individuality and human rights. We observed staff acting in a respectful, kind and compassionate way to patients and those close to them. The patients we spoke with were largely positive about the compassion and kindness of staff and their dedication to providing good care. Patients described their care as "brilliant" and "first-class". Patients described the staff on the ward as "lovely", "great", "fantastic", "good as gold", and a patient's relative described staff members as "angels in disguise."
- Staff in the critical care unit took the time to interact with patients and those close to them in a respectful and considerate manner. We observed staff communicating with patients, their relatives and carers in a kind and compassionate manner on many occasions during our inspection. A relative told us that staff had always been very patient with them when they were seeking advice or an update. Several patients and visitors told us that staff kept them regularly updated by telephone or in person and someone was always available when they called the unit to check on relatives.
- We saw evidence of care being delivered in maternity that was kind and compassionate. Feedback from the Friends and Family survey between April 2016 and March 2017 showed the percentage of women who would recommend the trust for antenatal treatment for friends and family was similar to the England average at 96%, although the numbers commenting on antenatal care were low, (for example, only 7% compared to a national expectation of 15% response rate). The Friends and Family antenatal questionnaire was still in most women's records we looked at on the postnatal ward, indicating that midwives had not given it to women to complete.
- The score for women's experience of birth was 97%, the same as the national average in May 2017. However the results for the postnatal ward were mixed over the year to May 2017, averaging 90% compared with the England average of 98%. However, many positive comments were seen in the free text section: "midwives have given me and my husband fantastic support during and after delivery", "friendly and reassuring midwife" although a minority mentioned that staff were 'overstretched' and indicated that some staff were more helpful than others.

Summary of findings

- We noted that two delivery rooms on the delivery suite did not have blinds for privacy when the lights were on at night. We were told blinds were on order, however no alternative arrangements had been made to ensure privacy and dignity was maintained.
- We spoke with staff in the unplanned pregnancy service and observed they were kind, non-directive and non-judgemental. This was borne out by feedback forms. They sought to maintain women's privacy by running small clinics (10 women) and allocating appointment times so women rarely needed to wait with others. We saw evidence of very positive feedback from women who had used the termination of pregnancy service, with over 95% rating this as excellent.
- Throughout our inspection, we observed children and young people being treated with the highest levels of compassion, dignity and respect. We observed interactions between staff and children and their families. Staff were open, friendly and approachable but always remained professional.
- The trust performed about the same as the England average for 12 out of 14 questions relating to compassionate care in the latest CQC children's survey. They performed better than other trusts for two questions; 'Were you given enough privacy when you were receiving care and treatment?', where they scored 9.63, and 'Do you feel that the people looking after you were friendly?' where they scored 10.
- Patients were treated with dignity and respect in the outpatient department. Staff were polite and helpful during conversations. Staff ensured patient confidentiality during conversations wherever possible. We spoke with twelve patients who had received care and treatment at the clinics. All spoke positively about their experiences. Comments of note were: "always a professional and friendly manner" and "I was respected each time I attended".
- Most outpatients departments had suitable rooms for private consultations. However, we observed that privacy was compromised in the fracture clinic because patients' personal information could be overheard by other patients. This was because the cubicles were very small and close to each other and simply curtained off.
- Feedback from patients at West Cornwall Hospital was consistently positive about the care and treatment they had received. We observed staff always treating people with kindness, dignity, respect, and compassion.
- We did not speak to any women who had given birth at penrice birthing centre as we did not meet any at the centre, although we heard from women who had antenatal appointments that

Summary of findings

midwives were compassionate, sensitive and supportive. The feedback the birthing centre had received over the past year on its Facebook page was consistently positive, and women who had given birth at the centre and shared their experiences, in turn increased other women's confidence in choosing this model of care.

Understanding and involvement of patients and those close to them

- At St Michael's Hospital, there was a strong, visible person-centre culture and patients were truly respected and valued as individuals, empowered as partners in their care. Patients were continually involved in their care and the decisions taken. In theatre patients were kept informed of the care and treatment they were receiving. Surgeons and anaesthetists visited patients in recovery to explain the surgery undertaken. We observed staff explaining things to patients and ensuring they were given the opportunity to ask any questions. All patients we spoke with said they understood their treatment and ongoing plans.
- Patients and relatives were encouraged to be involved in their care as much as they felt able to. One relative we spoke to who did not live in the same area as the patient commented how staff had arranged an earlier discharge time for them to give them the time to travel.
- The family members we spoke with in surgery felt well informed and updated by staff and the information was well explained.
- Staff in the critical care unit understood and respected patients' personal, cultural, social and religious needs and took them into account when delivering care. If changes in patients' conditions occurred, the patient or their families/carers would be asked if they had any specific needs and staff would endeavour to accommodate them. Staff communicated with patients so they understood their care treatment and condition. Patients told us they felt involved in their own care and treatment. All patients who could speak with us were able to describe their condition, progress and current treatment.
- Women we spoke with in maternity said midwives had supported them in making decisions about their care. They felt able to ask staff if they were unsure about something. Women had continuity of care before and after birth from a local team of community midwives which enabled them to establish trusting relationships.

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- Women seeking termination of pregnancy were offered counselling and time to reach their decisions. They were able to make an informed choice about the method of termination and about the disposal of foetal remains.
- Children, young people and their families were involved with their care and decisions taken. We observed staff explaining things to parents, children and young people in a way they could understand. For example, during a complex explanation, time was allowed for either the child or their parents to ask whatever questions they wanted to. One parent commented that they had been “updated on everything in language I understand.”
- Parents were encouraged to be involved in the care of their children as much as they felt able to. We observed that children and young people were also involved in their own care. Children, young people and parents that we spoke with all confirmed this was the case. One parent on the neonatal unit told us how staff had taken time to advise her about developmental care, positioning and turning of her baby, and the parent had gained a good understanding of the reasons why.
- Patients in outpatients spoke of having a full discussion with the doctor regarding their treatment options available to them. They said this made them feel listened to and part of the whole process.
- All healthcare professionals involved with the patient’s care introduced themselves and explained their roles and responsibilities.
- At West Cornwall Hospital, patients felt involved in their treatment and care. We observed staff explaining things to patients and ensuring they were given the opportunity to ask any questions. All patients we spoke with said they understood their treatment and had reported they had been given sufficient information.

Emotional support

- At St Michael’s Hospital, staff recognised and respected people’s needs and took in to account their personal, cultural, social and religious needs. Staff understood the impact the care, treatment or condition might have on the patient’s wellbeing and on those close to them both emotionally and socially. We heard how staff had moved forward a patients operation time as they had recognised how anxious and worried they were and the impact waiting was having on this.

Summary of findings

- Staff were kind and understood that patients needed home comforts. One patient we spoke with said, 'you are made to feel like you are at home as much as possible'.
- Patient care and support was not only limited to the condition patients were admitted for. One patient said staff had understood their mental health concerns, they had ensured this was appropriately managed, and care and support was in place for when they were discharged.
- Patients in surgery received the support they needed to cope emotionally with their care, treatment or condition. We observed caring interactions from staff when patients showed signs of being in distress. For example, while we were shown around a theatre, we noticed a patient who was visibly upset and the theatre staff immediately went to the patient to listen to their concern and reason for being upset. They spent time with the patient until they were reassured.
- The critical care unit was compliant with NICE QS15 (Patient experience in adult NHS services) as staff ensured patients' physical and psychological needs were regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. It was evident in the patient records we reviewed that assessments for the above had been carried out and were being reviewed daily.
- Staff supported bereaved relatives and carers. Staff gave them time to be with their loved ones on the critical unit and made the area around them as quiet as possible. If appropriate, deceased patients were moved to one of the isolation rooms so relatives could spend time with them in private. Staff also accompanied bereaved relatives to their cars or waited with them if using public transport so they were not alone. However, there were no formal arrangements for counselling services but the unit had developed close ties to the trust's chaplaincy service which provided patients with spiritual support.
- At the time of our inspection the critical unit was not using patient diaries. Research has shown how patients who are sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post-discharge. However, staff told us patient diaries had been discussed at clinical governance meetings and the unit had plans to implement them in the future.
- We saw that a specialist bereavement midwife provided sensitive and compassionate care to women or couples, as well as practical support while they were in the hospital. However, there was little counselling or follow up for women who suffered bereavement.

Summary of findings

- All women seeking terminations of pregnancy were encouraged to have discussions with an accredited counsellor. Women were routinely offered follow up appointments, and had telephone follow up. Post termination support was also available.
- Staff from across a range of departments told us of their appreciation for the pastoral care team, who were described as 'amazing' and 'excellent'. We heard examples of where they had sat with patients to provide emotional support when the wards were busy.
- We observed staff providing emotional support to children, young people, their parents, siblings and grandparents during their visit to the unit. Children's individual concerns were promptly identified and responded to in a positive and reassuring way. Children, young people and their families were spoken with in an unhurried manner and staff checked if information was understood. When speaking to parents on the telephone, we overheard staff encouraging them to call back at any time if they continued to have concerns, however minor they perceived them to be.
- In outpatients we found patients' emotional needs were supported. There was a policy and procedure on chaperoning in place, which was available to staff and patients on the trust website. Information on the chaperone service was displayed in waiting areas.
- We observed staff providing emotional support to patients and relatives during their visit to the department. We saw staff providing reassurance for patients who were anxious. This included a nurse spending time with a patient, explaining what the patient should experience and how staff would help.

Are services at this trust responsive?

Overall, we rated responsiveness of the services in the trust as 'inadequate'. For specific information, please refer to the reports for Royal Cornwall, St Michaels and West Cornwall Hospitals, and Penrice Birthing Centre.

Summary of key finding for responsive:

- Not all services were planned or delivered to meet the needs of the local population. Lack of capacity and resources in surgery, maternity and outpatients at Royal Cornwall Hospital meant that plans were not always delivered in a way which met patients' needs.
- Not all women were able to give birth in the community as planned as there was a low threshold for transferring women into the main consultant led unit. Since May 2017 the Penrice

Inadequate



Summary of findings

Birth Centre was only open on request out of hours, and staff shortage meant only one woman could labour at the unit out of hours. Women and their partners could not stay at the centre overnight, which had been an option before staffing reductions and was valuable for women in establishing breastfeeding.

- Some maternity services had to be closed at times because of staffing, such as the homebirth service, birth centres, early pregnancy unit and emergency gynaecology unit.
- People in surgery, cardiology and ophthalmology were frequently and consistently unable to access services in a timely way for initial assessment, diagnosis or treatment, and experienced unacceptable waits.
- Surgical patients were unable to access the care they needed at the right time, and referral to treatment times for incomplete pathways had been worse than average from March 2017. A high number of patients were not treated within 28 days of their operation being cancelled at short notice.
- Pressures from non-elective admissions and delayed transfers of care led to significant levels of cancellations of elective operations. Twelve patients with cancer had their operation cancelled from January to May 2017, seven on the day of their booked operation. There were long waiting times for referral to treatment for some (non-cancer) gynaecology procedures.
- Patients were not always operated on in the correct operating theatres, and assessments to identify patient risks were not always carried out.
- Due to the lack of capacity within the hospital for beds, critical care patients did not always receive optimal care at the right time. There were frequent delayed admissions, delayed discharges and discharges which took place out of hours. There had been too many occasions when surgical and level two patients had to stay in recovery overnight because there were no available beds.
- In maternity there were regular delays in transferring women to the labour ward because of capacity on the delivery suite, both from limitations of accommodation and staffing.
- The maternity service did not run a dedicated elective caesarean list. This could mean woman scheduled for elective surgery had to wait if there was an emergency underway on the day they were admitted.
- The day assessment unit only had two scanning slots a day. As a result, some women who attended for reduced foetal movements had to return for scanning on another day.
- There were capacity and demand issues in ophthalmology and cardiology. These demands had led to increased waiting times and unacceptably long waits for follow up treatment. The

Summary of findings

outpatients' transformation programme had not managed to improve patient flow through the outpatient clinics. There were a high number of cancelled appointments for avoidable reasons.

