Royal Cornwall Hospital

Inspection visit date(s): 8 April 2025, 9 April 2025

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Royal Cornwall Hospital
Location findings

Ratings for this location

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

Overall location summary

Date of assessment: 8 to 9 April 2025. Royal Cornwall Hospital provides a range of NHS hospital services. The assessment looked at medical care services and urgent and emergency care services as part of the System Pathway Pressures programme. We rated medical care services and urgent and emergency care services as requires improvement. The rating for medical care services and urgent and emergency care services has been combined with ratings of the other services from the last inspections. See our previous reports to get a full picture of all other services at Royal Cornwall Hospital. The rating of Royal Cornwall Hospital remains requires improvement.

In our assessment of medical care services we found the service did not always have a positive and proactive safety culture where events were investigated. The service did not always work well with patients and health system partners to maintain safe systems and continuity of care. There was not always enough staff to meet patients' needs. Staff were not always able to provide care and treatment in line with evidence-based practice that delivered good outcomes. Staff were kind, caring and compassionate. The service did not always respond to people's immediate needs. People were not

always able to access care in a timely manner due to flow challenges across the hospital. The department and staff were led by capable service-level leaders. However, governance and risk management structures were not robust and did not always support the delivery of high-quality care.

In our assessment of urgent and emergency care services we found consultant cover was not in line with national guidance. There was crowding in the department due to flow challenges across the hospital. Staff worked in a strong culture of evidence-based practice. Staff treated patients kindly and with compassion. Medicines were not always managed and stored safely. Governance systems were in place but were not always effective. The leaders were capable and driven, however there was concern for the wellbeing of leadership due to the pace of change.

Safe

Rating Requires improvement 

Our overall rating of safe at Royal Cornwall Hospital remains requires improvement. We looked at medical care services and urgent and emergency care services only. For both we rated safe as requires improvement.

Effective

Rating Good 

Our overall rating of effective at Royal Cornwall Hospital remains good. We looked at medical care services and urgent and emergency care services only. For medical care services, we rated effective as requires improvement. For urgent and emergency care services, we rates effective as good.

Caring

Rating Good 

Our overall rating of caring at Royal Cornwall Hospital remains good. We looked at medical care services and urgent and emergency care services only. For both services, we rated caring as good.

Responsive

Rating Requires improvement 

Royal Cornwall Hospital

Location findings

Our overall rating of response at Royal Cornwall Hospital remains requires improvement. We looked at medical care services and urgent and emergency care services only. For both services, we rated response as requires improvement.

Well-led

Rating Requires improvement 

Our overall rating of well-led at Royal Cornwall Hospital has changed and is now requires improvement. We looked at medical care services and urgent and emergency care services only. For both services, we rated well-led as requires improvement.

Medical care (Including older people's care)

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

Our view of the service

We carried out an assessment of medical care services (including older people's care) provided at Royal Cornwall Hospital on 8 and 9 April 2025, as part of our system pathway pressures programme.

We inspected 24 quality statements across the key questions Safe, Effective, Caring, Responsive and Well-led and have combined the score for each of these areas to give the rating.

During the inspection, we visited 12 wards. We reviewed the environment, staffing levels and looked at care records and prescription records. We spoke with patients and family members and staff of different grades, including; nurses, doctors, ward leaders and senior leaders responsible for medical services. We reviewed performance information about the trust. We observed how care and treatment was provided.

Royal Cornwall Hospitals NHS Trust (RCHT) is the main provider of acute hospital and specialist services for most of the population of Cornwall and the Isles of Scilly. The trust delivers care from three main sites: Royal Cornwall Hospital in Truro, St Michael's Hospital in Hayle and West Cornwall Hospital

Medical care (Including older people's care)

in Penzance

Medical care (including older people's care) services provided at Royal Cornwall Hospital are managed by 2 care groups: Acute Emergency Medicine (AEM) and Specialist Services and Surgery (SSS) Care Group.

The trust had faced significant operational pressures over the last year, which was intensified during peak holiday season where the visiting tourist population significantly increased demand for services. Although the trust had made changes to combat these pressures, including working with others in the local integrated care system, we found issues with the quality and safety of care delivered.

The service did not always have a positive and proactive safety culture where events were investigated, and learning was embedded to promote good practice. The service did not always work well with patients and health system partners to establish and maintain safe systems and continuity of care. They did not always involve people to manage risks. There was not always enough staff to meet patient's needs. The service did not always control potential risks to the environment, and they did not always manage medicines safely and effectively. Risks of infection were assessed and managed well.

Staff were not always able to provide care and treatment in line with evidenced-based practice that delivered good outcomes. Staff did not always work together well in the hospital to share information, however they worked well with external partners.

Staff were kind, caring and compassionate. Patients told us they felt supported by staff. The service did not always respond to people's immediate needs and patients lacked mechanisms to alert staff. Staff felt supported by their immediate team, however they did not feel engaged with leadership or the organisation.

The physical and mental needs of patients were considered when developing care plans, however patients did not always feel listened to by staff. The service mostly supplied up to date information for patients in accessible formats. People were not always able to access care in a timely manner due to flow challenges across the hospital.

The department and staff were led by capable service-level leaders who had a vision and strategy to make improvements. Staff worked well with partners and there were joint working arrangements, including learning across the system, which was encouraged and linked to improving experiences and outcomes for patients. However, governance and risk management structures were not robust and did not always support the delivery of high-quality care and there were gaps in governance lead roles. Staff

did not always feel able to speak up or be involved in decision making and reported a lack of a sense of belonging. There was improved governance and risk management, and a positive culture.

The trust took part in a ‘perfect week’ over Easter 2025 where providers in the system were testing and learning new ways of dealing with the increased demand seen at peak holiday times from tourists. Learning points were identified and allocated to each relevant provider to action, and the hospital took part in the process. Areas included in the work were community issues, risks, and care pathways. There was a log of key learning points to be actioned.

The service worked with system partners to coordinate discharges with appropriate community support. This included discharge from the hospital and from the virtual ward. The wards utilised discharge coordinators to facilitate appropriate transfer of care.

We found 5 breaches of the legal regulations in relation to safe delivery of care and treatment, premises and equipment, staffing, dignity and respect, and good governance.

Service users were not always treated with dignity and respect.

Staff did not always provide the safe delivery of care and treatment and assess risks to people's health and safety or mitigate them where identified.

Staff did not always ensure the proper and safe management of medicines and that premises and equipment were secure. The environmental layout of the building did not always keep people safe.

The service did not always ensure that persons providing care or treatment to service users had the competence, skill and experience to do so safely.

Governance systems did not always ensure risks relating to the health safety and welfare of service users were mitigated and that service users’ records were accurate, complete and kept secure.

We have asked the provider for an action plan in response to the concerns found during this assessment.

People's experience of the service

We reviewed 46 records across 10 wards. We spoke with 72 staff and patients. Patients told us there

was multidisciplinary team working and patients felt listened to by staff. Patients found staff caring and responsive and praised the care they received. Carers for one patient stated that staff had been "fantastic." There was clear person-centred care provided. When reviewing records, patients and their next of kin (NOK) were involved at all stages of planning and the patient's needs were considered at all steps. There was mixed feedback from patients regarding whether they had been provided information. One patient stated they were given constant updates and reassurances. Another patient stated they had been told different things by different members of the multi-disciplinary team (MDT) and was unsure what she was waiting for.

Safe

Rating Requires improvement 

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement.

We assessed 8 quality statements and looked for evidence that patients were protected from abuse and avoidable harm.

The provider was in breach of legal regulations in relation to safe care and treatment. In considering safe care and treatment, the provider was in breach of regulations regarding assessing the risks to the health and safety of service users receiving the care or treatment, ensuring that persons providing care or treatment to service users have the qualifications competence, skills and experience to do so safely, the proper and safe use of medicines, and premises and equipment being properly maintained.

The service did not always have a proactive and positive culture of safety based on openness and honesty. Safety concerns were not always investigated and learning identified and shared in a timely way. The service did not always work well with patients and health system partners to establish and maintain safe systems and continuity of care. People were not always involved to manage their risks and some aspects of care provided was not always safe or specific to patients' needs. The service did not always detect and control potential risks to the environment. There was not always enough qualified and skilled experienced staff and they did not always receive effective support and development. The service did not always make sure that medicines and treatments were safe and met patients' needs.

However, staff understood what safe meant for patients and they concentrated on trying to improve patients' lives while protecting their rights and infection risks were managed and responded to well.

Learning culture

Score

2. Evidence shows some shortfalls in the standard of care

There were delays in carrying out safety reviews following patient safety events, including patient deaths. For example, at the March Mortality Review and Oversight Group it was noted that there were 5 structured judgement reviews (SJRs) for patients with a learning disability outstanding. This meant there may have been missed opportunities for service improvement and to identify lessons learnt.

Due to operational pressures and gaps in governance leads at speciality level, some specialities across both care groups had not carried out regular Morbidity and Mortality meetings and there were sometimes delays in undertaking learning responses following incidents. For example, in the AEM care group, cardiology monthly morbidity and mortality meetings had been stood down due to operational winter pressures. Respiratory morbidity and mortality meetings had also not been held at speciality level due to gaps in the speciality governance team.

We reviewed a learning response that had been investigated to identify learning. The Patient Safety Review was detailed and considered an in-depth history of the patient, and external and internal factors that contributed to the incident. There were clear recommendations and accompanying safety actions. Within the last 12 months, the service had completed 7 system-based learning responses within inpatient medical areas.

Patient deaths were reviewed at trust level and tracked at executive level as well as monthly at the Mortality Review and Oversight Group (MROG). The MROG used data including the HSMR (Hospital Standardised Mortality Ratios) and ‘heat maps' to identify themes and trends in relation to in hospital deaths in specific services across the trust. Leaders told us if it was identified that there were excess deaths within a particular speciality this would prompt a detailed clinical review. To improve governance of mortality reviews, from April 2025 the trust would be introducing new monitoring of them using their AMAT (Audit Management and Tracking tool) system.