- At West Cornwall Hospital, theatres were not being used to full capacity and the target for less than five theatre cancellations a week was regularly not being achieved.
- There were delays in completing discharge summaries on the children's wards and performance required improvement.
- The facilities and premises used in outpatients, the pre-operative assessment area and some areas of maternity did not meet people's needs or were inappropriate.
- The temperature in the neonatal and maternity units was not always at a suitable level.
- There was a risk to women's privacy and dignity on the antenatal ward as some women gave birth on the ward. The ward did not have closed doors and was merged with the day assessment unit. Few partners were able to stay overnight on the postnatal ward as space was limited.
- The fracture clinic environment did not meet patients' needs and environmental and safeguarding issues identified following our January 2016 inspection continued.
- Patients were not always cared for in separate single sex areas due to patient flow issues.
- The critical care unit did not routinely screen for patients living with dementia when admitted onto the unit. Not all outpatient clinics were designed or appropriate for patients living with dementia.
- The surgery service consistently missed targets to respond to complaints within 25 working days. There was little evidence to show lessons had been learned and practice changed to demonstrate people who complained were listened to.

However:

- Services were tailored to meet the needs of individual children and young people and were delivered in a flexible way. Children and young people of all ages had timely access to care and treatment.
- The critical care unit had introduced measures to ensure patient flow in and out of the unit did not deteriorate. New systems for assessing bed capacity had been introduced which increased efficiency in the admission and discharge processes.

Summary of findings

- Surgical cancellations were low at St Michaels Hospital and there was good flow from theatres to wards. Reasons for cancellations were reviewed regularly. The referral to treatment time for the orthopaedic speciality was better than the national average.
- We found the time taken for diagnostic images to be reported was adaptable and managed demand. Imaging was performing well and managing many of its key waiting times.
- The environment for the neonatal service had improved considerably with the opening of the new unit in May 2017. Staff had been involved in the design and planning phase of the development of the unit.
- There were good facilities for babies, children, young people and their families.
- The critical care unit demonstrated outstanding examples of individualised and multidisciplinary care for their patients.
- There were good arrangements for supporting patients with a learning difficulty going into theatre.
- There was a good range of information leaflets for women with early pregnancy problems detailing ways of managing these. Good use was made of Facebook to communicate with women and young people.
- There were no barriers for those making a complaint in children and young people's services. Staff actively invited feedback from children and their parents or carers, and were very open to learning and improvement.

Detailed findings

Service planning and delivery to meet the needs of local people

- Service planning and delivery in surgery at the Royal Cornwall Hospital did not meet the needs of local people. Executives and senior managers of the service told us with winter pressures followed by the large influx of tourists over the summer months, services were under pressure all year around. Services were planned to meet local needs but due to a lack of capacity and resources they were unable to ensure services offered flexibility, choice and continuity of care.
- At West Cornwall and St Michael's Hospitals, capacity was not such an issue and the services were better able to plan and deliver to meet the needs of local people, however neither hospital was used to full capacity to help reduce the flow at the main hospital site.
- Services provided reflected the needs of the population served at St Michael's Hospital; however the ability for patients to

Summary of findings

choose this service directly was variable. Staff told us St Michaels Hospital was popular with patients and the local community, however via choose and book patients could not specifically choose St Michael's Hospital as it came under Royal Cornwall Hospital Trust.

- Cardiology and ophthalmology were not meeting the needs of the local people. We found there were capacity and demand issues in clinics that meant there were an insufficient number of clinics running to deal with demand. Managers and clinical staff also voiced their concerns at the number of patients requiring both services and progress to reduce the waiting list had been too slow.
- We observed that waiting times varied across the imaging departments. Most patients we spoke with were tolerant and understood if they were not seen at their scheduled appointment times. We found the longest wait for treatment was for magnetic resonance imaging scans, with an average wait of 54 minutes. The shortest waits were for X-ray with an average wait of 17 minutes.
- The maternity service was designed to avoid women having to travel too far from their homes. Antenatal care was delivered in GP practices, children's centres and a birthing unit. Some midwives visited women at home. However, not all women were able to give birth in the community as planned as there was a low threshold for transferring women into the main consultant led unit and at times the birth centres were closed.
- The facilities and premises at the Royal Cornwall Hospital were not always appropriate for the services which were planned and delivered. We saw evidence operations were occasionally undertaken in theatres which were not correctly equipped. In addition, patients were moved from one side of the hospital to the other after their operation to recover. We saw the two day-theatre units, Theatre Direct and the surgical admissions lounge were used too often as wards due to bed pressures across the hospital site.
- The delivery suite did not have enough rooms to accommodate the numbers of babies born at the hospital. The delivery rooms were too small to accommodate many birthing aids to support women with pain and labour, which meant women were more likely to need intervention in their births.
- The temperature in the neonatal unit was not always at a suitable level. The unit was very hot and plans to address the high temperature were in hand with air conditioning units and fans being used as a temporary measure to control the temperature. There were similar issues within maternity services with unacceptably hot temperatures.

Summary of findings

- Provision of suitable children's waiting areas was available in most clinics. However, the fracture clinic offered a very small area for those needing to elevate broken limbs and for children. The waiting area was out of sight of reception staff and children were found to be waiting alongside adult patients. Staff described this as inadequate for their needs and a potential safeguarding concern. These issues were noted in our last inspection in January 2016 but no action had been taken to address the concerns.
- There was not enough access to showering and toilet facilities on Theatre Direct, where patients were being accommodated to stay overnight. There were two showering facilities on the unit – one for male and one for female patients. However, these were situated inside the toilets in two of the three available toilets.
- Staff in the preoperative assessment unit told us there were not enough consulting rooms and the waiting area was often overcrowded. Staff also reported the unit was a long way from the main hospital for patients. Some patients were frail and exhausted by the time they reached the unit because of the lack of nearby parking facilities.
- The environment on the children's wards, the outpatient department, the child development centre and the neonatal unit were designed to meet the needs of babies, children and young people and their families. Staff had been involved in the design and planning phase of the development of the neonatal unit. Parents were keen to tell us how impressed they were with the new unit.
- In the critical care unit, services were designed and planned to meet patients' needs. The unit was located close to the emergency operating theatres next door, which is recognised as good practice. Improvements had been made to the premises since our last inspection, which included the installation of shower facilities, as recommended by Department of Health guidelines for modern critical care units.
- Patients told us the current signage and directions for moving through the hospital were challenging. Not all clinics were suitable for wheelchair users. We found waiting rooms to be small and limited the mobility of wheelchairs. The patient would have to wait in an area where movement of the chair was unhindered but not necessarily within the waiting area.

Meeting people's individual needs

- The trust did not comply with the NHS England Accessible Information Standard introduced in 2016. This required the trust to be able to identify, record, flag, share and meet the

Summary of findings

information and communication needs of patients with a disability or sensory loss. The trust did not have a specific Accessible Information Standard policy at the time of the inspection. It was not able to meet the required standard due to the administration system not enabling a flag for a relevant patient to be reliably seen by booking staff. The need for this has been built into the procurement process of the new administration system which was due to be rolled out in October 2017.

- Staff on the units and wards we visited were aware and could demonstrate how they would access interpreting services for people who did not speak English as a first language. There were services including British Sign Language, hearing loops and braille provision should the need arise. Nurses told us they were able to pre-book the interpreter service or access it in an emergency. The service was available 24 hours a day, all year around.
- The critical care unit demonstrated outstanding examples of individualised and multidisciplinary care for their patients. Several patients on the unit, who had been cared for on the unit for many months, had been supported and enabled to leave the unit on day trips. To do this, all staff on the unit went to great efforts to ensure the patient was safe and all necessary safeguards were in place. Consultants, nurses and anaesthetists came in on their days off to facilitate this.
- There were arrangements for supporting patients with a learning difficulty. This included a regular operating theatre list specifically for these patients. Recovery and outpatient nurses told us they had good access to support, including access to a team of specialist nurses.
- There was no written information for parents in the postnatal ward beside the beds about the ward routine. This was left for midwives to explain. There was a good range of information leaflets for women with early pregnancy problems detailing ways of managing these. Good use was made of Facebook to communicate with women and young people.
- There were a number of new Easy Read Material's developed in 2016 by the safeguarding services, extending the range of resources for patients. They included a dental aftercare leaflet, an easy acute liaison team leaflet for learning disabilities and autism, alongside an easy read comment card for feedback of the service.
- An innovative mental health choose and book service had been developed, by the mental health and wellbeing team, to meet the specific and diverse needs of people with mental health issues. An additional step had been created in the choose and

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book process so that referrals went directly to the mental health and wellbeing team who called the patient at home to offer reasonable adjustments. The referral and required adjustments were then forwarded to the booking team who made the appointment incorporating the adjustments required. Where required, the mental health and wellbeing team supported the patient during their appointment/procedure. The mental health and wellbeing team were finalists at the Health Service Journal (HSJ) awards for this service.

Dementia

- Services were generally planned and delivered around people with complex needs including patients living with dementia, although performance on surgical wards was variable with St Mawes meeting targets 100% of the time and Wheals Cotes only meeting targets 31% of the time.
- Dementia screening was not routinely carried out in critical care and staff were confused about when this should take place.
- Not all outpatient clinics had been designed to be dementia-friendly. Easy read clocks and toilet signs were apparent in some, but not all, clinics. Each clinic had access to dementia champions who could assist with patients with complex or advanced dementia.
- There was a full time dementia nurse specialist (admiral nurse) in post, jointly funded by the trust and an external agency. The admiral nurse service operated Monday to Friday between 8am and 4pm, and the wider safeguarding team provided backfill as required.
- The admiral nurse provided support, specialist advice, liaison and collaboration with families and external agencies and was able to offer training and patient specific advice to staff caring for patients with dementia.
- Five key performance indicators (KPI) were agreed for the admiral nurse service and were reported on quarterly to the admiral nurse steering group and the dementia action group. The five indicators were:
 - KPI 1: Over 90% of patients with dementia will have a fully-completed 'This is me' document (for families/carers to complete about the patient with information such as likes/dislikes) by April 2018. Figures across the trust as of April 2017 showed that 71% of patients had these completed.
 - KPI 2: Over 90% of patients will have a fully-completed Individualised care plan by April 2018. Figures as of April 2017 showed that 86% of patients had these completed.

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- At the time of the inspection, tools were not available to collect data for the following KPI's and there were plans to develop these:
 - KPI 3: Over 90% of carers of a person with dementia will have been offered a carers passport by April 2018.
 - KPI 4: Following delivery of the enhanced care success regime >90% of ward staff will report an increase in knowledge and skills whilst caring for people with dementia who have complex needs by April 2018.
 - KPI 5: The inappropriate use of 1:1 or 1:2 enhanced care for people with dementia will be less than 5% resulting in a reduction of behaviour that challenges, and encouraging positive interaction through meaningful activity by April 2018.
- There had been a number of positive initiatives implemented for patients living with dementia and work continued to embed these across the trust, for example, 'Baywatch' which was an intervention started on the trauma unit, to reduce the number of falls in patients with living with dementia.

Access and flow

- People at Royal Cornwall Hospital were frequently and consistently unable to access some services in a timely way. Between April 2016 and June 2017, the trust's referral to treatment times (RTT) for incomplete pathways for surgical services were variable when compared with the England overall performance. The latest figures for June 2017 showed there was a decline in performance from September 2016. The trust had failed to meet the target since March 2017 and was at 90.7% in May 2017 (92% is the national target). The overall size of the referral to treatment waiting list was continuing to grow. As at May 2017, the backlog of patients was at 2,238. Trauma and orthopaedics (80.8%), paediatric surgery (69.5%) and colorectal surgery (76.1%) accounted for the three longest waiting lists across the trust.
- There were significant delayed discharges out of the hospital. During the inspection, there were 52 medical and surgical patients unable to leave the hospital due to packages of care not being available for them to be safely discharged at the time. Consequently, patients were at risk of deteriorating both physically and mentally while remaining in hospital. Pressures from emergency patient admissions and delayed transfers of care led to significant number of cancellations of planned operations. This, in turn, led to reduced bookings for future planned operations, affecting both patient experience and staff

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morale. The result was the under-delivery of the number of planned operations, and a rise in the number of patients not being treated in line with the target. At the time of the inspection, delayed transfers of care were at 9.8%, equating to 61 per day.

- Data provided by the hospital showed 5% of operations were cancelled across the hospital sites in 2016/2017, and this figure was increasing. NHS Improvement set all hospitals a target of a maximum of 5.1% of operations cancelled due to non-bed related issues. Across all three hospitals in the trust, 90 (7.9%) of operations were cancelled for this reason in April 2017, and 138 operations (9.1%) were cancelled in May 2017.
- There was a high proportion of last minute cancellations of surgery. If a patient had not been treated within 28 days of a last-minute cancellation then this was recorded as a breach of the standard. The patient should be offered treatment at the time and hospital of their choice. For the period between April 2016 and March 2017, the trust cancelled 2,095 operations for non-clinical reasons. Of these, 543 (more than a quarter) were not treated within 28 days. The trust's performance was consistently worse than the England average over this period.
- Surgery service managers confirmed three patients admitted for breast cancer surgery were cancelled because of lack of high dependency beds post-operatively in the last 12 months. A further 11 patients with cancer had their operations cancelled between January and May 2017, seven cancelled on the day of their surgery. Reasons included lack of an available critical care bed, allocation to an inappropriate surgeon, or because other urgent patients took priority. For each of these cases, the hospital had exceeded the referral to treatment targets of 31 or 62 days.
- We were also told about cancellations for bariatric patients on the day of surgery. This was particularly of issue for these patients, as most would have been on a special diet for six weeks prior to their operation.
- The Newlyn ward was designated to care for day surgery patients having surgery in the Trelawny wing theatre suite. However, managers told us day surgery was also undertaken in theatres in the Tower theatre suite. This made managing patients admitted to the Newlyn ward but operated upon across both sites difficult. Coupled with this were patients admitted to the Newlyn ward when no other beds were available.
- Bed management meetings took place every weekday to identify where there were staff shortages, outlying patients, and how these could be managed. We attended a bed management

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meeting. Managers confirmed the surgery division was more often affected by bed pressures. For trauma and orthopaedic and maxillofacial patients attending the hospital on a Sunday, there were no formal arrangements for them to be reviewed. Therefore, these teams were playing 'catch up' on Monday and Tuesday, when most elective operations were booked. This meant more operations were cancelled on these days. This was a known issue and senior managers were looking at options to address this concern. We saw there were good levels of cooperation at bed management meetings to maintain or reach safe staffing levels. Managers across the hospital adjusted their staffing rotas to help keep patients safe.

- The service had identified a risk that patient follow up reviews were not happening due to a lack of standardised administrative processes, not enough ward clerk cover, and the high workload. The Information Services team had developed a post inpatient follow up report and monitoring process. This used completed discharge summaries, to ensure the hospital knew which patients had not been seen at follow-up. However, the report could only identify patients where a 'requires follow-up' had been entered onto the hospital electronic patient system. It had been recognised this was not entered for all patients, even when it was required.
- Critical care beds were not always available for those patients who needed this level of care. As identified during our previous inspection, there were occasions when patients had to remain in theatre recovery, while waiting for a critical care bed. Staff told us that patients requiring level two care could be kept on the recovery unit for up to 24 hours after surgery, if there were no critical care beds available. Throughout April 2016 and March 2017 there had been 92 patients who had an overnight stay in the recovery area due to a lack of beds in the critical care unit. Additional data showed there had been 44 patients who had an extended recovery stay, not involving an overnight stay, over the period from August 2016 to July 2017.
- As identified during our previous inspection there were still too many delayed discharges from the critical care to a ward, when the patient was ready for transfer. The data in the ICNARC report, for the period from April to December 2016, demonstrated 6.7% of all patient discharges from the unit had been delayed by up to eight hours, which was higher (worse) than the national average of 5.1%. The number of delayed discharges had also been higher than the national average throughout 2015/2016. At our previous inspection we also identified too many patients were discharged from the unit out of hours (between 10pm and 7am). This remained an issue. The

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ICNARC report told us that 4.8% of all patients had been discharged from the critical care unit out of hours, which was significantly higher (worse) than the national average of 2%. Studies have shown discharges at night can increase the risk of mortality; disorientate and cause stress to patients.

- There were consistently long delays for patients requiring follow up treatment in ophthalmology. At the time of our inspection, there were 1,200 patients who had experienced the longest delays for follow up for Wet Age Related Macular Degeneration injections. While initial gains had been made to reduce the number from 2,000, the continued growth in demand for the service meant this number continued to grow beyond the capacity of the trust.
- In cardiology, from December 2016 to June 2017, 554 patients had been delayed past their agreed date for a follow up appointment. A backlog had developed due to a change in model that removed an outpatient consultant, and cardiology had yet to appoint a speciality lead. Therefore the consultant cardiologist had to cover multiple roles, reducing their capacity.
- In ophthalmology 6,503 people had breached the time for follow up appointments from December 2016 to June 2017. Extra clinics had been opened and staff trained to enable further accessibility to patients, but demand continued to place pressure on the service.
- Action plans to improve services to reduce patients waiting for cardiology and ophthalmology had been developed but progress had been slow. Some key milestone dates for each service had not been completed. Several actions had extensions in an attempt to achieve these targets but had not reduced the number of patients on the waiting lists.
- The outpatient transformation programme had attempted to reduce waiting lists and cancelled clinics. The 2016/2017 target to reduce the “did not attend” (DNACPR) rate to 5.7% had not been met, with rates remaining above 6% in most months, peaking at 7.4% in December 2016. The DNACPR rate was at its lowest at 6.14% in April 2016. The inability to reduce the cancellation rate meant that patients were waiting longer for clinics slots to be available.
- A target had been set by the outpatient transformation programme to reduce the ‘new to follow up’ ratio. New to follow-up ratios are performance measures that look at the numbers of new appointments against how many then require follow up appointments. Reducing unnecessary follow-up is part of improving patient experience of the health service. The aim was to reduce the number of follow up appointments to

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1.9. However, this remained above target peaking at 2.28 in April 2016 and the lowest achieved ratio was 2.05 in April 2017.

This meant more patients were returning for follow-up appointments and slowing the flow through outpatient clinics.

- The outpatient transformation programme had set a target to reduce the number of clinics cancelled with less than six weeks' notice for avoidable reasons. The target was 26%. However, the trust peaked at 83.90% in June 2016 and its best performing month was 54.50%. The programme had not achieved its goal and clinics continued to be cancelled. This left patients having to be re-booked for an appointment.
- There were also a high number of avoidable cancelled appointments with more than six weeks' notice. In the four months leading up to our inspection figures ranged between 10.22% in February 2017 and 17.4%. In April 2017. The trust reported that the main reason for cancellations over six weeks from the appointment date was annual leave. Of those cancelled within six weeks, the top reasons were annual leave followed by sickness.
- The maternity service saw a slight increase in the number of births in the summer months when the population of Cornwall increased through tourism. This put pressure on the service at a time when many midwives also wanted to take annual leave. We did not see evidence that this pressure was taken into account in the staffing review.
- The second theatre on the delivery suite was only used for emergency procedures when the main theatre was in use. Staff would opt to use the main theatre wherever possible for emergency caesarean sections. This meant that sometimes a woman expecting an elective caesarean section had to wait until later in the day after an emergency case was completed. Midwives said there was not always sufficient staff cover when elective caesareans were carried out later in the day as staffing levels were weighted towards the mornings.
- The Day Assessment Unit was an appointment only service, on referral from a doctor or community midwife. It was open 9am to 9pm but had only two slots a day for scanning women, which were mainly used for women reporting reduced foetal movements. This meant some women had to return another day.
- The Day Assessment Unit (DAU) assessed women referred by community midwives, because of complications in pregnancy. There was no dedicated medical cover for the DAU and

Summary of findings

midwives told us they warned women they might have to wait for a medical review. Data was not collected about waiting times in the DAU. Midwives told us doctors were usually available to review women.

- The flow from the antenatal ward to the delivery suite was poorly managed. In 2016, 19 women arriving in the Day Assessment Unit in established labour were admitted to the antenatal ward rather than being transferred immediately to the delivery suite. This affected women's experience of privacy and of supportive care. Thirty babies in 2016 were delivered on the antenatal ward and larger numbers of women were in established labour on that ward. Of those who delivered on the antenatal ward, only 57% of women gave birth in a single room and two gave birth in a bathroom.
- Communication sometimes hindered access and flow. Anaesthetists said midwives did not always alert them to high risk women in the delivery suite. Community midwives told us it could be difficult to make appointments for women to be seen in the Day Assessment Unit, and their judgements on the need for referral were questioned.
- Expectant mothers who were judged to have a clinical need for their labour to be induced came to the antenatal ward for induction and stayed on average for 24 hours. We were told that as far as possible, high risk mothers were induced on the delivery suite but that it was not always possible. This was not audited to provide any assurance that this was the case.
- The hospital was performing better than average for treating gynaecology patients needing medical rather than surgical treatment within 18 weeks of their referral date with a performance of 99% in 2017, above the target of 95%.
- However, only 89% of patient seen within 18 weeks of referral - below the standard of 92%. The longest wait for general gynaecology patients was 44 weeks. There was a backlog of 171 patients waiting to be seen in March 2017.
- Cancer treatment times had worsened over the past year. 76% of gynaecology cancer patients were treated within 62 days from referral to treatment in March 2017 which was below the target of 85%. However they were performing above the target of 96% for women being treated within 31 days.
- When community midwives were called into the hospital to support hospital deliveries, women in the region covered by that on-call midwife were unable to have their choice of birth. The Helston birth centre had closed once in 2017, although midwives anticipated more closures during the summer of 2017 because of midwives holidays and vacancies in the community team for West Cornwall.

Summary of findings

- Most surgery for gynaecology was provided at the main hospital site, but consultant led clinics took place in seven locations across Cornwall. This allowed women access to clinics closer to their home.
- Children and young people of all ages had timely access to initial assessment, diagnosis, care and treatment. The service was effective for those children and young people who did not require a tier 4 inpatient bed. However, there was a risk that young people admitted with mental health issues would not receive appropriate and timely care and treatment. This was caused by a lack of level 4 tier beds locally and could result in a longer length of stay in an acute inpatient ward and a higher incidence of self-harm and potential harm to other patients, families and staff.
- During the period April 2016 to March 2017 most referral to treatment times for non-admitted paediatric referrals reached the 92% trust target. All referrals to paediatric respiratory medicine, metabolic disease, neurodisability, cardiology, general paediatrics and community paediatrics were in target.
- Due to the high acuity and activity on the paediatric wards and lack of ward clerk cover at night, the timely recording of patient movements remained a challenge. Although there had been an improvement during the day following reminders to all staff of the importance of timely discharge, out of hours remained a focus for improvement.
- Data from March to June 2017 showed the percentage of discharges sent within 24 hours. They ranged from 55% to 72%. Data was also shown for discharges sent after 24 hours and this ranged from 28% to 45%. At the time of our inspection, there was an electronic discharge backlog of 39 for paediatrics with a maximum delay of four days. Staff said the backlog was normally no more than four to five days. The backlog of discharge summaries was monitored every day and details were incorporated into morning handover.
- Imaging was performing well and managing many of its key waiting times. For example, in January 2017 the imaging department had 7,205 patients waiting for imaging procedures. None of those patients waited more than eight weeks, significantly better than the department of health guidelines which set a maximum wait time of 18 weeks.
- Imaging consistently performed well in keeping waiting times low. Between January 2017 and May 2017 imaging maintained waiting times below eight weeks. Only in April did two patients wait longer than ten weeks.

Learning from complaints and concerns

Summary of findings

- The Trust received 377 formal complaints between 1 April 2016 and 31 March 2017. This was a decrease of 18.5% compared to the 463 complaints received in 2015/2016 and the second successive year that numbers of formal complaints had decreased (544 complaints were received during 2014/2015). This was attributed, at least in part, to more proactive resolution of concerns as they arose in frontline services and a focus on de-escalating some potential complaints by resolving more quickly and informally via PALS.
- The top five categories for all complaints were; communication (299), clinical treatment (287), patient care (215), admissions and discharges (152) and values and behaviour of staff (104). These top five categories had been exactly the same in the previous year.
- Systems and processes for providing assurance around the complaints process were not operating effectively. The trust Patient and Service User Feedback Policy dated December 2014 set out guidance for staff in relation to complaint handling, but did not reflect current practice and had not been updated when processes changed. We were told a revised policy would be available by September 2017.
- Some complaints were incorrectly coded in the trust database, for example, two complaints were showing as in progress, although they also had a date closed entered. It was not clear which entry was correct and whether these complaints were open or closed.
- The number of complaints reopened because complainants were not happy with the trust response over the last 12 months was 57 out of 329. This was a re-opened rate of 17.5%. The trust had flagged this as an area of improvement.
- The trust's policy said that the trust would aim to respond to complaints within 25 working days. For cases graded as high, complex cases and cases involving other organisations, this can be extended to 45 working days. There were 44 closed complaints between June 2016 and May 2017 for which no closed date was entered (even though the outcome of the complaint was shown).
- Although the trust told us complaints were only marked as closed four weeks after they had been responded to, this process was not followed for five out of ten closed complaints that we reviewed.
- We twice asked the trust to supply the date that these data were extracted from their complaints system (this is required so that we can calculate how long open complaints had been open for). In both cases the trust misunderstood the question

Summary of findings

and failed to supply the information. This cast further doubt on the accuracy of the raw data and the internal systems and processes being followed and meant the trust cannot be fully assured that the reported data is accurate.