Complaints were not always investigated and responded to in agreed time scales. The key

performance indicator (KPI) for formal complaints being responded to within the agreed timeframe was 95%. During the 6 months prior to our visit, an average of 82.5% of complaints across the Specialist Services and Surgery (SSS) and Acute and Emergency Medicine (AEM) care groups were completed within these agreed timescales. Compliance with this KPI varied monthly across both care groups. For example, in March 2025 only 57% of complaints (8 out of 14) received in the AEM care group were responded to and completed in line with trusts set timeframes. There were 6 outstanding complaints. The care group prioritised these for review to identify if a Structured Judgement Review (SJR) was required. SJR is a methodology for reviewing the quality of care provided to a patient who died.

The service provided us with information following our inspection, acknowledging that due to the complexity of managing individual cases, complaints had not always been investigated and responded to within agreed timescales. A defined process for cases that could not be resolved within the standard 30 working day timeframe provided appropriate oversight and accountability for delays beyond the standard process.

The top 3 themes for complaints in both AEM and SSS were communication, clinical treatment, and patient care. Trends within these themes included: patients not feeling listened to, conflicting information, care needs not adequately met and delay or failure in diagnosis, treatment and procedure. We reviewed responses to 3 complaints and found the trust had investigated families' and patients' concerns in full, provided responses to the concerns and made improvements.

Service wide safety briefings were circulated to inform staff of learning identified following incidents or where areas for improvement had been identified. Learning was also shared with staff at daily ward briefings and weekly senior management team meetings. A monthly learning from incidents newsletter was also circulated with staff via email.

We found the SSS care group invited all colleagues to attend virtual shared learning events to discuss learning and improvements with staff. Past topics included: end of life care, falls, debriefs, patients experience and pressure ulcers. This was part of the care groups work on promoting an open learning culture.

Staff gave mixed responses regarding the learning culture of the organisation and how leaders respond to incidents. Some staff told us they were passionate about reporting incidents that affected patient safety, gave multiple examples of when they had reported incidents, and

received feedback, including from the patient safety team leader. However, not all staff felt listened to or that they received feedback when they reported incidents. For example, on Tintagel Ward, staff raised a concern about an incident when a patient without a bed space suffered seizures. Although a matron attended the ward to support staff and the patient at the time of the incident, staff did not feel their underlying concerns about the lack of bed spaces to ensure the safe care and treatment of patients had been addressed with lessons learned.

Safe systems, pathways and transitions

Score

2. Evidence shows some shortfalls in the standard of care

The hospital faced significant operational pressure and demand across its Medical Care and Urgent and Emergency Care services. Average bed occupancy across all medical care wards from October 2024 to March 2025 was consistently above the trust target of 92%; in March 2025 it stood at 97.21%. This impacted the number of delayed discharges which also remained significantly above target in March 2025 (96 against the target of 46).

The service introduced a Clinical Vision for Flow programme from March 2025, which intended to positively impact overall system risk, reduce harm, and improve patients' experiences while improving flow through the hospital.

A revised medical model of care which aimed to facilitate patient moves to the correct ward, saw the Acute Frailty Unit (AFU) and Acute Medical Unit (AMU) merge in mid-March 2025 to create a combined Acute Medical Frailty Unit (AMFU) for short stay patients and increased the availability of senior clinical decision makers on wards at the times of greatest demand. The standard operating procedure (SOP) was being revised to reflect the new medical model being implemented.

Flow varied between services which impacted how patients moved through the hospital. The same day medical assessment unit (SDMA) was working as a same day emergency care (SDEC) and temporary escalation area. Referrals were received from the acute GP service, specialist services and the emergency department for patients to receive diagnostics, treatment and

criteria-led discharge. SDMA had a faster, more predictable flow, whereas flow on the wards varied by speciality. Discharges from all areas were impacted by community support, availability of family or carers, and whether the patient's usual residence was a care home.

Staff in the discharge lounge felt the service was underused, and they had seen a reduction in the number of patients they cared for.

To support the move of patients onto medical wards, 'Your Next Patient' assessments and new handover processes had been introduced. In February 2025 the service had implemented a timely handover protocol (THP) and a revised medical model to improve performance and patient flow. The THP facilitated moving additional patients onto medical wards. Where bedspaces were not available, patients were moved into temporary escalation spaces (TES).

Risks and individual needs of patients being transferred under the THP were not always communicated to staff effectively, which put them at increased risk of avoidable harm. The exclusion criteria within the procedure were not always adhered to.

The THP protocol was not always carried out safely which put patients at risk of avoidable harm. We found examples where patients who met the exclusion criteria were moved into TES spaces. Staff told us about a patient who was moved to the fit to sit area on Tintagel Ward who needed support for personal care, which meant they would have been excluded from the area if guidance had been followed.

Staff raised concerns that handovers continued to not be carried out safely which impacted the quality and safety of patient care. Most staff raised concerns about patients who were transferred to wards either with no written handover, or a poor handover. For example, a renal patient had been transferred to Eden ward as a medical outlier without prior knowledge of the ward. The patient had not been seen by a specialist in ED and there had been no handover by staff. Staff on Karensa ward told us a lack of clear communication on patient transfer led to a patient experiencing a fall

Some patients were transferred and treated in TES spaces on wards when staff felt it was not always safe to do so. Feedback from staff on wards was not always listened to and transfers onto wards took place when they felt it was not safe to do so.

Some staff expressed concerns about the surge protocol and the suitability of ward areas to

meet patient needs. For example, on Eden ward, 2 patients living with dementia were accommodated in chairs outside the line of sight of staff. On Tintagel ward, the escalation space was a chair space in the day room. We heard about two incidents where patients had seizures in this area.

During the assessment we identified a theme in the quality of handovers which had affected patient safety. The trust took action to address these issues. Actions included implementing new measures to protect critical nursing time and ensure robust communication. The practice of completing the paper handover form and transferring the patient will stop and instead timely escalation and direct communication between clinical teams will occur. [AH1] [CS2]

All reasonable steps to mitigate risks to patients had not always been taken, because not all risk assessments and care plans had been completed. There were gaps in patients' documentation that left them at risk of harm following transfer. Of the 46 patient records we reviewed, 13 patient records had gaps in notes, documentation of conversation, or completion of risk assessments. On AMU, one patient had suffered a fall, and this had not been documented in their notes. We were assured by staff that this would take place. However, the following day when this patient was being transferred this had still not happened. On Pheonix ward, 1 patient's care plan had not been transferred to the electronic patient observation system and there were assessments that had not been completed.

The April 2025 Integrated Performance report demonstrated that while efforts were actively being pursued to address falls and their number had reduced, there was an increase in patients experiencing moderate to severe harm. Leaders told us that a thematic analysis of incidents, along with data obtained from the National Audit of Inpatient Falls (NAIF) would inform the service-wide initiatives being outlined in the Integrated Falls Prevention Improvement Plan for 2025-2026, which was currently under development.

We raised concerns with leaders, and they took immediate action to make initial improvements and provided further assurance after our assessment. Leaders described a proactive model to help them shift from a 'push' to a more efficient 'pull' system, particularly supporting AMU in moving patients to the base ward. Early indications were that some improvements had been made.

There were two stroke pathways for patients who were more and less acute, however the

service was experiencing challenges maintaining the pathways, due to resources and capacity.

Patients who did not require level 3 stroke care were sometimes admitted to the hyper-acute stroke unit (HASU) as outliers, and there were stroke patients outlying on other medical care wards where staff did not have specialist knowledge and experience. The trust had worked hard to decrease the proportion of non-stroke patients on the ward in the last 12 months, however 26% of patients admitted to the stroke ward remained non-stroke patients, which impacted on the stroke pathways.

Staff on Wellington Ward told us there was an established discharge process working with community liaisons. Discharge Coordinators had been implemented in the inpatient areas to support nursing staff with discharge planning, liaising with families, community services, social care and charities to support safe, effective and timely discharges. For patients with complex needs, there was a Community Hospital Allocation Team (CHAT) who triaged these patients and responded to requests within 18 hours. We found 2 patient notes that we reviewed in the discharge lounge contained all the required information and a good handover using the Situation, Background, Assessment, and Recommendation (SBAR) form.

However, staff in the discharge lounge expressed concerns regarding recent changes that had been made regarding medical cover and the take home medicine arrangements as the previous processes had worked well and supported prompt discharges. They also told us that transport was an issue and sometimes patients were still waiting at 6:30 pm for transport to arrive.

The Virtual Wards Standard Operating Procedure 20/10/23 guided the delivery of the multidisciplinary virtual ward across the integrated care system (ICS), to prevent avoidable admissions and support early discharge from the hospital. It provided chronic disease management from the hours of 9am-5pm, 7 days a week. The service could access community diagnostic services. There were appropriate escalation processes and an out of hours service was provided by the community assessment team unit.

Safeguarding

Score

3. Evidence shows a good standard of care

There were mechanisms to ensure effective systems, processes and practices to protect people from abuse and neglect. The safeguarding policy reflected national guidance and best practice and outlined the processes that staff should follow. The policy emphasised the importance of safeguarding responsibilities and encouraged nurses to take on link nurse roles to address safeguarding issues.

The service's policy highlighted the importance of (at least quarterly) mandatory safeguarding supervision for designated and safeguarding leads and mandatory training for all staff in all roles. This was to ensure mechanisms were embedded to foster a strong understanding of safeguarding and commitment to taking immediate action to keep people safe, including collaboratively with partners. Information provided to us by the service demonstrated overall compliance rates with training across each level ranged between 88.7% and 90.9%

Three members of staff discussed the safeguarding training and told us they completed level 1 and 2 each year and that level 3 was optional. They also told us that children safeguarding concerns would be discussed on a case-by-case basis.