- Complainants have the right to refer their case to the Parliamentary and Health Service Ombudsman (PHSO) for review if they are not satisfied with the local resolution process within the Trust. During 2016-2017, the PHSO accepted 16 complaints for investigation, where complaints had previously been investigated by the trust, compared with 17 the previous year. During the same period, the trust received eight final reports from the PHSO. Four were not upheld. Of the remaining four, three were partially upheld, and one was upheld.
- The trust provided us with six complaint case files; of these, two did not contain the original complaint letter, and none of them contained the investigation reports or supporting information such as staff statements. We were told by the Complaints lead for the trust that these were held in the division. There was not a clear process for ensuring that this information was retained or stored such that it could easily be retrieved.
- The chief executive did not directly respond to complainants; it is good practice to send the complainant in writing a response, signed by the responsible person. This was the chief executive of the organisation although the functions of the responsible person may be performed by any person authorised by them to act on their behalf. It is widely recognised as good practice that letters come from the Chief Executive. A cover letter from the chief executive explaining they have read and reviewed an enclosed letter or report from another member of staff would be acceptable.
- There are however, some good examples of the trust learning from complaints; in response to issues where relatives of deceased patients were upset that the patients' property was returned to them poorly packaged or indeed had been lost, during Dying Matters Awareness Week, the Palliative Care team launched 'butterfly bags' for the personal belongings of deceased patients. An outcome from a complaint in Maternity Services was that the complainant agreed to be included in 'Whose Shoes?' workshops in order to help learn from her experience. 'Whose Shoes?' is an initiative to help participants 'walk in the shoes' of others by experiencing some of the scenarios that occur and explore whether their own systems are really allowing end users to get the service or support that they need. In addition, one relative had been invited to the trust to assist in the delivery of human factors training for over 100 staff.

Summary of findings

Are services at this trust well-led?

We rated well-led at the trust overall as inadequate. For specific information, please refer to the reports for Royal Cornwall, St Michaels and West Cornwall Hospitals, and Penrice Birthing Centre.

Inadequate



Summary of key findings for well-led:

- The trust had in place a clear vision, underpinned by a set of values. However awareness of this was variable across different services and staff groups.
- The overarching strategy setting out the vision and values was due to be reviewed and updated. There was no current clinical strategy in place. Individual service strategies were at different stages of development and not all areas had specific strategies; staff could not consistently describe their service strategy, how it aligned with the corporate strategy or their role in achieving it.
- Governance arrangements and their purpose were unclear. Some new governance structures had been put in place, devolving responsibility to divisions, but these lacked clarity within divisions and were not effective across all areas of the trust. Finance and quality governance were not integrated to support decision making.
- The system for identifying, capturing and managing risks at team, division and organisational level was not effective. Risk registers did not accurately reflect the risks to patient safety and the quality of care and treatment.
- The board had recently reviewed and consolidated the risks on the board assurance framework (BAF) and these were tabled for discussion at each board meeting. The board assurance framework was now aligned to the key issues facing the organisation. However, the assurance systems in place were not sufficient to ensure appropriate action had taken place or that the information used to monitor and manage quality and performance was accurate, valid, reliable, timely or relevant.
- The level of scrutiny and challenge at the board had improved. However, not all of the assurance reports submitted to the board contained key information.
- The culture across the trust was variable. In some areas there was a positive culture, where staff felt respected, listened to and able to raise concerns. In other areas there were examples of a directive culture which was not based on openness, honesty, transparency, challenge and candour. Some staff reported bullying, harassment and discrimination.

Summary of findings

- There was minimal engagement with the public, patients who used services and their families over and above the NHS Friends and Families Test. In most areas of the trust there were no proactive programmes to engage patients in the development or improvement of the services provided.
- According to the 2016 NHS Staff Survey (published in March 2017) there were low levels of staff satisfaction, high levels of stress and work overload. This latest survey showed small improvements in several areas; however, many of the results remained within the bottom 20% of trusts with some results worsening. Senior medical staff told us of poor clinical engagement over the last few years, which some said was starting to improve. Others told us they felt disengaged and disempowered. A staff engagement action plan had been developed and approved by the board. This was focused on understanding the results from the NHS Staff Survey and improving engagement with staff across the trust.

However:

- The trust board was fully recruited to with all executive posts having permanent appointments. Staff within the trust felt more confident that the current executive team were resilient and would stay.
- The trust was increasingly engaged in the wider healthcare system and had taken a lead in the sustainability and transformation plan for Cornwall. They had taken a progressive and positive step forward with the formation of a joint provider board with another local NHS trust.
- The trust was meeting its obligations under the Workforce Race Equality Standard.
- Significant improvements had been made in the compliance with the fit and proper persons requirement. A clear policy had been implemented and records demonstrated compliance with this policy.

Detailed findings

Vision and strategy

- The trust had set out their vision as “Working together to achieve outstanding care and better health outcomes”. This was captured in the strap line “One + all we care”. This was displayed prominently around the trust, on the website and on trust documentation.
- The trust had five values: care and compassion; inspiration and innovation; working together; pride and achievement; and, trust and respect.

Summary of findings

- There was a high level operational plan setting out the overarching priorities for the trust for 2017 to 2019. This briefly reiterated the trust's vision and values as well as identifying the challenges the trust was facing. This reflected the changing environment of the NHS and the new working arrangements that were emerging between organisations for delivery of the sustainability and transformation plan: 'Shaping our Future'.
- The trust had set out four strategic aims: quality – provide compassionate, safe, effective care; people – attract, develop and retain excellent staff; partnership – offer integrated care as close to home as possible; and, resources – make the best use of all our resources
- Each of the four strategic aims had common key priorities, which were: delivering core standards for emergency and elective care; improving the safety and responsiveness of services, as reflected in the findings of the CQC inspections in 2016 and 2017; working with partners to develop and implement the sustainability and transformation plan (STP); and, adopting a transformation programme to achieve quality and financial goals, consistent with the STP 'Shaping our Future'.
- Although there were strategic aims in place, the trust had not yet developed a current clinical strategy, in partnership with clinicians, as highlighted in the external review of governance in 2015. It remained unclear where progress in delivering the strategy was monitored or reviewed, or how the trust were delivering key communication messages around the proposed changes. This had not been addressed since our last inspection.
- Awareness of the trust's values was variable across different services and staff groups. The values were prominently displayed and referred to in policies and on the intranet, however as we found in January 2017, not all staff could consistently tell us what they were or how they impacted on their work.
- Staff could not consistently describe their service strategy, how it aligned with the corporate strategy or their role in achieving it. Individual service strategies were at different stages of development, for example, the maternity services did not have a specific strategy, and overall progress against the 2016/2017 priorities was not captured or recorded.
- There was active involvement within the executive team in the local transformation and sustainability plan. The trust chief executive was the lead for the sustainability and transformation plan in Cornwall and the Isles of Scilly and members of the executive team were also actively involved. All senior leaders

Summary of findings

were positive about the STP work and felt it was vital to improvements across the system. However, some expressed anxiety about the chief executive taking on the lead role for the STP, and the demands on the other executives involved in the STP, at a time when there was still much to do within the hospital, and the impact this would have on internal leadership.

- A positive development that had taken place was the formation of a joint ‘provider board’; this was an initiative from the trust, alongside another local trust to form ‘committees in common’. This arrangement provided the governance mechanism to underpin the collaboration agreement previously agreed by the two organisations’ boards, and allowed the two entities to make decisions jointly in the interests of local service improvements and integrated, collaborative working. It also represented a fundamental ‘building block’ of the development of an accountable care organisation within Cornwall and the Isles of Scilly. The board had met twice since formation in early 2017 and had debated the opportunities regarding joint recruitment campaigns, joint appointments and exploring the benefits of unified human resource policies and procedures. This was seen by senior leaders we spoke to as a progressive and positive move forward. It was noted that there was huge potential to share skills, experience, knowledge and resource to provide the best care for the population.

Governance, risk management and quality measurement

- Governance arrangements and their purpose remained unclear. Progress in implementing the cross cutting recommendations from a comprehensive external review of governance within the trust in July 2015, was slow and those which had been implemented lacked clarity.
- Since 2015, the trust had not undertaken a self/external-assessment against the Monitor (now NHS Improvement) quality governance framework (QGF) or similar governance model. We were provided with some narrative around the trust’s internal self-assessment processes; however the trust did not supply any evidence of these as part of our request for data. The audit and risk assurance committee minutes from April 2017 record ‘the need for a board effectiveness evaluation to be completed (self-assessment followed by an external process) after the provision of the CQC report to the trust’. The trust told us it was planning a further external governance assessment in 2018 (once every 3 years).
- Governance structures lacked clarity within divisions. Some of the high level divisional changes had been approved at the December 2016 board meeting, and were not fully understood

Summary of findings

by, or articulated to staff. The structure and arrangements for subcommittee level meetings in January 2017 had yet to be agreed. We were told by senior leaders that some of the delay was due to the need to align the new structures with the sustainability and transformation plans.

- The new structure in place had four divisions overseeing a number of specialities, with each division comprising clinical directors, associate directors, deputy associate directors and divisional nurses, with input from finance, human resources and divisional governance leads. Senior staff told us this model had been in use for some months prior to approval and feedback was that it was working well for some divisions, but not for others. The trust told us it was planning to review this model again, with a view to further reorganisation.
- Some of the subcommittee arrangements had been approved, including terms of reference, at the March 2017 board meeting, but as they had been implemented immediately prior to our inspection, it was too soon to assess how effective these were. The trust told us that as a result of the new arrangements, the board received assurance directly through the non-executive chaired committees which included the quality assurance committee, finance committee, and the people and organisational development committee. Within these arrangements finance and quality governance were not fully integrated to support decision making.
- There was a draft document which set out the new subcommittee structures. These had not been set out in a formal approved document that staff could reference, and they were not available on the staff intranet. Senior staff told us that new arrangements were communicated through the divisional structures. We did not see evidence of this from the divisional governance minutes we reviewed, although there was discussion about what needed further clarity and review.
- Senior leaders acknowledged the governance structures needed improvement. We saw evidence that some of the governance issues were emerging as agenda items at the high level governance committees and at board level. This included: a review of the sub-structure below the newly formed quality assurance committee, to ensure every aspect of patient safety, experience and clinical effectiveness received sufficient board focus; and the need to establish a strengthened trust management group which put senior clinicians alongside the executive team at the centre of senior management decision-

Summary of findings

making. Other improvements identified included: the standardisation of meeting sub-structures within the divisions; and, ensuring sufficient focus on key quality, finance and performance issues at all levels of the organisation.

- The system for identifying, capturing and managing risks at team, division and organisational level was not effective. The board had implemented an accountability framework to devolve more responsibility and control to the clinical divisions with the aim of strengthening corporate governance arrangements. Senior leaders also acknowledged that the internal risk and assurance systems were not effective, particularly in relation to the management of incidents and serious incidents, risk and clinical audit. Alongside this the trust had an ambition to have a STP system wide risk and assurance framework despite not having effective internal assurance systems in place. Resource and capacity was cited by some senior managers and leaders at the trust as a blockage to addressing their issues with managing risk.
- There was still inconsistency in the approach between divisions, with overall accountability remaining unclear. Divisional and departmental staff were not always aware of the focus on devolving responsibility, for example, at departmental level, several staff told us that the central teams managed risk, complaints and incidents with input from the various areas. Some senior staff told us during this inspection that things had started to improve since we raised this at our last inspection, but there was still uncertainty in terms of resources, capacity, roles, responsibilities and accountability that needed to be addressed.
- Tolerances for risks had been reset at the time of our January 2017 inspection and this had caused some confusion with senior staff being unable to explain how the new risk tolerances worked. The risk management policy had not been updated in a timely manner to reflect these changes, and when we returned in July 2017, it was still unclear to some senior staff we spoke to, how they were to manage or escalate risk. The trust told us this information had been communicated through the divisional structures and by email.
- The corporate risk register was managed and reviewed by the divisions on a monthly basis to ensure progress on mitigating actions was sufficient. However, we found that the risk registers in place at the time of the inspection did not accurately reflect the risks to patient safety and the quality of care and treatment. The weakest area in terms of staff knowledge on how to identify, escalate and manage risk up through the risk register

Summary of findings

process lay at departmental level. This meant that divisional level leaders may not be aware of all risks within their division. It also meant that the trust board could not be assured that all relevant risks were escalated, managed or monitored.

- The corporate risk register did not set out controls or actions for all stated risks. Some of the controls in place were not sufficient to mitigate against the immediate risks, for example, the risk of pest control, cleaning standards and stores function not working effectively had a control in place to review the existing contract, and ongoing actions to meet with the external provider to discuss and address issues. These actions did not address the immediate risks to patients.
- The board had recently reviewed and consolidated the risks on the board assurance framework (BAF) and these were tabled for discussion at each board meeting. The board assurance framework was now aligned to the key issues facing the organisation. However, the assurance systems in place were not sufficient to ensure appropriate action had taken place or that the information used to monitor and manage quality and performance was accurate, valid, reliable, timely or relevant. Information submitted to us by the trust contained contradictory data to that published, or to additional information requests that we made for clarity. For example, information regarding complaints and staff vacancies. In some cases, the trust was unable to supply the data or information we had requested, for example key risk assessments in maternity services. The trust told us they were not assured that their internal database for training was an accurate reflection of the numbers of staff trained.
- Information provided by the trust did not demonstrate that evidence to support assurance of performance monitoring was in place. A number of data requests that we made to the trust were not responded to in a timely or comprehensive way and further requests had to be made, in some cases requests were made more than twice for the same information. In many cases, the trust failed to supply the evidence to support their responses to us. For example, when asked for information and evidence regarding seven day working at the trust, we received a narrative explaining how they managed this, but the supporting evidence such as a gap analysis or audit/review/report was not supplied.
- Equally we found evidence that the assurance provided to board about a spate of never events was not valid. The

Summary of findings

information provided to the board was that the never events were not all linked, when they were intrinsically linked by the failure of the processes and ineffective operation of basic systems designed to prevent them.

- There was a lack of overarching assurance at board level that the audit programme was fully embedded and implemented. There was insufficient evidence to demonstrate that the clinical/non-clinical audit programmes mapped to key risks. Not all divisions had audit plans in place, and those that did, did not all have a combination of planned and reactive audits. The trust told us they did not have the required internal assurance that the systems and processes around audit were robust.
- The quality assurance committee in May 2017 received the progress report on the clinical audit programme and discussed the need for commissioned audits to be linked to the trust's key priorities/risks and the need for audit outcomes to drive the trust's quality improvement agenda. However, apart from a request for an update on plans at the next meeting, no actions were set or agreed and it was therefore unclear how the trust intended to take timely action to improve this situation.
- There was a lack of transparency in the records relating to complaint and grievance investigation, which had an impact on the identification of risk, issues and concerns. A large amount of information was not retained centrally, for example, investigations into incidents and complaints. For example, complaint case files contained the original complaint and outcome letters, but not the supporting information such as staff statements or investigation reports. The trust told us those were kept by the division or relevant departments. There was no formal process in place for this, or guarantee that this information was stored or retained should it be required for future reference.
- We reviewed case files for three grievances during the inspection. These files did not contain the record of the investigation carried out or any evidence of the decision making process. In two files, we were only supplied with the original communication and the outcome letter to the person raising the grievance. We asked for the investigations for these two cases, and we were told by the trust: "the grievance paperwork as per policy consists of the complaint letter and the outcome letter. No report is generated (unless in the event of further disciplinary action recommended) or given to the complainant." We asked for further clarification on this and we were told that the investigation officer kept the notes but no report was prepared. We were not satisfied that the trust could

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be assured that due process and decision making had been followed in line with expectations, or that a robust system was in place to securely store and retain all relevant case information.

Leadership of the trust

- The hospital has over the last few years, seen significant and ongoing periods of instability at board level. Since the first inspection in January 2014 there had been three chief executives, two of those on an interim basis. A permanent chief executive was appointed in April 2016.
- A new chair was appointed in January 2017, but prior to this there had been three chairs in post since 2015. The director of nursing was newly appointed in May 2017 and in post at the time of the inspection; prior to this there had been an interim director of nursing in post since November 2015. The interim medical director had been in post since October 2016, and we were told this post had recently been made substantive on an honorary contract for a period of 12 months. The chief interim operating officer had been in post since October 2016, and we were told that this post had been filled by an external candidate who was due to commence employment in August 2017. The director of human resources started in post in December 2016, and the director of corporate affairs in January 2017.
- The director of finance was the longest standing executive member of the team having been in post for six years. There had been changes to this post in recent months with the current finance director taking a lead on the sustainability and transformation plan (STP), and a co-appointed (with another local hospital) finance director had been in post since May 2017. This meant that by August 2017, there would be a full complement of board directors in permanent posts for the first time in a number of years.
- Executive and non-executive leaders felt there was a sense of change for the better with the appointment of the current chief executive and the energy and drive she brought to the role, in conjunction with the sustainability and transformation plans and progression of integrated care across the system. This was somewhat tainted; however, by concerns about who would take the lead internally as it was recognised that much of the chief executive's time would be consumed with outward facing issues (as the county STP lead).
- Senior leaders told us they were fully committed and supportive of the sustainability and transformation plan and understood this was essential to bring about required systemic

Summary of findings

changes. However, anxieties remained that whilst directors were being pulled away from the trust to focus on the sustainability and transformation plan work, more backfill and support was required to ensure full focus remained on the trust's internal pressures and challenges.

- Since our inspection in January 2017, the staff were more positive about the stability of the executive board. A number of senior staff told us they felt more confident in the current leadership than they had for many years. In addition, staff across the trust told us they felt the current leadership team had more 'staying power'. Some senior clinicians told us that although an improving picture, more productive engagement with the executive team was required.
- There was variability in the visibility of the leaders; staff in some areas told us the executive team were very visible and could name a number of senior leaders, whereas other areas said they had only very recently seen any senior leaders in their areas.
- The trust had started a new programme of board level 'walkabouts' in March 2017 to increase visibility in the clinical areas to strengthen the board to ward connection. Some staff told us they had visits from executives to their clinical areas recently as part of this programme, and this was welcomed and appreciated by staff.
- During 2016 an in-house leadership programme had been designed and developed, which at the time of the inspection, had supported the top 60 leaders to align behaviours and values and drive performance. During 2017/2018, the trust planned to extend this course to develop a further 120 leaders across all disciplines.
- A board development programme was also planned to assist with board cohesion and a shared understanding of the trust's key priorities, goals and ways of working. As this was in the early planning stages, we were not able to review any evidence of this.
- There was improvement in the scrutiny and challenge by the board since our inspection in January 2017, although further development and improvement was required. Improvements seen included: the layout of some of the board papers and the quality of the content of the minutes, with clear statements recorded such as "the board was assured" or "the board was not assured". In addition, the trust told us they were moving to monthly board meetings to ensure there was sufficient time and capacity to address the key issues and risks.
- However, not all of the assurance reports submitted to the board contained key information. For example, the report on

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incident management in May 2017, although improved in the level of detail, made no mention of the often severe delays with reporting or investigating incidents, or the concerns around monitoring and closing off actions to ensure learning had taken place.

- Due to the lack of internal assurance around the quality and accuracy of data held by the trust as highlighted elsewhere in this report, for example on rates of mandatory training and lack of some key departmental risk assessments, it remained a concern that the board did not have full oversight of all potential or known issues that affected quality and safety.

Culture within the trust

- The culture across the trust was variable. In some areas, for example, West Cornwall Hospital, St Michael's Hospital and in some areas of Royal Cornwall Hospital, there was a positive culture, where staff felt respected, listened to and able to raise concerns. Other areas, for example, maternity and outpatients were very different. In those areas there were examples of a directive culture which was not based on openness, honesty, transparency, challenge and candour. Staff reported bullying, harassment and discrimination.
- Within maternity, staff were reticent to raise concerns because those who had at a previous inspection had been penalised. An external cultural review had been carried out in May 2016, which highlighted areas for improvement and initiatives such as listening in action events had been implemented to support midwife lead improvements. Some changes in practice were being implemented as a result of these, for example, an increase in management time for band 7 coordinators and extending the role of midwifery support workers. However, further action was required to build a supportive and open culture. We saw evidence that senior maternity managers were actively working on improving culture.
- Within outpatients, some staff claimed that they were discriminated against because of their grade or disabilities, and human resources processes were not felt to be fair or follow proper procedures. Concerns were raised with inspectors about bullying and harassment and although these had been escalated to a more senior manager, the situation had not been resolved and they felt they had been punished for reporting the matter. Other staff felt they could not go above their manager when they had reported concerns to them, but they were not actioned.

Summary of findings

- Systems and processes for managing staff performance were not operating effectively. We found a number of examples where poor behaviour, grievances and performance management issues were not being addressed in a timely manner.
- Action was not always taken to address behaviours and performance which was consistent with the vision and values, regardless of seniority. Senior managers told us responses to underperformance were dependant on the situation, and management of underperformance was variable. Actions taken ranged from informal discussions to dismissal, but were not consistently applied.
- Senior managers told us there had been an historical poor performance and behaviour of some surgeons and consultants, and clinical directors were tasked with dealing with these issues. Senior leaders told us there was an embedded culture of poor performance and behaviour in some areas, and it was difficult to turn this around.
- We found examples where grievances had been raised by senior staff, and these had not been addressed for several months. We found other examples where serious allegations had been made, and performance management had either not been initiated, or had been halted. For example, in one case where performance management had been initiated, this had been halted as the individual had raised a grievance. This grievance having been raised at Easter time, still had not been fully communicated to those that the grievance had been made against by July 2017, and performance management was still on hold.
- Senior leaders told us that historically the culture at the trust had been inward looking and due to its location contact with external peers had been challenging. Some initiatives were in the pipeline to address this, for example the trust was hoping to recruit more academic posts in conjunction with a local university.
- Senior leaders also told us the culture at the trust was reactive and not proactive, focused on demand relating to a particular situation and not the overall need. The board had recognised this and were working toward change.
- The medical director told us that staff felt like they had not been listened to, but done to. In light of the continued poor staff survey results the board were actively trying to turn this around with clinical walkabouts, and by revisiting the effectiveness of the listening into action programme.
- We had varying reports from doctors at all levels in terms of culture, with some telling us things were much improved and

Summary of findings

engagement was good, and others telling us they continued to feel that they were not consulted or listened to. We heard a similar pattern from nursing and other staff across the trust. It was noted that there was a general and tangible improvement in what staff were telling us from the information we gathered at the January 2017 inspection.

- The trust has appointed a freedom to speak up guardian who started in post a few weeks before our inspection and worked in this role for 15 hours per week. The medical director was the executive lead for this post and a non-executive director lead had also been appointed. This appointment had been well promoted in the newspaper, on social media and the trust website, and a generic email had been created for staff to raise concerns.
- The Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy had been refreshed in June 2017 and had been promoted to staff. The trust had a plan to recruit and train raising concerns officers across the trust.

Equalities and Diversity – including Workforce Race Equality Standard

- As part of the new Workforce Race Equality Standard (WRES) programme we have added a review of the trusts approach to equality and diversity to our well led methodology. We looked at what the trust was doing to embed the WRES and race equality into the organisation as well as its work to include other staff and patient groups with protected characteristics. The equality & diversity function was overseen by the associate director of workforce.
- The trust's total workforce included 86.5% white British and 3.9% white other representation. There were 6.4% of staff whose ethnic origin was not disclosed. The defined black, minority and ethnic (BME) representation in the overall workforce was therefore 3.21%, which was higher than the percentage of BME people living in Cornwall (1.8%, 2011 Census).
- An equality and inclusion strategy was presented to the board for approval in February 2017 which set out how the trust would support the delivery of the equality and inclusion agenda. In addition, the trust had revisited the Equality Delivery System (EDS2) grades; the EDS2 is a tool that can help the trust to respond to the public sector equality duty, helping to eliminate discrimination, harassment and victimisation; advance equality of opportunity; and foster good relations. There are 18 goals within the EDS2 which were previously assessed in 2014. The lowest six grades awarded in 2014 were re-evidenced and

Summary of findings

assessed by relevant stakeholder panels, including members of the public. Improvements had been seen from a patient focus point of view. There were two patient related, two staff related and two leadership related goals which the trust had identified and presented to the board in June 2017.