Three members of staff we spoke with were able to provide examples of where they had implemented the safeguarding policies and procedures including when the Mental Capacity Act was applicable. These staff demonstrated a good understanding of their roles and responsibilities as well as those of partner agencies.

To support patients who exhibited behaviour that challenged, staff, including security staff, received an in-house initial training course on restraint and de-escalation skills during their induction. This training was then refreshed on an annual basis. While 92.9% of NHS staff had undertaken this training, at the time of our visit, only 67% of security staff had completed this training. The service was taking action to address the remaining 33% non-compliance.

Although the 'Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs)' combined training

was not mandated in Royal Cornwell Hospital, Mental Capacity Act 2005 training was mandated and Safeguarding Adults Level 2 syllabus covered MCA and DoLs. Compliance of Mental Capacity Act 2005 training was 77.62% across all staff groups at the time of our assessment, above the trust's target of 75% but below the target for statutory compliance of 90%. The Safeguarding Adults Level 2 training compliance was 88.7% across all staff groups.

Staff we spoke with about MCA and DoLs demonstrated a good understanding of this in their day-to-day work.

Involving people to manage risks

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always holistically assess and manage risks to patients. This meant some aspects of care provided was not always safe or specific to people's individual needs.

Nursing Fundamental of Care Audits were carried out monthly to review the quality and completeness of patient care records. The audits included reviewing skin care bundles, falls risk assessments and mitigations. Indicators used across care groups showed some areas where compliance was consistently low and the quality of patients care record keeping was at a varying standard. For example, indicators for acute and emergency medicine (AEM) care group compliance had varied for the 6 months prior to our assessment from 63% to 83%. Compliance for the completion of patient's Treatment Escalation Plans and holistic safe handling care plans was low at 50% in April 2025.

Venous thromboembolism (VTE) assessments were not always completed within 14 hours of admission, as recommended in national guidance. The service was aware of this, and compliance had been improving since January 2025. However, in March 2025, VTE assessments completed within 14 hours was 71% across SSS services and 76% AEM services. This increased the risk of patients developing a VTE because these assessments help identify individuals at risk and reduce the chance of VTE by ensuring treatment was given as soon as possible.

To help address overdue assessments of patient care and treatment, teams created 'Live Overdue Dashboards', which would flag any overdue assessments to staff at handover times and make it easier for teams to allocate these for completion. The service told us by making this change, the SSS Care Group had reduced overdue assessments significantly and there had been an improvement with patients care planning standards.

The service did not always assess and mitigate potential risks to patients' health. The themes from the top three incidents for AEM were pressure ulcers, falls and the discharge processes. For example, we found that staff conducted safety checks for 1 out of the 5 patients we reviewed when the patient was in the hospital over two admissions. When planning the discharge for both visits, staff did not conduct risk assessments to understand the level of care need the patient would need at home. However, 2 out of the 5 patients and next of kin (NOK) were involved in risk mitigation discussions prior to discharge.

There was a new sepsis audit that was rolled out up to April 2025. Records available at the time of our assessment showed compliance with this had varied across the different wards. Across the 9 records viewed, only 55.5% of the full Sepsis Six was delivered within 1 hour. The lead sepsis nurse was continuing to promote the new Sepsis 6 tool at the time of our inspection and a Trust-wide Safety briefing, 'Trust Standard for the Recognition of High-Risk Sepsis and the documentation of the delivery of the Sepsis 6 for adults over 16 years,' had been circulated. The brief updated all staff on the current clinical guidelines, the requirement to use the Sepsis Screening tool and the need to record Sepsis Six care in the electronic observation recording system as standard.

The service had also held a Sepsis World Day joint conference with a neighbouring trust for staff to attend and raise awareness of current best practice.

Patients NEWS2 scores were calculated via an e-observations module and there was a live screen on the wards that reported and highlighted high and overdue NEWS2 observations. While there was no adult NEWS2 audit undertaken within the adult inpatient wards, every 6 weeks a report which included analysis of various incidents, risks and near misses was presented at the Deteriorating Patient Operational Group. Themes and trends were identified, and action would be taken in response to these. Data presented at the May 2025 Deteriorating Patient Operational Group meeting, demonstrated that there had been an improvement in the KPIs of NEWS2 scores being recorded.

The Stroke dashboard showed while there had been improvements in the number of patients who had immediate and appropriate care following a stroke, there was still significant room for improvement. For example, in March 2025, the rate of patients that had a dysphagia (dysphagia is where you have problems swallowing), occupational therapist and dietician assessment following a stroke was higher than the previous month, however it was still worse than the average of the last 24 months. This meant there was a risk that patient's recovery from a stroke may not be impacted upon.

Safe environments

Score

2. Evidence shows some shortfalls in the standard of care

Mechanisms to monitor the safety and upkeep of the premises were not fully effective. While the facilities and equipment used with patients were mostly well maintained and in good working order, there was a lack of oversight regarding fire safety procedures and some inconsistencies and gaps in record keeping.

Information provided by the service demonstrated that the Patient Led Assessment of the Care Environment (PLACE) scores across ward areas for condition appearance and maintenance were generally good and above 80%. In addition to this, the service completed ligature point risk assessments to identify potential risks to patients.

Most areas were well maintained and clutter free, with accessible toilet and shower facilities. However, the environmental design did not always meet people's needs and keep them safe and there were unsafe environments in some areas. Some areas were cluttered, and staff had difficulty moving patient beds around the unit.

On Pheonix ward, each bed space was not supplied with the required equipment; 2 beds in the hyper-acute stroke unit (HASU) did not have monitors available. Additionally, a chair in the temporary escalation space (TES) blocked an exit.

Some staff also told us that a considerable amount of equipment was condemned with a

shortage of equipment for all patients.

The service did not always assess and mitigate risks to the safety of patients. Fire safety prevention processes were not consistently applied throughout the department and floor plans did not always accurately reflect evacuation plans in the event of a fire. For example, on Wellington ward, there was no evacuation plan completed, and a bed had been stationed in front of doors which allowed access to AMU. In AMU, fire safety folders were partially out of date, and the date on the fire risk assessment had not been updated. These issues were escalated to a leader so they could be addressed.

The safe storage and use of equipment was inconsistent. For example, the resuscitation trolley in AMU 2 was secured and all equipment was in date. However, in AMU1 and Roskear ward, there were gaps in record keeping for the resuscitation trolley, oxygen and suction supplies due to duplication of dates. We also found an incomplete resuscitation trolley audit on MDU which showed 4 months in 2024 and 1 week in January where no checks were recorded.

The ward environment was not always secure. As a result, patients and visitors were not always kept safe from contact with substances hazardous to health. The storeroom on AMU was unlocked and used as a thoroughfare between AMU 1 and 2. COSHH (Control of Substances Hazardous to Health) products and venepuncture devices were stored here. We also found in the treatment room on Roskear ward that antibiotic medicines had been drawn up for use but had been left in a tray unattended. We escalated this to the nurse in charge.

Safe and effective staffing

Score

2. Evidence shows some shortfalls in the standard of care

Leaders were committed to keeping staffing numbers at a safe level with a suitable skill mix and checked these twice daily. Agency and bank staff were used when necessary, ensuring they were familiar with systems and processes. However, there were not always enough skilled and experienced staff available to effectively provide safe care that met people’s needs.

The service benchmarked Care Hours per Patient Day (CHpPD). This data gives ward leaders, nurse leaders and senior leaders a picture of how staff are deployed and how productively) against the national and regional performance for registered and non-registered CHpPD through the national Model Hospital platform. Model hospital data shows the organisation was performing in-line or slightly better than regional and national peers for CHpPD. In addition, the service also monitored safer staffing levels across the service daily and produced annual reports highlighting issues and improvements/ recommendations as part of their governance arrangements. (Data collection was undertaken using the National Safer Nursing Care Tool (SNCT)).

However, staff vacancies had the potential to impact safe and effective staffing levels. The trust had a vacancy rate target of less than or equal to 10%. The medical care vacancy rate in March 2025 for substantive medical and dental staff was 9.6%, with the highest vacancies for resident doctors at 13.1% and middle-grade doctors were over recruited by 16.6%. The overall medical care vacancy rates for substantive adult registered nursing, midwifery and health visiting staff was 10.7% and vacancy rates of substantive clinical support staff was 16.6%. This demonstrated that although the service was hitting the trust vacancy rate target for medical staff, patient care may be impacted by the above target vacancy rates of the nursing and support staff.

The service relied on some bank and agency medical staffing to meet the needs of patients. The ward to board report for AEM showed that the use of agency staff had been reducing, though there were 5.9% unfilled medical shifts in AEM over the last 3 months. In November 2024 to April 2025, the staffing ratio for medical shifts was substantive doctors filled 79.7% of medical shifts (18819 shifts), 17% shifts filled by bank/overtime staff (4005 shifts), and 3.3% shifts filled by agency staff (784 shifts).

The April 2025 Integrated Performance report demonstrated that vacancy and turnover rates in medical care for registered nurses in May 2025 (including, adults, community & midwives) had reduced. However, the shift fill rate for support staff within the care group of AEM had slightly reduced.

Staff were noticeably busy, worked under pressure and 24-hour safer staffing models were being used. Staff were positive about the standards of care and treatment they delivered and spoke of a supportive team who pulled together to maintain these standards.

Most staff we spoke with across 10 wards described staffing levels as a challenge and stated there were times when they were short staffed, worked under pressure, or were pulled across different wards to provide cover. However, they felt supported and that they could escalate staffing concerns to the matron who addressed issues. Though some staff told us they were frequently asked to manage without adjustments to the staffing levels or resolution of the staffing concerns.

Staff working on 3 wards spoke of heavy reliance on temporary agency and bank staff as there was not enough substantive staff to fill all shifts.

Staff confirmed where required, out-of-hours and specialist cover was provided. For example, some medical patients were being cared for in St Mawes ward and general surgery. Staff on these wards informed us there were processes to ensure that the patients' care and treatment needs were met to support their recovery and health and wellbeing. Although most staff felt confident about addressing patients' needs promptly using resources available, less senior staff in the surgical wards, told us they felt out of their depth providing care to medical patients.