- Under the specific equality duty requirements of the Equality Act 2010, all public sector organisations are required to publish equality data on an annual basis to prove compliance with the public sector equality duty. The trust submitted its annual equality report to the trust board in December 2016. This report highlighted the performance of the trust in relation to race equality and actions required to support further development.
- The trust had identified an issue with staff not entering their ethnic, religious or other sensitive information onto the employee self-service system which meant there were gaps in the data capture. For example, doctors and midwives had the highest number of unknown fields ticked against equality and diversity declarations. A campaign to raise awareness of the need to do this had been launched and was ongoing in 2015/2016, but there had been no significant improvement since the launch with many areas still showing a high number of not declared returns within the annual report.
- The trust had reported a proportionately high number of staff with a declared disability, impairment or health condition going through disciplinary processes which required further investigation. However, the trust could not be precise about exact numbers due to the gaps in the data capture described above.
- Every policy and service at the trust had an equality impact assessment completed to assess for any negative impact against the nine protected characteristics.

Fit and Proper Persons

- When we visited the trust in January 2017, systems and processes were not sufficient to meet the requirements of the regulations and did not provide appropriate assurances that adequate checks were being made and recorded to confirm directors were suitably 'fit and proper'. The trust had acted swiftly to rectify the deficiencies in the processes in place to meet the fit and proper persons requirements for directors (FPPR) highlighted in our inspection in January 2017. They had developed and ratified a comprehensive policy for FPPR which was available on the trust website. There were also systems in place to ensure board members were fit and proper in order to meet the requirements of the Health and Social Care Act 2008.

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- We reviewed the personnel files of seven directors and non-executive directors, including the chair, chief executive and director of nursing. The files provided evidence that relevant checks had been undertaken. For example, right to work in the United Kingdom, references and Disclosure and Barring Service (DBS) checks. The trust had a system in place to ensure where required, such checks were repeated annually.

Public engagement

- There was minimal engagement with the public, patients who used services and their families over and above the NHS Friends and Families Test. In most areas of the trust there were no proactive programmes to engage patients in the development or improvement of the services provided. The exception to this was within services for children and young people, where support groups were engaged with, and in surgical services where members of the public were involved in patient-led assessments of the care environment (PLACE) assessments.
- The trust engaged with patients and the public in a variety of different ways, including local and national patient surveys, the NHS Friends and Family Test and contacts via the trust patient advice and liaison service (PALS). Patients were encouraged to be involved and had attended trust board meetings. Patients had attended board meetings to present their patient stories.
- The trust had recently created a wonder-wall where patients could leave comments for the trust. Staff were very positive about this and told us it had helped to improve morale.
- The trust's Friends and Family test performance (% recommended) was generally about the same as the England average between April 2016 and March 2017. In March 2017 trust performance was 95% compared to an England average of 96%. The trust had acknowledged that the response rate was lower than the national average and had plans to actively encourage more patients to participate. These plans included building a network of patient experience volunteers to gain real time feedback and improve patient involvement in improving services, and to engage with more patients using social media platforms.
- In the CQC Inpatient Survey 2015, the trust performed about the same as other trusts for all the questions.
- As part of a continued effort to improve public information, the trust had redesigned and relaunched the public website. It was

Summary of findings

user friendly, easy to navigate and set out information clearly. In addition, the trust had added a section providing real-time information on access to urgent and emergency care and minor injury units throughout Cornwall and Isles of Scilly.

- There was a commitment from leaders at the trust to conduct and take account of public consultations with regards to any proposals for changes to the way care and services are delivered as part of the sustainability and transformation plan (STP), and this was reflected in discussions recorded at board level.

Staff engagement

- All of the staff we met as part of our inspection were committed and motivated to deliver high quality and compassionate care, and there was a clearly stated commitment to making sustainable change to staff engagement from the executive leaders that we spoke with. However, a number of barriers were perceived and reported by staff and senior leaders, both during this inspection and during previous inspections. In response to those barriers, ongoing work streams had been underway throughout 2015/2016/2017; for example, a series of 'big conversations' led by the chief executive, and 'listening into action' sessions, led by clinicians, to understand and better tackle the issues. Pulse check surveys had also been implemented to track the changes coming out of the listening into action programme. Despite these initiatives, progress had been slow.
- Staff engagement had been on the corporate risk register since August 2010, and the trust had a long history of poor staff survey results, which were consistently in the bottom 20% of acute trusts across many key areas surveyed.
- There were low levels of staff satisfaction, high levels of stress and work overload. The 2016 NHS Staff Survey (published in March 2017) showed small improvements in several areas; however, many of the results remained within the bottom 20% of trusts with some results worsening. The trust was in the bottom 20% of trusts for 22 questions and in the middle 60% for the remaining 12 questions. In addition there had been a 5% increase in response rates when compared with the 2015 survey.
- Staff engagement at the trust was scored at 3.58 (out of five) which was in the lowest (worst) 20% when compared with trusts of a similar type, indicating that staff were poorly engaged with their work, their team and their trust. However,

Summary of findings

this had slightly improved from 2015 when the score was 3.54. Staff recommendation of the trust as a place to work was also in the bottom 20% of trusts with a score of 3.38 (out of five), although this score had increased (from 3.30) since 2015.

- The top five ranking scores where the trust compared favourably with national scores were: 54% of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (2% better than national); 2% of staff experiencing physical violence from staff in the last 12 months (same as national); 10% staff experiencing discrimination in the last 12 months (1% better than national); 90% staff reporting errors, near misses or incidents witnessed in the last month (same as national) and; 66% staff/colleagues reporting most recent experience of violence (1% better than national).
- The bottom five ranking scores where the trust compared least favourably with national scores (one being unsatisfactory and five being highly satisfactory) were: 3.65 for staff satisfaction with the quality of work and care that they are able to deliver (0.31 lower than national); 3.42 for effective use of patient/service user feedback (0.30 lower than national); 3.79 for staff satisfaction with level of responsibility and involvement (0.13 lower than national); 3.49 for fairness and effectiveness of procedures for reporting errors, near misses and incidents (0.23 lower than national) and; 3.45 for staff confidence and security in reporting unsafe clinical practice (0.20 lower than national).
- Although still in the bottom 20% of scores nationally, the following scores had improved from the 2015 survey: 89% of staff felt their role made a difference to patients (3% increase); 3.69 (score out of 10) for effective Team Working (0.08 increase); 3.68 (out of five) for support from immediate managers (0.07 increase); 84% of staff appraised in the last 12 months (4% increase) and; 3.45 (out of five) for staff confidence and security in reporting unsafe practice (0.07 increase).
- The percentage of staff/colleagues reporting the most recent experience of violence was 66%, which had worsened since 2015 (76%).
- In the General Medical Council National Training Scheme Survey 2016, the trust performed “worse than expected” for induction and feedback and “similar to expected” for 12 other areas covered by the survey.
- Senior medical staff told us of poor clinical engagement over the last few years, which some said was starting to improve. Others told us they felt disengaged and disempowered.
- A staff engagement action plan had been developed and approved by the board and was being overseen by the people

Summary of findings

and organisational development committee. The plan aimed to gain understanding of the NHS Staff Survey scores and to work with staff to deliver activity that would ensure improvements in engagement and the way staff felt about working at the trust. The trust had commenced a series of single question surveys to better understand staff views through direct feedback, and was planning to identify staff experience champions to inform and co-design staff engagement across the trust.

- Additional raising concerns support officers were to be recruited to support staff in raising issues, along with recruitment and training of health and well-being officers to raise awareness and ensure staff knew how to access those services.
- The chief executive had in place a range of short video conversations accessible to staff through YouTube, aimed at changing the way staff heard messages directly from senior leaders. Staff were encouraged to submit questions which would be scheduled into future conversations with the chief executive.
- The trust communicated with staff through a team talk newsletter, and a daily bulletin; staff told us there was a lot of communication sent out to them but they did not always have time to read it.
- Individual staff and teams were recognised for their outstanding achievements and contribution to care and services at the trust's One + all | We Care Awards. In November 2016, 150 individuals/teams were nominated for this award and 21 were successful.

Innovation, improvement and sustainability

- The trust was a demonstrator site for the 'scan for safety' pilot that was launched in 2016; this was an organisation wide-system, similar to those systems used in shops by retailers, that used barcoding standards to better identify and match patients, products, and locations. The aim of this system was to increase patient safety and experience, and improve operational efficiency; early indications from the introduction of this system were positive in terms of increased productivity and staff efficiency.
- There were areas of innovation, improvement and sustainability across all sites and areas we visited. These are all set out in the location reports. Examples include; the appointment of a dedicated critical care and critical care outreach matron to support the unit. The matron had been able to dedicate her time to addressing patient flow issues and had introduced new processes, which laid the foundation for

Summary of findings

improvement. In maternity, in order to ensure a stable senior midwife team a project had begun to train midwives on a rotational basis to be senior midwives. While they were on their rotation they would receive additional training and support and have a small payment uplift to compensate for the added responsibility and work. In May 2016 the hospital was one of six neonatal units nationally to be awarded the prestigious Burdett funding to support work in attaining the Neonatal Baby Friendly Accreditation from UNICEF. Well Child, the national charity for seriously ill children funded a new children's nurse post following a joint bid from the trust and another provider of community services in the county. The post supported children, young people and families living with complex medical conditions in the community, hospitals and other specialist centres to ensure quality care was delivered. Help to reduce the time children had to spend in hospital was also provided by arranging and coordinating the care they needed at home and providing specialist advice as well as emotional and other practical support for the whole family. In radiotherapy the successful transition from ISO 9001:2008 Quality Management System (QMS) to ISO 9001:2015 (April 2017) had been completed. Companies use this standard to demonstrate the ability to consistently provide products and services that meet customer and regulatory requirements.

Overview of ratings

Our ratings for Royal Cornwall Hospitals NHS Trust

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

Outstanding practice and areas for improvement

Outstanding practice

- The critical care unit had arranged for an external provider to provide shiatzu massage to patients on the ward to help with muscular pain. The service was also available to staff.
- The unit was using a local private ambulance to enable patients to go on day trips to local destinations. Nurses and doctors from the critical care unit would accompany them on these visits following a thorough risk assessment process. The patients suggested the destination and the unit endeavoured to grant their wish. Payment for the use of their services comes from the Charitable Fund.
- Emotional support and information was provided to those close to patients. Following the participation in the Provision of Psychological Support to People in Intensive Care (POPPI), three nurses from the unit had undertaken training to enable them to deliver psychological support to improve outcomes for patients being discharged from the unit. The nurses in question were delivering this support to patients during our inspection. The nurses were also able to provide support to colleagues when required.
- An initiative was put forward to deliver additional support to bereaved children. We saw many tools to help children to cope with their loss. For example, the unit had invested in story books surrounding death. There were also puppets, colouring books and toys which could be used to distract and comfort children.
- The outpatient department had introduced an improved treatment option for the rapid removal of blood clots from veins and arteries following the purchase of new equipment. In some instances this prevented patients having emergency surgery and reduced length of stay.
- The development and implementation of “RADAR” by Royal Cornwall Hospitals NHS Trust improved monitoring of referral to treatment, delays and clinic cancellations. It had won several national awards for innovation.

Areas for improvement

Action the trust MUST take to improve

- Improve the approach to identifying, reviewing and investigating incidents and never events.
- Adopt a positive incident reporting culture where learning from surgical incidents is shared with staff and embedded to improve safe care and treatment of patients.
- Ensure there is an effective system in place to monitor and scrutinise incidents relating specifically to end of life care ensuring subsequent learning can be implemented.
- Take immediate steps to improve incident reporting timeliness, consistency, investigation, learning and sharing of learning processes.
- Review and implement the systems and processes to ensure staff follow the principles of duty of candour.
- Review the security of the antenatal ward to ensure the privacy and security of women who were inpatients.
- Take immediate steps to address the fracture clinic environmental issues that have been present since the January 2016 inspection, including adequate safeguarding systems for children.
- Ensure safety checks on surgical equipment are carried out by the planned dates.
- Provide surgical patients with sepsis with timely access to intravenous antibiotics.
- Securely and confidentially manage all patient information.
- Ensure that patient records are stored securely across the trust. Patient confidentiality must be maintained in accordance with the Data Protection Act.
- Ensure that the causes of incomplete treatment escalation plans are addressed and compliance is improved in critical care.
- Ensure patients are risk assessed and operated on in the correct theatre with the correct equipment and staff available.

Outstanding practice and areas for improvement

- Ensure emergency resuscitation teams have immediate access at all times to a member of staff who is able to deal with difficult airway intubation.
- Ensure full compliance with the Five Step to Safer Surgery World Health Organisation (WHO) checklist to prevent or avoid serious patient harm.
- Meet expected levels of medical and nurse staffing levels on surgical wards to keep patients safe.
- Ensure there are sufficient numbers of midwives and nurses, with the right skill mix on duty at all times to deliver safe care.
- Ensure inductions of labour are safe in relation to capacity, activity and staffing on the delivery suite.
- Ensure there are sufficient numbers of suitably qualified nursing staff in the paediatric emergency department and formal processes in place to ensure appropriate cover was provided at all times.
- Improve compliance with the use of surgical patient care bundles.
- Ensure better quality data about processes and outcomes within the maternity services is available for analysis and to support improvement.
- Ensure the maternity dashboard includes sufficient information to provide a comprehensive overview of maternity performance. Proactively benchmark processes and outcomes in the maternity service against comparable trusts in rural areas.
- Ensure all surgical staff receive annual appraisals, mandatory training, appropriate supervision and professional development.
- Ensure all midwives update their training to a level where they all have the skills needed for their roles, and set targets for completion of training in line with trust targets of 95%.
- Ensure there are clearly articulated and understood processes in place for identifying and managing deteriorating women and that the processes are monitored.
- Review the risks and contingency plans for opening and staffing the second theatre and ensure there is a robust process in place that is well communicated and practiced.
- Identify, analyse and manage all risks of harm to women in maternity services, ensuring local risk registers are maintained in all discrete units and feed into the divisional and corporate risk register.
- Review and improve the high dependency processes and facilities for managing high dependency care in maternity services ensuring there are adequately skilled and trained staff on duty at all times.
- Take immediate steps to ensure the privacy and dignity of patients using the fracture clinic cubicles
- Improve the incomplete referral to treatment pathway compliance for surgical patients.
- Review the arrangements on the antenatal ward to ensure one-to-one care and women's privacy and dignity when giving labouring and giving birth there in the absence of additional capacity on the delivery suite
- Ensure all patients have their operations at the right time, whether in an emergency or for a planned procedure.
- Ensure surgical facilities are appropriate to meet patients' needs.
- Improve bed management, and discharge arrangements to ensure a more effective flow of patients across the hospital to improve cancellations of patient's operations.
- Ensure access and flow into the critical care unit is improved to ensure delayed admissions, delayed discharges and discharges out of hours are reduced so patients receive the right care at the right time and in the right place.
- Take immediate steps to ensure that the backlog of patients awaiting cardiology procedures is eradicated.
- Take immediate steps to ensure that the backlog of 24 hour cardiac recordings and echocardiograms are reviewed.
- Take immediate steps to ensure that the backlog of patients awaiting WARM ophthalmology procedures and glaucoma service is eradicated.
- Improve the response times for patients' complaints.
- Ensure governance processes are embedded in practice to provide assurance that surgical services are safe and effective and provide quality care to patients.
- Ensure that systems are in place so that governance arrangements, risk management, and quality measures in maternity are effective. Ensure audits are aligned to incidents and identified risks.
- Ensure governance systems and processes are established and operated effectively to ensure the trust can assess, monitor and improve the quality and safety of the services provided to patients receiving end of life care.

Outstanding practice and areas for improvement

- Ensure action is taken to address behaviours and performance which are inconsistent with the vision and values of the hospital, regardless of seniority.

Action the hospital SHOULD take to improve

- Review the trigger list for incident reporting to consider whether the thresholds are correct.
- Develop Local Safety Standards for Invasive Procedures.
- Ensure all of the learning points and actions identified during monthly mortality and morbidity meetings in critical care are recorded and followed-up.
- Continue to ensure safeguarding training compliance is brought up-to-date in the children and young people's service and sustained at trust target levels.
- Ensure medical staff mandatory training completion rates in critical care improve to comply with trust targets.
- Continue to ensure staff in the children and young people's service have their mandatory training brought up-to-date and sustained at trust target levels
- Improve compliance of patient screening for MRSA.
- Promote the use of hand gel for visitors and patients in the ophthalmology department.
- Ensure cleaning checklists in the cardiology outpatients department are used.
- Ensure there is access to patient toilet facilities within the surgical assessment unit and theatre recovery area.
- Repair the toilet facilities on Pendennis ward, to ensure they do not overflow and lead to closure of a bay.
- Ensure all areas of non-compliance with the Department of Health guidelines for critical care facilities (Health Building Note 04-02) are included on the local risk register.
- Ensure the environmental problems in the postnatal ward are resolved as quickly as possible
- Reposition the high dependency unit on Polkerris ward to ensure observation of children at all times.
- Improve the environment around the MRI scanners to allow better access for beds and patients.
- Consider improving directional signage around the tower block area of the hospital.
- Improve access facilities within outpatient waiting areas for wheelchair users when clinics are busy.
- Ensure all checks carried out on the difficult airway trolley are permanently recorded to ensure all equipment and medicines are available in the event of an emergency.
- Ensure all resuscitation trolleys in use on the critical care unit are in tamper-evident containers.
- Consider the use of air/oxygen blenders and pulse oximetry on the neonatal unit as recommended in quality standards for cardiopulmonary resuscitation.
- Improve the secure storage of breast milk stored in the fridges and freezers in the milk kitchen on the neonatal unit.
- Improve the processes to identify and dispose out of date medicines in surgery.
- Ensure all controlled drug register checks are carried out and recorded every day, in both the north and south sides of the critical care unit.
- Ensure the issues around the electronic drug charts in use, on the critical care unit and throughout the hospital, are rectified.
- Review the method for checking controlled drugs on the neonatal unit to ensure that stock checks and signatures are recorded for each individual drug.
- Continue to consider an electronic record system for the community paediatric teams and in the meantime to ensure there are systems in place for the secure carrying of multiple paper records.
- Ensure there are regular nurse meetings on the critical care unit.
- Ensure there are sufficient gynaecology nurses to run clinics at times that suit women.
- Review the back-fill arrangements when midwives working on call have to work at night to ensure they are fit to work their shift next day.
- Examine whether the provision of specialist palliative care can be expanded to provide a seven day a week service as per national guidelines, to meet the needs of the trust.
- Review the provision of physiotherapy resource on the critical care unit to improve compliance with NICE Guidance 83 (Rehabilitation after critical illness in adults).
- Review the benefits of multidisciplinary handovers in the delivery suite.
- Develop clear written guidance for midwives about MEOWS, managing community obstetric and neonatal emergencies, baby weight loss and feeding concerns.

Outstanding practice and areas for improvement

- Ensure staff in the outpatient departments are aware of their roles and responsibilities during a major incident.
- Develop policies and guidelines in maternity with more involvement of a range of relevant staff, particularly those who will need to implement the policy or are affected by it
- Ensure there are effective means of communicating changes to guidelines and audit compliance in maternity.
- Proactively promote smoking cessation to reduce smoking in pregnancy to national levels.
- In line with national guidance, routinely audit and evidence if patients are achieving their preferred place to receive their end of life care.
- Expand the scope of audit of end of life care documentation to assess the competency and understanding with which it is used.
- Improve the clarity of outpatient clinics outcome data to allow staff to have ownership and value to the work they do.
- Ensure the use of diaries is offered to patients on the critical care unit to help them, or their loved ones, document the events during their admission.
- Ensure patients, parents/carers are aware of the Friends and Family test and promote good use of this tool.
- Ensure all nursing staff are competent in using specialist equipment on the critical care unit.
- Ensure that there are mechanisms in place which effectively capture feedback from staff, patients and those close to them that can contribute to the design of end of life services.
- Ensure that governance processes and systems can provide assurance that delays with fast track discharges for end of life patients are being monitored and managed in accordance with national guidance relating to end of life care.
- Ensure there is a clear incident reporting process to follow in the event of delayed fast track discharges.
- Continue to improve the discharge paperwork provided to ward staff in critical care to improve compliance with NICE Guidance 50 (Acutely ill adults in hospital: recognising and responding to deterioration).
- Continue to improve the completion rate of discharge summaries in children and young people's services.
- Improve start times in operating theatres.
- Consider using the second theatre for elective caesarean sections so women did not have to wait in the event of emergencies in the main theatre.
- Review the number of scanning slots available to the day assessment unit so women do not have to travel more than once to the hospital.
- Reduce waiting lists for women awaiting non-cancer gynaecology treatment
- Fix the problem with post inpatient follow up appointments.
- Take further action to reduce the number of outpatient clinics that are cancelled for avoidable reasons.
- Improve the procedures used to monitor waiting lists, waiting times and the frequency of cancelled clinics for avoidable reasons.
- Give ownership management of the cardiology waiting referral to treatment lists to the bookings team.
- Improve systems and processes to show how complaints have been scrutinised for themes and level of impact in end of life care and what subsequent actions have been taken.
- Ensure surgical leaders have the time to lead effectively.
- Improve communication between executive level staff and local end of life care teams about the development of the end of life service at the trust.
- Ensure there is a process in place which monitors the delivery of the end of life strategy and the actions held within it.
- Review the effectiveness of the outpatient transformation team.
- Clarify individual accountability for decision making within specialty outpatient clinics.
- Ensure the risk register in use within the critical care unit includes all risks identified by the unit. This includes ensuring that continuing risks are not closed and remain open until the risk is mitigated.
- Ensure there is an effective system at governance level to review, mitigate and improve services in relation to quality, safety and risk for end of life care at the trust.
- Develop a vision for the maternity and gynaecology services, including the community midwifery services and the birth centres and share this with staff.
- Take steps to improve the culture within the outpatient departments where bullying and harassment are present.
- Improve the engagement of both staff and the public in outpatients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>(1)The care and treatment of service users must—</p> <ul style="list-style-type: none">(a) be appropriate,(b) meet their needs, and(c) reflect their preferences. <p>(3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—</p> <ul style="list-style-type: none">(a) carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user;(b) designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met; <p>The provider had not taken adequate steps to provide appropriate care and treatment in critical care to meet patient needs.</p> <p>Not all level two patients were able to receive critical care following their surgery due to a lack of beds in that service.</p> <p>Patients were not always discharged from critical care onto wards from the service in a timely way when medical fit for to do so. The number of patients discharged at night was higher than the national average and the occupancy on the critical care unit frequently exceeded recommended levels.</p>

This section is primarily information for the provider

Requirement notices

Staff were not always able to respond appropriately to changing risks of people receiving end of life care.

Not all of the TEPs that we looked at had been completed fully by doctors. The sections that were left blank included confirmation that an assessment of a patient's capacity to consent had been completed, and whether a discussion had been held with the patient/ relatives/ carers about the content of the TEP.

This meant that the trust could not be assured that all patients at the end of life were being treated appropriately if their condition deteriorated.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

- (1) Service users must be treated with dignity and respect.
- (2) Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular —
 - (a) ensuring the privacy of the service user;

The cubicles within the fracture clinic were very small and close to the neighbouring cubicle. Patients' personal information could be overheard when clinicians were discussing treatment options and other confidential details.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- (1) Care and treatment must be provided in a safe way for service users.

Requirement notices

(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include-

(a) assessing the risks to the health and safety of service users of receiving the care or treatment;

(b) doing all that is reasonably practicable to mitigate any such risks;

(g) the proper and safe management of medicines;

The hospital did not ensure that confidentiality was maintained at all times. Pregnancy test results with patient identifiable information were found in two sluice rooms.

Systems to assess monitor and mitigate risks relating to the health, safety and welfare of service users receiving care were not operating effectively, including protecting service users from avoidable harm.

Patients were not always risk assessed prior to their operations and equipment and staff were not in place, or operated on in the correct theatre with appropriate facilities. WHO checklists were not robustly undertaken or audited. Incidents were not identified, reviewed and investigated in a timely manner.