According to the trust wide Integrated Performance report, while appraisal compliance was at 77.61%, below the trust target of 90%, this had improved. The service provided evidence to confirm that they were focussing on work with care groups and the corporate teams to identify those staff whose training was out of date to ensure this was completed. Recommendations had been shared at Strategic Workforce Group in May 2025 and leaders were actively involved in making improvements.

Although leaders were committed to providing support to staff to keep up to date with mandatory training and any role specific training they needed to deliver safe care and treatment, compliance rates were below the trust target. Expected statutory training compliance was 90% for the 19 mandatory/statutory training modules but compliance rates for 12 out of the 19 core competencies were below 90%. Compliance rates for 5 out of the 19 core competencies were below 75%. For example, only 61% of staff had completed adult basic life support (BLS) training and only 31.7% of staff had completed Paediatric basic life support training. Although only 21.3% of staff had completed the required Oliver McGowan Mandatory Training on Learning Disability and Autism (Tier 2), the service was working to ensure staff had the skills necessary to support patients with learning disabilities and autism.

Staff on Roskear ward, Pheonix ward, Wellington ward, AMU, and SDMA confirmed they had received extensive training during induction with further opportunities for additional training, which they felt was adequate. However, they spoke of training being cancelled due to staff shortages, and not receiving protected time for training, which impacted on their ability to complete the training.

In the 2024 staff survey in AEM (excluding ED) and SSS, the percentage of staff who agreed they were able to access clinical supervision opportunities when needed was lower across both care groups. In AEM, only 47.3% agreed and in SSS only 47.8%, the trust's comparator was 54.3%. However, these percentages were still in line or above comparison organisations and other areas within the service.

Infection prevention and control

Score

3. Evidence shows a good standard of care

The service had mechanisms, in line with current national guidance, to effectively assess the risk of infection, including clear roles and responsibilities around infection prevention and control. The service's Infection prevention and Control (IPC) policy outlined how it was the top priority for the service and there was an Infection Prevention and Control team who provided education, support and advice. Governance and reporting structures were outlined in the policy, as well as expected standards and practices, relevant legislation and guidance and training requirements for staff. Staff received information about clinical guidelines and patients received information leaflets to keep them informed and to embed the infection control principles.

There were dedicated cleaning staff who were required to maintain high standards of cleanliness. The documentation provided by the service demonstrated that training compliance with IPC level 1 and 2 was at 92.2% and 75% retrospectively.

The environments we visited were generally clean and uncluttered with appropriate cleaning processes for equipment to keep people safe from infection. Staff followed proper IPC

processes for hand hygiene, use of personal protective clothing and equipment.

While audits took place, the completion of these and the data acquired was sometimes inconsistent. The IPC audit for January 2025, showed mixed results in wards achieving the required standards. We were assured by leaders that where audits had not been completed matrons raised this with the wards and took action to improve compliance. When issues with IPC were identified these were discussed and actions were put into place. This had taken place on one ward and they had made improvements and achieved 100% compliance.

Medicines optimisation

Score

2. Evidence shows some shortfalls in the standard of care

Patients we spoke with on AMU told us they had not been given their regular medicines. However, medicines including antibiotics were generally given as prescribed.

Staff were supported with the use of electronic tools to identify and support high risk patients. Staff spoke highly of the “Parkinsons Friends” tool which supported staff to administer people’s Parkinson’s medication in a timely manner. Data provided by the trust post assessment showed that less than 1% of medicines were missed due to inappropriate reasons. This had been achieved by allowing easier ordering of medicines for staff on wards and optimising pharmacy opening hours.

Medicines were generally stored safely and securely. Access was restricted to authorised staff. Wards were supported by a pharmacy top up service to ensure medicines were available. Staff showed us they could easily order medicine when required. However, some cupboards, drawers and fridges where medicines were stored were not always tidy or in the right place.

We could not be assured that staff were administering controlled medicines in line with the service policy. Controlled drugs that expired were not always disposed of line with guidance. We found expired controlled drugs on 2 of 4 wards visited. This included Zennor ward, where an expired liquid-controlled drug for pain relief had been administered to a patient on multiple

occasions. We did not see “return to pharmacy” stickers used on the unwanted CD stock which was not in line with the services policy. Furthermore, there were multiple instances of a controlled drug where staff who had witnessed an administration had not signed the register. These were raised with the ward leader to investigate.

Wards were supported by a pharmacy service for clinical queries including discharge planning, prescribing and medicines reconciliation. There were examples of good collaboration with doctors, discharge coordinators and primary care colleagues. For example, additional pharmacist input on medicines discharge summaries highlighting the key changes and reviews required for patients on new medicines. This was well received by colleagues in the community. Furthermore, discharge information was regularly shared with people’s community pharmacy through the “Discharge Medication Service” (DMS). The DMS is an NHS collaborative communication scheme which aims to improve medicine related outcomes and reduce readmission for patients on discharge from hospital.

However, pharmacist support was stretched due to vacancies. Whilst most patients on medical wards had their medicines reconciled as an inpatient, only 40% of them had their medicines reconciled within 24 hours of being admitted in line with national guidance to reduce the risk of medicine related errors. Leaders told us they were aware of the issue and had put forward a business case for increased resources for the admissions team and worked to fill vacancies. They also told us they expected vacancies to be reduced in the summer 2025 when new trainee pharmacists qualified.

Medicines “to-take-away” (TTAs) were supplied in a timely manner. Leaders tracked the performance of the service, and they generally supplied TTAs in line with the trust target of 2 hours.

Venous thromboembolism (VTE) assessments were generally completed in line with national guidance. The service used electronic systems to remind clinicians to complete and review VTE assessments and prescribing where appropriate.

Medicines for people on discharge were supplied in a timely way and the service worked well to identify areas that could be improved. The pharmacy regularly met the trust target for the timely supply of discharge medicines to medical wards.

There were examples of initiatives to improve medicine optimisation for people. For example, one initiative demonstrated improvements in de-labelling inappropriate allergy statuses of patients. This tested whether people were truly allergic to recorded allergies of antibiotics and allowed safer use of antibiotics.

Staff we spoke with told us they knew how to access relevant local medicines policies, procedures, and guidelines.

Effective

Rating Requires improvement

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

We looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

We rated effective as requires improvement. We assessed 4 quality statements. Staff were not always able to provide care and treatment in line with evidence-based practice or to achieve good outcomes. Not all staff had a good understanding of consent and capacity. Staff did not always work together in the hospital to share information when assessing people's needs to maintain continuity of care. However, staff worked well with external partners to support discharge and community care.

Delivering evidence-based care and treatment

Score

2. Evidence shows some shortfalls in the standard of care

The service planned care in line with national guidelines and legislation. Clinical guidelines were readily available, and staff told us they were widely used, especially during the night when consultants and senior decision makers were on call. This ensured resident doctors could provide safe care. Pathways we reviewed were based on good practice and national guidance.

However, care delivery was not always in line with evidence-based practice. The stroke service did not deliver good quality care to patients in line with national standards and best practice. In March 2025, the Sentinel Stroke National Audit Programme (SSNAP) had notified the trust that again it had been classified as an outlier for 30-day stroke mortality rate.

The stroke service was a part of the Acute and Emergency Medicine Care Group and was managed directly by the Service Manager for Eldercare and Stroke and the Consultant Specialty Lead for Stroke. Performance was monitored monthly through the Stroke Improvement Board, Chaired by the Director of Nursing, Midwifery and Allied Health Professionals. The Trust Board received a monthly update from the Stroke Improvement Board within the Integrated Performance Report. A Royal College of Physicians peer review was scheduled and pre-review documentation had been submitted.

There was a trust wide approach to improving dementia and delirium care, with an action plan developed in line with national recommendations, guidance and the National Audit of Dementia outcomes, insights gained from patient safety incidents and incident themes. This was overseen by a clinical lead and progress was monitored through the annual dementia and delirium report and quarterly Dementia and Delirium Action Group meetings.

In most patient records we reviewed, care was recorded in line with guidance, however in 4 records, care provided was not documented in line with guidance, for example not recording fluid balance when intravenous (IV) fluids were administered, and no record of family or next of kin involvement in discussions about future care planning and do not attempt cardiopulmonary resuscitation (DNACPR).

Most patients reported their pain was managed well.

How staff, teams and services work together

Score

2. Evidence shows some shortfalls in the standard of care

Staff and patients shared mixed experiences about how staff spoke with and about each other.

Some teams worked together well to deliver the best care they could to patients, but we heard some examples of challenged relationships and poor handovers including between doctors and nurses and between services.

Within teams, staff worked well together to make sure patients received regular review, continuity of care and ongoing oversight. There were daily medical and nursing handovers. Staff supported each other across grades and roles and had effective systems to prioritise patient reviews and urgent assessments, with clear escalation routes that staff felt comfortable following.

However, communication and handover processes between wards did not always work well.

Poor handovers between wards and departments resulted in harm to patients, including patients in temporary escalation spaces. For example, a patient was admitted to Kerensa ward following a fall at home. The patient had a falls risk, but this information was not communicated in the handover and so staff were unaware. Patient was sat in a temporary escalation space. The patient had a witnessed fall by staff and passed away due to a bleed on the brain.

Lack of adequate communication and clear processes in the handover process between wards resulted in direct harm to a patient.

Pharmacy support was available on the wards by request, and some services had a direct telephone line to them. Staff reported they did not always utilise this because they did not have time to call.

We heard examples from staff on medical wards who worked well with other services in the community to support discharge, for example the homelessness team, acute carer at home team and using virtual wards to provide support in the community when a patient no longer needed inpatient care.

Virtual wards were consultant led and were multidisciplinary. They could make direct referrals to primary, community and social care services to enhance care and support out of hospital.

Multidisciplinary team (MDT) huddles and meetings took place to discuss and agree management plans for patients with complex needs, and different specialities and clinicians

were included where appropriate. We reviewed 5 patients' records and spoke with the patients and their clinical teams to understand their journey throughout the care system. 5 out of 5 records showed clear and comprehensive handover between teams and clear communication throughout MDT working. For example, for a patient with a broken leg, there was a joint approach from the medical and orthopaedic surgeons in caring for the elderly patient. Early occupational therapy and physiotherapy input was sought and received to aid recovery and discharge.

Discharge coordinators were in inpatient areas and supported planning discharges, family liaison and working with community, social and charity sector services. Planning started early in a patient's journey and included relevant referrals to occupational therapy and safeguarding services. When young adults were admitted with mental health needs, staff reported working well with safeguarding and child and adolescent mental health services (CAMHS). Patients who regularly attended were discussed at the longest stay and discharge meetings, and staff worked collaboratively with specialties and other teams to make appropriate referrals before discharge.

There was positive working with the chaplaincy service. Once a patient was referred to the chaplaincy service, staff completed an assessment and if required they were seen each day of their stay in hospital.

Monitoring and improving outcomes

Score

2. Evidence shows some shortfalls in the standard of care

Care and treatment were not always provided in line with current evidence-based guidance, standards and best practice; patients on the stroke pathway did not consistently experience positive outcomes.

The stroke service did not deliver good quality care to patients in line with national standards and best practice and had faced challenges since 2021. Due to demand for beds across the hospital, there were issues ringfencing beds for stroke patients on the stroke ward. In March

2025, the Sentinel Stroke National Audit Programme (SSNAP) notified the trust that it had been again classified as an outlier for 30-day stroke mortality rate. The trust had historically been notified that it was an outlier for this rate in 2018, and in 2024 for the 2021-2023 period.

Stroke patients were not always assessed by Allied Health Professionals in good time. Data in March 2025 showed for stroke patients 50% of patients received a dysphasia assessment, 48% of patients received an occupational therapy assessment and 45% received a physio-therapy assessment within 72 hours, which was not in line with recommendations.

Leaders had made changes to the medical model to increase the hours senior decision makers and stroke specialists were available. As a result, the rate of patients reviewed by a stroke specialist within 14 hours of arrival had increased from 57.8% in February 2025 to 69% in March 2025 and early results of 89.5% in April, aiming for the trust target of 85%.

During 2024-2025, the trust participated in national clinical audits. These included Society for Acute Medicine Benchmarking Audit (SAMBA) and National Heart Failure Audit. The trust also carried out 82 local audits within Acute and Emergency Medicine and Specialist Services and Surgery. The majority of the audit findings confirmed good practice however a number also identified areas for improvement. For example, a local audit about 'Improving driving advice provided to cardiology patients' resulted in refreshing staff knowledge around patients need to contact the relevant government agency following cardiovascular events and the SAMBA made recommendations to improve access and capacity to same day services.

The annual dementia and delirium care improvement plan was informed by national recommendations, audits and local incident thematic reviews. It was monitored quarterly, and an annual report was produced which showed better outcomes for patients with dementia were being achieved. Examples included reduction in prescribed medications which enhance delirium, reduction in out of hours transfers and updated training and awareness for staff in assessment, treatment and management of delirium.

Local nursing and care audits were completed monthly and most areas achieved above the 75% target in the AEM care group. The data was at care group level, so we could not determine that medical wards were meeting the required standards of care.

Consent to care and treatment

Score

2. Evidence shows some shortfalls in the standard of care

Staff had a mixed understanding of consent and capacity assessments.

Not all records we reviewed were completed appropriately and there were examples across multiple wards where consent, capacity and best interest decisions were not recorded in line with the relevant legislation. For example, on AMU we reviewed a patient record where covert medication was administered and records did not show appropriate legislation had been considered. 2 out of 5 do not attempt cardiopulmonary resuscitation forms (DNACPR) reflected appropriate decision making had not been documented, and families were not involved in the decision making.

Recording next of kin details for patients varied, and there were examples where patient records had conflicting information. For example, where next of kin details were recorded on a patient record, but DNACPR decisions were not discussed with family, or DNACPR forms stated there was no next of kin, when their details were elsewhere in the patient record.

However, in other examples records showed appropriate conversations with patients and their families had happened, including about DNAPCR and consent to care and treatment.

Staff we spoke with gave mixed examples of their understanding of capacity and consent. For example, we spoke with staff about the records of a patient with a cognitive impairment about their incomplete Deprivation of Liberty Safeguards (DoLS) care plan. Some staff we spoke with were not aware of DoLS and could not explain them, but other staff could explain the principals of consent and actions they would take if a patient did not consent to treatment.

Audits on MCA and DoLS had not taken place for the 6 months prior to our visit due to staff absence. The trust confirmed the audits would be restarted by 6 June 2025, however there was no system to check staff applied their training around capacity and consent and that patients received appropriate information when decisions were made.

Staff received mandatory training in the MCA 2005 and compliance was 77.6% across all staff

groups which met the trust target of 75% but below the standard of 90%. The Safeguarding Adults Level 2 syllabus also covered MCA and (DoLS) which 88.7% of staff had completed, which also met the trust target.

Caring

Rating Good

At our last assessment, we rated this key question as good. At this assessment the rating has stayed good. We assessed three quality statements: kindness, compassion and dignity, responding to people's immediate needs, and workforce wellbeing and enablement.

The provider was in breach of legal regulations in relation to dignity and respect.

People were treated kindly and felt safe and supported However, patient dignity was not always protected across wards.

The service did not always respond to people's immediate needs.

Staff felt supported by immediate managers, but did not feel engaged with the organisation and staffing issues negatively affected some staff member's physical health.

Kindness, compassion and dignity

Score

3. Evidence shows a good standard of care

Several patients told us nursing staff were compassionate and advocated for patients. Patients described staff in Roskear ward as "amazing" and staff in Same Day Medical Assessment unit (SDMA) as "fantastic." From the most recent Friends and Family Test, between 1 January and 31 March 2025, 98.6% of the 733 respondents rated their care as very good or good.

There was compassionate support for end-of-life patients. The service used the "butterfly scheme" in wards: specially trained volunteers offered comfort and companionship to dying

patients. The chaplaincy service also supported the wards and liaised with the palliative care team to provide support for patients with a terminal diagnosis. The service worked with the patient and the patient's family to transfer the patient to their preferred location of death, ensuring all care needs were met throughout the process. There was a reserved courtyard in the hospital with a garden for patients to spend their final moments. Staff members treated this reserved courtyard with respect and solemnity.

However, dignity was inconsistently protected across wards. In Tintagel ward, staff told us it was difficult to provide good care and preserve patients' dignity in escalation spaces as there were no curtains. In AMU, there were no curtains for patients in boarding beds. In the 2024 Patient-Led Assessments of the Care Environment (PLACE) Area Scores, patients rated the privacy in AMU2 at 76.4%. However, in Wellington ward, staff had access to portable screens to protect patient privacy if needed. Across the Acute and Emergency Medicine wards overall, the average privacy rating was 71.6%. During our inspection we did not observe any incidents of patients' dignity not being maintained.

There was evidence the service did not protect the privacy of service users. The trust reported 27 mixed sex breaches from October 2024 – March 2025. 24 mixed sex breaches were in the Coronary Care Unit, 1 in the Same Day Medical Assessment Unit (SDMA) and 2 were in Wellington ward. However, there had been no mixed sex breaches in SDMA and Wellington ward since December 2024. Staff told us mixed sex breaches occurred in the discharge lounge when a patient on a trolley or a bariatric (a patient with a high body mass index) patient was brought down to the discharge lounge. Staff were aware of mechanisms to report same sex breaches. RCHT had a Same Sex Policy, reviewed in February 2024, which outlined the organisation's commitment to maintaining patients' privacy and dignity. There were robust reporting arrangements and monitoring mechanisms. There was clear decision-making guidance for staff and justification of breaches. The same sex policy had not been reviewed recently.

There was record of one incident demonstrating patient information was not treated as confidential: a patient was sent home with another patient's notes and medical directives. However, we were assured this was an isolated incident and the trust investigated with steps taken to learn.

Responding to people’s immediate needs

Score

2. Evidence shows some shortfalls in the standard of care

Patients in SDMA had to travel the full length of a public corridor to AMU to use shower facilities due to the lack of shower in SDMA, delaying immediate needs.

There was a lack of appropriate safety equipment across the wards. There were multiple incidents where admitted patients did not have access to call bells. For example, additional beds had been placed in bays on AMU to increase ward capacity. These beds were not in a designated bedspace. There were no call bells for patients to request help from staff. One patient told us, "I just wave at the staff if I need anything". In Pheonix ward, there was a chair placed in the temporary escalation space (TES), however the space did not have a call bell or curtains. The chair also blocked an exit.

Records did not reflect that immediate needs were consistently addressed. Staff responded to people’s immediate needs when in pain, however, there were inconsistent records of pain medication given across patients’ paper and electronic records. Additionally, patient records in AMU showed inconsistency in completing nursing assessments. Staff aimed to complete initial nursing assessments within 24 hours, however following the first 24 hours, nursing assessments were not consistently completed across wards and care planning was incomplete. For example, a medical patient’s record in St Mawes ward reflected they had only been reviewed for VTE once, and there had been no further assessment in the following 5 days. In Pheonix Ward, we reviewed a patient’s records and found gaps in the written record with the Malnutrition Universal Screening Tool (MUST) and National Early Warning Score (NEWS2) score outstanding. The MUST tool is used to identify a patient’s nutritional status and the NEWS2 score is a standardised system to assess the patient’s risk of deterioration.

Across wards, there were different structured clinical models that allowed staff to work across multi-disciplinary teams to meet patients’ immediate needs. There were clear lines of escalation in the service. Staff we spoke with knew the process for contacting the critical care outreach team and other departments when a patient became critically unwell.