Surgery services were not meeting the incomplete pathway referral to treatment times for all of the surgical specialties.

Patients requiring emergency surgery were sometime delayed unnecessarily.

Patients with cancer had operations cancelled on the day of planned surgery.

Bed management, medical patients in surgical beds, and delayed discharges of care impacted on the flow of patients in surgery

Incidents were not identified, reviewed and investigated in a timely manner. Learning from incidents and never events was not shared with staff and others to promote learning.

The hospital was poorly compliant with care bundles to effect improvement in a particular disease area, treatment or aspect of care.

Requirement notices

Patients with severe sepsis were not given intravenous antibiotics within one hour.

Care and treatment was not provided in a safe way for all maternity service users, and not all risks were identified and mitigated effectively. Some staff did not have the skills to care for women and babies safely.

Women were labouring in the antenatal ward and the day assessment unit, because there was not enough capacity on the delivery suite. These women did not receive one-to-one care which is proven to support good outcomes

The processes for identifying deteriorating women using the maternity early warning score were not routinely used.

The progress of women's labour was not routinely recorded on the partogram recommended in trust guidelines

There was no process to ensure a safe skill mix including high dependency skills on the delivery suite

More women sometimes had their labour induced than the unit could safely manage in a day and decisions to induce labour did not take account of capacity, activity and staffing on the delivery suite.

Some midwives in the community were not confident in cannulation and potentially not able provide basic life support in the face of ambulance delays to remote communities/birthing centres.

This section is primarily information for the provider

Requirement notices

There was a lack of scrutiny and subsequent learning from incidents relating to end of life care at the trust. There was not an effective process in place at the time of our visit which had responsibility for the oversight of incidents.

Incidents that affected the health, safety and welfare of people using outpatient services were not consistently reported internally and to relevant external authorities/bodies. Incidents that included the potential for harm were not always reported. Adequate steps to ensure learning was identified and shared with staff were not in place.

The trust was not safely managing the backlog of cardiac 24 hour recording tapes.

The trust was not safely managing patients on WARM injection follow up lists and glaucoma lists coming to harm.

Out of date medicines were stored on wards, and on a resuscitation trolley, and had been administered to a patient. On the trauma unit we found a batch of lorazepam which had expired in April 2017. We also noted an incident had occurred on the trauma unit during the inspection period when a patient was administered an out of date controlled drug. However, the report stated there was 'no apparent injury or minor injury not requiring first aid'. On the surgical admissions unit we found two bags of intravenous energy feed which had expired in November 2016.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

(1) All premises and equipment used by the service provider must be —

(a) clean

Requirement notices

(b)secure

(c) suitable for the purpose for which they are being used

(e) properly maintained

Premises where care and treatment were being delivered were not always clean, secure, suitable for the intended purpose or well-maintained:

There were not adequate toileting and shower facilities on Theatre Direct and surgical assessment unit. There were two showering facilities on the unit – one for male and one for female patients. However, these were situated inside the toilets in two of the three available toilets.

Safety checks on equipment were not carried out by planned dates. A maintenance record of medical devices report dated June 2017 showed planned preventative maintenance had not been carried out by the expected date on three out of 18 anaesthetic machines (17%); and 11 out of 110 (10%) anaesthetic syringe pumps.

On the trauma unit we found a bladder scanner which was due a safety test in January 2017. In Theatres Direct we found a manual blood pressure cuff which was due a safety check in January 2014.

On the surgical admissions lounge we found an oxygen saturation monitor and an electrocardiogram monitor which were due to be safety checked in June and July 2016 respectively.

The antenatal ward was not secure as it had open access to members of the public during the day as the entrance was shared with the day assessment unit and nurse consulting rooms.

Requirement notices

The delivery suite did not have a facility for women needing higher levels of care.

The second theatre on the delivery suite was not kept ready for immediate use and not used as a second theatre for elective lists

The capacity of the delivery suite was too small for the number of women delivering so some delivered on the antenatal ward

The postnatal ward was too hot and large freestanding fans used to cool the corridors had trailing wires causing a risk of falls

Emergency drugs were stored outside the postnatal ward due to high temperatures which meant staff did not have ready access to emergency medicines

The fracture clinic was not fit for purpose. A number of issues reported following our previous inspection in January 2016 were still present during this inspection. The trust had previously advised us this was only a temporary location but the clinic had been relocated and we did not receive adequate assurance that this was still the case.

Issues included:

- The seating area being worn and torn increasing the risk of bacterial harbourage.
- The seating area being hidden from the receptionists' view.
- Children were not adequately safeguarded because there was no dedicated waiting area for children.
- Deeply chipped wood work throughout the clinic increased the risk of bacterial harbourage.
- The paintwork around the reception desk was black with what appeared to be body grease, increasing the infection risk.

This section is primarily information for the provider

Requirement notices

- Insufficient waiting areas for patients with fractures that need elevation.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

(2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

Complaints were not dealt with within 25 working days in line with the hospital policy. From June 2016 to May 2017 the service consistently missed the target of closing complaints within 25 days. The target was for 90% to meet this deadline. The average working days for complaints to be closed was 69 days.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to –

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

Requirement notices

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

Systems and processes were not effective enough to identify, monitor or mitigate risks to the health, welfare and safety of people who use the service, or the quality of the service.

Governance processes were not embedded in practice to provide a robust and systematic approach to improving the quality of surgical services.

Risks, issues and poor performance were not always dealt with appropriately or in a timely way. Managers lacked time and support to lead effectively.

Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the maternity services provided because;

The quality and accuracy of performance data was not adequate and some data was poor quality and not used to identify trends or areas for improvement.

The information management system for the maternity service did not hold the information needed to run an efficient service.

Maternity guidelines were not properly aligned and made different recommendations about the same issue.

Requirement notices

The service had not identified all risks such as the number and skill mix of staff or provided adequate mitigation for some of the risks identified.

There was limited audit activity to review for the quality of processes in maternity and for improvement or benchmarking.

There was little evidence that anybody at a governance level was taking overall responsibility to review, mitigate or improve services in relation to quality, safety and risk for End of Life Care at the trust.

There was no oversight or governance processes that gave assurance that issues with fast track discharges for end of life patients was being monitored or managed. This is against national guidance relating to end of life care.

There were no mechanisms in place which effectively captured feedback from either staff or patients and those close to them that allowed any input into the design of end of life services.

The systems in place for monitoring at risk patients on waiting lists were not effective in preventing patients coming to harm in both ophthalmology and cardiology.

Despite having actions in place to monitor and reduce waiting lists, the number of patients waiting for treatments had grown.

Patient records were not stored securely in cardiology. Patients' medical records and other patient identifiable data were left unattended behind reception and in a room accessible by the public.

Requirement notices

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

(2) Persons employed by the service provider in the provision of a regulated activity must -

(a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

(c) where such persons are healthcare professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practice or a requirement of their role.

There were not sufficient nursing staff on duty on all surgical wards (with the exception of Wheal Coates) to ensure the safety of patients at all times to monitor and provide care and treatment to patients. The surgical assessment unit and Theatre Direct which only had 82% of planned nurses during the day in April, 85% in May and 88% in June. This was of particular concern as the numbers of healthcare assistants also fell short of planned levels during the day in these two areas where there were 81% of planned numbers in April, 75% in May and 75% in June.

There were high vacancy rates in medical staffing. In March 2017, there was a vacancy rate of 14.2% (relating to 44 WTE vacancies). Senior managers confirmed recruitment was a significant challenge. For example, there were eight anaesthetic vacancies at the time of the inspection. This was managed on a daily basis. The highest vacancy rates were in the trauma and orthopaedics specialty, where there were 39.1% middle grade vacancies and 25.6% junior doctor vacancies.

Requirement notices

There were not sufficient numbers of suitably qualified, competent, skilled and experienced midwives in the maternity services because

There were risks to women because there were not enough staff to cover workload in the delivery suite

The escalation policy to ensure safe staffing was not working effectively

There were insufficient numbers of suitably qualified nursing staff in the paediatric emergency department to provide safe care at all times.

RCN guidance recommends a minimum of two registered children's nurses at all times in all inpatient and day care areas. However only one suitably qualified nurse was available in the department.

There were no formal processes in place to ensure appropriate cover was in place during periods of absence.

There were occasions when the nurse was away from the department i.e. when they accompanied a child being transferred to the paediatric ward, attending to children and parents' needs, fetching snacks and drinks from the kitchen or taking a break. During these times staff from the adjacent main adult emergency department, who had completed a paediatric module, provided cover if available. However, there were occasions when the reception area was left unattended.

Compliance with mandatory training and appraisals for surgical staff were below target. Only 57.8% of the required staff were up to date with duty of candour training. Only 70.1% were up to date with infection control training.

Compliance with mandatory training was significantly below the trust target of 95%

This section is primarily information for the provider

Requirement notices

Not enough staff on the delivery suite were trained to manage high dependency patients so women were sometimes cared for by staff without appropriate training.

Not all midwives were skilled in cannulation, epidural knowledge and suturing.

On call community midwives were not trained in STAN monitoring or hospital computer systems but were sometimes required to work on the delivery suite

Only 55% of midwives were up to date with new born life support training updates.

Not enough midwives were trained in new-born checks even though the maternity service had assumed responsibility for this in April 2017.

Action was not always taken to address behaviours and performance in surgery which was consistent with the vision and values, regardless of seniority.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

(1) Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

(2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—

(a) notify the relevant person that the incident has occurred in accordance with paragraph (3), and

(b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

(3) The notification to be given under paragraph (2)(a) must—

(b) provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,

Requirement notices

(c) advise the relevant person what further enquiries into the incident the registered person believes are appropriate,

(d) include an apology, and

(e) be recorded in a written record which is kept securely by the registered person.

(4) The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—

(a) the information provided under paragraph (3)(b),

(b) details of any enquiries to be undertaken in accordance with paragraph (3)(c),

(c) the results of any further enquiries into the incident, and

(d) an apology.

(6) The registered provider must keep a copy of all correspondence with the relevant person under paragraph (4).

We saw that the trust's duty of candour 'being open policy' was not used in all situations where duty of candour applied in surgery.

We saw that discussions may be had with patients/relatives but a written apology did not always occur. One person was responsible for producing duty of candour letters and there were no provisions for cover in case of absence.

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements

The trust must take action to address serious failings to ensure quality care and treatment and safety of patients.

Where these improvements need to happen

Systems to assess, monitor, and mitigate risks to patients receiving care and treatment are not operating effectively.

Ensure there is a clear process in place for identifying and managing deteriorating women in maternity.
Ensure there is an adequate system in place to manage and care for women requiring high dependency care in maternity, including suitably trained and sufficient staff.
Ensure the second obstetric theatre is properly risk assessed and risks identified are addressed and/or mitigated.
Ensure there are adequate systems and processes in place for identifying, reviewing, grading and investigating incidents in a timely manner.
Ensure learning takes place and is shared from never events and all other incidents.
Ensure there are sufficient numbers of Registered Nurse (Child Branch) deployed to meet the needs of children and young people in the emergency department at all times.
Ensure that lone working community midwives are able to respond effectively and efficiently to emergency situations should they occur in a community setting.
Ensure there are effective systems and processes in place for monitoring and managing risks to non-admitted cardiology and ophthalmology patients.
Ensure there are adequate systems and processes in place for meeting the incomplete pathway referral to treatment times for all of the surgical specialties and that emergency operations are not delayed unnecessarily.
Ensure there are adequate and improved systems and processes for managing access and flow in the critical care unit.
Ensure all patients are risk assessed prior to surgery and that they are operated on in an appropriate theatre with the required level of skilled staff and equipment. Safety briefings should occur before each list.

Enforcement actions (s.29A Warning notice)

Ensure systems and processes for improving compliance with the WHO surgical safety checklist are in place and monitored.

Ensure there are effective systems and processes in place to make sure that equipment is of good repair, has been serviced, maintained, tested or calibrated across the whole organisation.

Review the location and environment in the fracture clinic to ensure that the area is fit for purpose and that safeguarding concerns are addressed.

Governance systems and processes are not operating effectively.

Ensure there are adequate systems and processes in place to ensure patient confidentiality at all times.

Ensure that adequate systems and processes are in place such that duty of candour is appropriately applied in a timely way in all relevant cases.

Ensure systems and processes to address poor behaviour, grievances and performance management related issues are operating effectively and issues are addressed in a timely way.