However, there was concern that staff treating medical outliers would not be able to respond to people's immediate needs. Due to the presence of medical outliers on non-medical wards, staff in St Mawes ward (surgical) told us they felt "out of their depth" treating medical patients.

There were initiatives to upskill staff to increase staff availability to respond to people's immediate needs. For example, specialist stroke nurses conducted swallow assessments and were trained to insert nasogastric (NG) tubes to increase the response time of providing medications, fluids, and nutrition for patients suffering from a stroke.

It was clear that patients' wishes were considered in conversations. We found several examples in records of clinicians speaking with the patient and their family to discuss the patient's wishes and plan the immediate next steps. Four out of 5 patients we spoke with told us their wishes were considered.

Patients told us they were consistently provided food and drink. Lunch was served from a hot trolley, and we saw staff check each patient had food. We received mixed feedback from patients on the quality of the food, however the Patient-Led Assessments of the Care Environment (PLACE) scores of the inpatient food were 88.95%, demonstrating patient satisfaction with the food and drink provided.

The environment in the wards was mostly equipped to meet the immediate needs of patients living with dementia and with a learning disability. The PLACE scores for the inpatient wards for people with disabilities was 76% and for people with dementia was 80.6%. 'This is Me' booklets were used to support communication and medical plans with patients with dementia.

Workforce wellbeing and enablement

Score

2. Evidence shows some shortfalls in the standard of care

Staffing shortages and organisational challenges affected staff wellbeing and team morale. In Karensa Ward, staff positively encourage each other to take lunch breaks and offer coverage. However, in the Medical Day Unit (MDU), staff told us they were frequently unable to take

breaks and would take lunch around 5pm. Staffing issues affected workload and stress across teams. Staff told us their physical health suffered because of short staffing. In the March 2025 staff pulse survey, only 74% of staff reported that they feel a strong personal attachment to their team, below the trust target of 90%. Although overall staff sickness absence was 4.6%, the lowest since May 2024, staff stress-related absence rates had increased by over 2% from 25.9% in February 2025 to 28% in March 2025. The trust attributed increased staff stress to the increase in communication to staff regarding the trust's financial challenges.

However, staff told us they felt valued by their teams, their matron, and head of nursing. Staff felt comfortable escalating concerns and initiatives for improvement to their manager. Staff told us that the ward leaders were strong advocates for staff.

The trust had a dedicated wellbeing team currently focused on changing the wellbeing strategy to improve working conditions for staff. The trust sought to create a positive working environment through building emotional resilience and addressing current challenges. In February 2025, the trust received the Gold Defence Employer Recognition Scheme for the organisation's role in promoting and supporting their employees in the Armed Forces.

Although managers and leaders tried to foster a culture of psychological safety and equality when delivering compassionate care, there were mixed results in the Workforce Race Equality Standard (WRES) Survey 2024. [AH1] For example, in AEM (excluding Emergency Department), 53% of white staff believed that there were equal opportunities for career progression / promotion compared to 48% of staff from ethnic minority groups. In SSS, 52% of white staff believed there were equal opportunities for career progression / promotion compared to 58% of staff from ethnic minority groups. Twelve percent of white staff in AEM (excluding Emergency Department) and 8% of white staff in SSS in the last 12 months personally experienced discrimination from any of the following: manager / team leader or other colleagues. However, 30% of staff from ethnic minority groups in AEM (excluding Emergency Department) and 23% of staff from ethnic minority groups in SSS reported experiencing discrimination from manager, team leader or colleagues.

As part of the wellbeing strategy, emotional wellbeing and resilience training was provided to management staff and leadership. Additionally, Trauma Risk Management (TRiM) training was available for staff to support their emotional wellbeing when dealing with traumatic events. Across the Trust, there were 82 TRiM practitioners with plans to increase the volume through

additional training. There was a dedicated inbox for colleagues to request support from TRiM practitioners.

There was clear support for staff professional development from service leadership. Staff told us they had appraisals every 6 months. However, in the March 2025 staff survey, only 77.6% of eligible staff had completed their appraisal, below the trust target of 90%.

The chaplaincy service provided emotional support to staff when needed, offering spiritual comfort and a physical space. There were mechanisms for staff to contact a chaplain for staff support. Staff spoke positively of the chaplaincy providing support to wards after a member of staff had passed away.

Responsive

Rating Requires improvement

At our last inspection we rated this key question requires improvement. At this inspection the rating remained the same.

We looked for evidence that the service met people's needs.

We assessed 3 quality statements on equity in access. Flow challenges and staffing issues meant people did not always receive timely access to care. People did not always feel listened to and they received conflicting information. The trust had awareness of their populations needs and worked with partners to address health inequalities, and patients with dementia and learning disabilities had access to support and resources.

Person-centred care

Score

2. Evidence shows some shortfalls in the standard of care

The physical and mental needs of patients were not always considered when developing care plans. Four out of 5 patients' records we reviewed had clearly documented patient and family

involvement at all sets with the patients' needs considered. However, patients told us they did not always feel listened to by staff. Nursing staff advocated for patients and complaints from Acute and Emergency Medicine (AEM) and Specialist Services and Surgery (SSS) patients highlighted that patients similarly did not always feel listened to by staff members when they raised concerns.

The service had resources to support the care needs of patients with dementia and learning disabilities and worked towards ensuring that its workforce had the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability. The service commenced its roll-out of the required Oliver McGowan Mandatory Training on Learning Disability and Autism (Tier 2) in March 2023, and demonstrated commitment by recruiting and training its own experts and facilitating trainers to build their Oliver McGowan team. At the time of our inspection, 21.3% of all staff had completed this training. NHS England has recognised that it may take up to 3 years for large employers to fully roll out this programme.

The service provided support boxes to patients living with dementia and learning disabilities to alleviate the stress of the experience. "This is Me" booklets were available for patients living with dementia and hospital passports were available for patients with a learning disability. Although it was unclear that these communication booklets were used to inform care decisions. For example, there was a "This is Me" booklet within a medical patient's record in St Mawes ward. However, it was placed at the back and staff felt it was not used to influence communication with the patient.

Protected characteristics under the Equality Act were identified and considered in patient records. Appropriate steps were taken for patients with MCA and DoLs. DoLs applications were present, and the patient's support network was involved in discussing the patient's best interests in the care plan.

Following the Healthwatch April 2024 report and the Family and Friends Test results, the service worked to provide tailored mental health support for armed forces members and veterans.

Staff and the trust supported patients and their families when experiencing a distressing diagnosis. The service ensured there were care plans and volunteers were available to support family members.

Staff used online translation services and the trust's language line when communicating with patients who did not speak English. For example, a patient living with dementia who did not speak English was unsettled and refused to eat or drink. Staff used online translation services to help the patient feel comfortable.

The service was mindful to minimise unnecessary patient transfers and used visual mechanisms to discourage transfers. If a patient had been moved 3 times or more, the patient's identifier would be purple in the ward.

The service tailored the patient discharge to each patient. Discharge coordinators worked with each patient to explore all applicable resources such as the homelessness team or the virtual ward to coordinate a safe discharge.

Providing information

Score

3. Evidence shows a good standard of care

The trust used online translation and language line to communicate with patients who do not speak English including British Sign Language.

The trust's website provided clear and accessible information for patients and their families on what to expect throughout the patient journey in the medical care service. There was information about visiting hours and important information to know for each ward, including ward telephone number and matron name, on the trust's website.

There was clear information on the trust's website on expected waiting times for first outpatient appointment, diagnostic waiting times, and referral to treatment waiting times. Each wait time list was broken down by specialty and showed how frequently the page was last reviewed by the trust, providing transparent and up-to-date information for patients.

There was clear signage for patients in the medical ward on how to provide feedback to the service. The signage included information about the steps the service takes after receiving

feedback.

Discharge letters were sent electronically to GPs and other specialists if needed.

However, there was mixed evidence that the service supplied up to date information for people using the medical care services. We spoke with one patient who stated staff had updated them on test results in an accessible and timely manner. However, another patient's relatives told us that they had not been updated on their care. Another patient stated that they had been told differing information by different members of their MDT. A total of 76 complaints were received between October 2024 and March 2025 for medical services. Lack of communication and conflicting information were among the top complaint topics.

Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

The service was aware of the population's health inequalities and worked with partners to address the population needs. The trust's quality assurance committee met with the Cornwall Partnership NHS Foundation Trust and reviewed information from partners, including Healthwatch, to shape the trust's health inequalities agenda.

There were accessible toilets in the main corridor of the medical care services. These toilets had automated voice recordings to provide directions on the layout for patients with visual impairments.

There were processes to move patients to their appropriately allocated wards. However, because of flow challenges across the hospital, patients were not able to access services in a timely way. For example, There were high rates of delayed discharges due to a high volume of medical outliers in wards, short staffing of specialty doctors on weekends, and short staffing of occupational therapists and physiotherapists in the Early Supported Discharge (ESD) team. The high rate of delayed discharges had a knock-on effect, directly impacting ED admission rates.

Short staffing impeded discharge flow and patient care progress. Staff told us it was difficult to find a specialty doctor to review a patient on the weekend and to make an agreement to discharge medical outlier patients at the weekend. Additionally, the staffing levels of Occupational Therapists, Physiotherapists, and social workers on the ESD team for stroke patients were below operational need due to the volume of referrals in Cornwall and the Isles of Scilly. The trust was completing a capacity and demand exercise to inform a case for further expansion of this team.

To address these discharge challenges, the trust employed discharge coordinators. The discharge coordinator attended board rounds and liaised with transportation and community services to ensure patients were appropriately supported during discharge.

The trust collected patient feedback to improve the patient pathway. The AMU used two iPads to collect patient and family feedback prior to discharge to improve the patient experience. Responses were reviewed and discussed at ward meetings.

The trust had also made significant improvements to waiting lists for trust-wide services and the cancer treatment pathway. Patients waiting over 65 weeks for access to services trust wide improved from 1,603 in January 2023 to 16 in March 2025.

The trust's March 2025 IPR report showed that the trust's combined 28 day performance and combined 62-day performance in cancer diagnosis and treatment exceeded the national targets. The trust's combined 31-day performance of 89.8% sat just below the England average of 91.8%. The trust was developing an improvement plan to address these rates as part of the 2025/26 operational planning.

Well-led

Rating Requires improvement

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

We looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

The provider was in breach of legal regulations in relation to good governance systems and processes.

Acute services

Medical care (Including older people's care)

We rated well-led as requires improvement. We assessed 6 quality statements on leadership and governance. The service did not always understand the challenges and needs of people. Leaders did not always have the skills and knowledge, experience and credibility to lead the service. The department was prepared for emergencies and major incidents and worked with other partners and community organisations to plan care for their communities.

However, governance and risk management systems and freedom to speak up arrangements were not always robust to improve how the service could deliver safe and good quality care and treatment.

Shared direction and culture

Score

2. Evidence shows some shortfalls in the standard of care

The trust had a strategy which included the vision and values for the hospital. The overarching vision for 2022-2032 was to achieve outstanding care for one and all by 2032, and the strategic objectives included supported and valued people, safe high quality care and a journey of improvement over the first 3 to 5 years of the plan. There were priorities and a delivery plan aligned with the vision and objectives.

Senior leaders in the trust were aware of areas that needed improving, and the trust was introducing a new Clinical Vision for Flow which had been developed with input from clinical teams during a workshop in March 2025. The model outlined ambitions for future patient flow and set clear goals for improving patient outcomes, including: reduced preventable mortality, "home first" (increasing the number of people discharged back to their home), reduction in higher level harm events increased number of patients seeing a consultant on same day as being admitted, reduced outliers, being an 'active hospital' and increased patient awareness (every patient to have a "what matters to you" conversation record). The Clinical Vision for Flow outlined specific actions for services to take.

Due to changes to the health and social care landscape, there were trust-wide plans to refresh the strategy in Summer 2025, to ensure it reflected the needs of the local population and aligned with national and local policy and longer-term legislative and national plans.

Staff were given opportunities to engage in the development of the service strategy across the trust, with over 50 departments and 580 staff involved in feeding back on proposals. However, we did not hear staff talk about being involved from medical wards.

Some staff told us there was a clear focus in the organisation on the value of structured processes, clear guidelines and established protocols for example in managing care pathways and prescribing antibiotics. However, we heard from other staff they did not feel listened to by leadership or asked about ideas for improvements, and there was a focus on improving flow in the emergency department, forgetting about patients on the wards.

Staff also did not feel they were able to directly contribute to organisational and service decision-making. For example, due to recent significant ward changes, several staff told us they felt let down by the lack of communication regarding this direct change from leadership. As a result of staff not feeling they could directly contribute to decision-making, there was a lack of staff sense of belonging to the organisation. In the 2024 staff survey, the percentage of staff who would recommend the organisation as a place to work was 51%, below the trust's target of 55% and below the previous year. Additionally, in the March 2025 staff friends and family survey, only 58% of staff would recommend the trust as a place to receive care, below the trust's standard of 65%.

Capable, compassionate and inclusive leaders

Score

2. Evidence shows some shortfalls in the standard of care

The leadership team was made up of senior nurses, medical staff and general managers who lead services across the urgent and emergency and medical care wards and departments.

The leadership team were working hard under significant pressure to address the challenges faced by medical care services. The trust had mechanisms to support future and succession planning.

There was a strong, committed and capable leadership team who had the skills, experience and

knowledge to lead the service effectively and with credibility. They were open, honest and willing to learn and improve. However, we were concerned that the wellbeing of the triumvirate leadership team was not prioritised, given the number of significant changes they were delivering, at pace.

There was a disconnect between other leadership teams in the trust, and leaders told us decisions were often operationally driven, rather than clinically led. Staff also felt changes had been operationally led and their clinical judgement was not always listened to. For example, one staff member had told managers they had been unable to accept any more patients onto their ward and did not feel it was safe, but this had not been listened to, and they had been sent an additional patient.

However, there were some gaps in governance leadership roles which impacted on the service's ability to identify learning and improvements. Some specialities in both AEM and SSS care groups had gaps in their governance structures and had not had governance leads for some time. Due to these gaps, and operational pressures some governance structures were not working well.

Staff told us they felt supported by managers and had opportunities for development. Service and care group level leaders and managers were visible and approachable. Leaders of the service were knowledgeable about the issues and priorities of the service and worked for change and improvement when needed. They recognised where the service needed to be improved and were working to make improvements. They focused on staff wellbeing and ensured a culture promoting good practice, good quality and aspired to provide safe care and treatment.

As part of the trust leadership and management training, managers completed modules in emotional resilience and wellbeing to support them to be compassionate leaders.

Staff had mixed views about leaders. On 3 wards, staff spoke highly of nurse leaders, and told us they were approachable, visible and supported staff who escalated concerns. However, on one ward there were mixed opinions on the service leadership, and staff told us they knew the leadership team and felt some leaders were approachable, but some were not.

Medical and nursing leaders of the board did regular walkarounds. This allowed staff to raise

concerns directly, improve their understanding of services and ensure they remained visible to staff. However, some staff were unclear about the leadership structures above the care group leaders and told us they did not know who the executive team were.

There were trust wide mechanisms to attract young talent to careers in the hospital. In January 25 the trust held a 'discovery day' event to provide information and advice to young people considering a career in health and social care. More than 300 young people considering a career in health and care attended to explore the work of various departments in the hospital.

Freedom to speak up

Score

2. Evidence shows some shortfalls in the standard of care

Staff knew about the Freedom to Speak Up (FTSU) arrangements in the organisation and details were displayed in some wards we visited.

Staff surveys showed staff did not always feel secure raising concerns, this had declined from 2024 to 2025.

In the 2024 staff survey over 70% of staff in the care group that included medical care said they would feel secure raising concerns about unsafe clinical practice. However, the trust reported from the March 2025 staff pulse survey, only 59.6% of staff responded that they felt secure raising concerns or speaking up. This had declined from the staff survey position.

We heard that concerns raised by staff did not always result in improvement or action.

Staff told us they had escalated concerns regarding patient safety and needs but they did not always feel they were listened to or action was taken even when it resulted in harm to patients. Staff had escalated concerns about using temporary escalation spaces and the surge policy but did not feel listened to. Staff told us they felt under pressure to take patients even when it wasn't appropriate or safe. Additionally, staff pushed for patients with dementia to remain in the same ward for consistency of environment. However, staff told us they were frequently

overridden by leadership, causing distress to the patient.

Ward leaders in some areas told us they escalated concerns to senior leaders and the executive team but had seen no changes.

However, some staff told us they were comfortable speaking up and there was a good culture of feeling heard. Staff in some areas of medical care spoke about doing reflection when things went wrong on the ward.

Governance, management and sustainability

Score

2. Evidence shows some shortfalls in the standard of care

Risks were not always reviewed and updated in a timely way, and the risk register showed a number of risks where patient care may be compromised, often there were capacity and resource challenges across medical care. Of the 54 risks on the register, 22 were overdue for review, with the oldest date in October 2023, and 7 other risks were due for review in the 4 weeks before our assessment. Extreme risks related to major trauma staffing and higher than target mortality for stroke patients, and there were 34 risks rated as high, relating to stroke pathways, staffing challenges, environment and equipment and pathway delays in referral to treatment for various pathways, including cancer care. Half of the risks categorised as patient safety were past their review date, including oldest date in October 2023. They were all moderate or high risks, and workforce capacity, or failure to maintain safe staffing was a common description in the areas concerned. It was unclear from the risk register how often risk entries were updated, because dates were not always used to update the controls.

Service leaders were aware of the risks and performance issues, and monitored them closely to make improvements, for example within the stroke service and delayed discharges.

Changes to the trust medical model had improved performance in some areas of the stroke pathway, by increasing the hours that senior decision makers were available and in March and April 2025 performance was improving. However, in April 2025, the improvement plan had

some areas off track for delivery, including the financial support required, and “significant cost pressures remain to address recognised staffing shortfalls”.

The Stroke Improvement Board met monthly, chaired by the Director of Nursing, Midwifery and Allied Health Professionals to review progress against a service improvement plan. The Integrated Care Board (ICB) were supporting the trust to improve and had a system-wide external peer review planned in April 2025.

Delayed discharges remained above the trust target; the trust reported 96 delayed discharges in March 2025, which was worse than the target of 42. Although there was a system wide priority to move to a discharge to assess model in 2025/26, we did not see plans or actions taken to make improvements in this area.

Actions were taken to address action plans, but we did not always see evidence that actions turned into outcomes. For example, for 3 wards the service was responding to FFT responses with action plans to address concerns. However, there was no evidence of the outcome and if the actions had been successful.

Ward leaders had the knowledge and skills to provide clinical leadership. However, senior ward leaders told us decision making around the use of surge spaces had been taken out of their control. We heard examples of ward leaders refusing patients because they were not appropriate for an escalation space being overruled or that patients were moved after these staff members left the shift.

There was a governance meeting structure for each care group. Meetings were held weekly, attended by the ward leaders and a governance lead to discuss and escalate issues. They fed into a monthly care group business and governance board, attended by senior leaders and supported by human resources (HR) and finance.

However, due to gaps in governance leadership and operational pressures some governance structures were not working well. There were no governance leads in cardiology or respiratory, and meeting minutes reflected that actions in those areas were not always progressed in a timely way. For example, in February 2025 there was an action to benchmark the AEM care group against other hospitals, but no progress had been made.

Additionally, some morbidity and mortality reviews and oversight group meetings had not

taken place in the appropriate time frames, which meant case reviews, action plans and shared learning were not agreed and disseminated, and speciality specific and structured reviews were not taking place in a timely way. Meetings minutes showed 5 specialties had not held meetings in the last quarter. Mitigating the overarching risk, mortality was reviewed trust-wide and any specific condition with excess deaths prompted a detailed clinical review..

Audits were carried out to provide assurance about the quality and safety of care provided. Most care audits met the trust target of 75%, however they were carried out across care groups, so we did not receive assurance that medical wards were meeting this target. We also found there were delays to mental capacity act (MCA) and Deprivation of Liberty Safeguard (DoLS) audits due to capacity challenges.

Leaders were aware of key areas of risk to be addressed. They had introduced a new Clinical Vision for Flow in 2025 which was developed with input from clinical teams to improve flow in the service and patient outcomes. It was early in the implementation phase to see improvements, but this evidenced action was being taken to address long term issues with flow in the hospital.

The trust had plans to ensure business continuity to enact in unexpected circumstances including fuel disruption, severe weather, heatwaves and other emergencies.

Partnerships and communities

Score

3. Evidence shows a good standard of care

Staff worked with partners to enable services to work well for patients. For example, staff in the AMU explored all resources to support discharge, including the homelessness teams and acute carer at home.

There were virtual wards so patients could receive acute care in the community, to support recovery and discharge as an alternative to hospital admission. Clear escalation processes were embedded and once care and treatment had been completed with the virtual ward, staff could

make referrals to primary, community or social care to ensure relevant support for patients when discharged.

The trust took part in a 'perfect week' over Easter 2025 where providers in the system were testing and learning new ways of dealing with the increased demand seen at peak holiday times from tourists. Learning points were identified and allocated to each relevant provider to action, and the hospital took part in the process. Areas included in the work were community issues, risks, and care pathways. There was a log of key learning points to be actioned.

There was also an integrated pressure ulcer prevention improvement plan and through joint working, a reduction had been seen across both organisations in pressure ulcers resulting in harm. As part of these plans the trusts were considering moving towards delivering integrated tissue viability team as well as falls, given the lack of skilled staff within these specialties. There was an integrated falls prevention improvement plan with another local trust as part of a system wide priority to reduce falls and make improvements. The trust was engaged in delivering the plan.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

The service encouraged improvement and innovation, and there were examples of quality improvement (QI) initiatives that were mapped to the clinical vision of the care group and areas for improvement that had been identified and improving patient outcomes.

For example, the trust was introducing a new "Clinical Vision for Flow" in 2025 which outlined their ambitions for future patient flow and set clear goals for improving patient outcomes and specific actions to take to make service improvements.

In SSS care group, to help address overdue patient care and treatment assessments, teams had created "live overdue dashboards" on their electronic monitoring system to flag any overdue assessments at handover times to improve handovers. We were told this had reduced overdue

assessments and improvements had been made in care planning as a result.

The service shared learning and best practice with partners. We reviewed a report which outlined the last 12 months, and it highlighted internal and external engagement to share learning. They held an annual QI conference where acute, community and third sector partners came together to learn and demonstrate commitment to supporting improvement and national initiatives.

The SSS care group were promoting an open learning culture and held virtual shared learning events to discuss learning and improvements with staff. Past topics included: end-of-life care, falls, debriefs of patients and staff experience and pressure ulcers. A nutritional steering group also identified and made improvements to how key areas of care in nutrition and hydration were recorded, and changes were communicated to staff, including learning from the audit, which prompted improvements.

Staff told us there was clear support for staff to learn, and innovate in their professional development, with departmental teaching weekly and educational support available. They were encouraged to do QI projects. The trust ran a preceptorship programme for newly qualified professionals as a multi-disciplinary team programme. Staff completing this programme gave positive feedback of learning with colleagues. Staff were encouraged to participate in a quality improvement project in their preceptorship.

Urgent and emergency services

Urgent and emergency services

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

Our view of the service

On Tuesday 8 and Wednesday 9 April 2025 CQC carried out an assessment at Royal Cornwall Hospital. This assessment was part of our System Pressures Programme where we inspected Medical Care and Urgent and Emergency Care (UEC) services. We last inspected UEC in May 2024 when we rated UEC as Requires Improvement. At this assessment the ratings stayed the same. At this site visit, there had been some improvement against the areas of concern found at the previous inspection.

We assessed 24 quality statements across the safe, effective, caring, responsive and well-led key questions. We have combined the scores for these areas with scores from the last assessment to give the rating.

We found three breaches of regulation where care and treatment was not always provided in a safe and timely way in line with clinical guidance. Patients were not always admitted from the emergency department to a ward bed in a timely manner. Consultant cover was not in line with national guidance. Mandatory and specialist training compliance was below the trust target. There were not effective processes for the management of risks within the department. However, appraisal compliance for staff

and ambulance handover delays had improved.

There was crowding in the department with patients staying for extended periods in the department awaiting a ward placement. This included extended periods in environments that were not intended for patient care. This was due to the emergency department being full and patients who needed admission or specialty review being managed in waiting rooms and temporary escalation areas.

The trust and local ambulance provider had implemented Timely Handover Process (THP90) which was in operation between 08:00am and 6:00pm. The ambulance staff stayed with the patients during this time and were released at 90 minutes. However, staff told us that this had been poorly implemented.

There were concerns with the safe management and storage of medicines in the department. The crowded nature of the department meant that escalation areas were in use. The use of escalation areas, did not offer privacy and dignity. Governance systems were in place but not always effective.

However, staff followed infection, prevention and control procedures when carrying out their work. The service carried out regular audits, including monitoring against the emergency care standards. Staff worked in a strong culture of evidence-based practice. We observed staff offering compassionate care to patients and patients we spoke with were positive about the care they received. Most staff were positive about where they worked, and leaders were sighted on the risks to the workforce and the support required. However, we were concerned about the wellbeing of leaders delivering multiple changes at pace.

We spoke with 17 patients and 2 relatives/carers. We reviewed 8 adult patient records and 5 records of children and young people. We spoke with more than 40 staff which included: consultants, resident doctors, nurses, senior leaders, healthcare assistants, administration staff, pharmacists, housekeeping staff, occupational therapist and a student nurse.

We have asked the provider for an action plan in response to the concerns found at this assessment.

People's experience of the service

Most patients, families and carers we spoke with were positive about the staff, who treated them with warmth and kindness. The majority of patients said communication with them was good and they

were kept informed of their care and treatment. Patients said they were seen quickly when they arrived and were asked appropriate questions to find out more about why they had attended the ED. Records we reviewed showed they were given the tests they needed usually promptly. Although care was being delivered in temporary escalation areas, we observed staff interacting with patients in these areas and staff apologised to patients for delays.

There were really good examples of the ED team using MDT working to treat patients' comprehensive needs which included using the learning disability team and the homeless patient advisor to obtain the background history of a patient history. There were examples of joined up care within the trust, however the discharge process and discharge planning was lacking especially for 1 out of 5 of the patients we spoke to.

Safe

Rating Requires improvement 

At our last assessment we rated this key question good. At this assessment the rating has changed to requires improvement. We assessed 8 quality statements.

We looked for evidence that people were protected from abuse and avoidable harm.

The service was in breach of legal regulation Safe care and treatment and staffing. Care and treatment was not always provided in a timely way in line with clinical guidance. Patients were not always admitted from the emergency department to a ward bed in a timely manner. Consultant cover was not in line with national guidance. Mandatory and specialist training compliance was below the trust target. Risk assessments including National Early Warning scores 2 were not always completed in line with trust policy. Medicines were not always managed safely and staff did not always follow trust policy in relation to the disposal of controlled drugs.

There was a positive learning safety culture where events were investigated, and learning was shared and embedded to promote good practice. Staff we spoke with were open and honest when things went wrong, and they had the opportunity to learn and gain experience. Patients and staff were encouraged and supported to raise concerns they felt confident that they would be treated with compassion and understanding. The environment was safe and well maintained. Staff maintained high standards of infection prevention and control.

Learning culture

Score

3. Evidence shows a good standard of care

Patients told us they were happy to raise concerns with staff and that they were confident they would be listened to.

Staff told us they felt there was a strong and positive safety culture where staff were open and honest. In the 2024 NHS Staff Survey, 63% staff working in the Emergency Department (ED) said they felt safe to speak up about anything that concerned them in the organisation. This was slightly above the England average.

The trust was an early adopter of the NHS England's Patient Safety Incident Response Framework (PSIRF). The trust focused on effective learning and compassionate, meaningful engagement with those affected when incidents occurred.

Staff at all levels had a good understanding of how to use incident reporting systems and what to report. Data showed between 1 October 2024 and 31 March 2025, a total of 2789 incidents were reported. The vast majority of the incidents reported (81%) resulted in no apparent injury or minor injury requiring first aid. The top three themes for incidents reported were in relation to: Pressure ulcer (65% of the total reported were reporting concerns on admission), slips, trips and falls and relating to discharge.

The service had an up-to-date Patient Safety Incident Response Framework (PSIRF) policy and a Patient Safety Incident Response Plan, which set out how the service sought to learn from patient safety incidents reported by staff, patients, their families and carers. Leaders analysed incident reports and took urgent actions to manage or remove risks.

There was a culture of safety and learning. Safety events were analysed, investigated, thoroughly, and lessons were learned to continually identify and embed good practices. For example, fall huddles had been implemented in response to a theme of patient falls.

Learning had been taken and shared with staff following incidents within the department.

Learning responses resulting from patient safety events demonstrated a good level of family and patient involvement in the investigation of patient safety events. Families and patients were given the opportunity to ask questions as part of the investigation. Patients and their families received copies of the final report.

The trust had processes and policies to foster a learning culture. Senior staff met regularly, and evidence showed staff feedback was documented and taken forward with teams for learning.

Leaders could articulate the themes and trends of incidents, the action they had taken to address these, and the methods used for feeding back to staff.

There were several ways that learning was shared across both the service and trust wide. These included safety alerts encrypted electronic messages, safety huddles, handovers and newsletters. There was a central log of National Patient Safety Alerts, which were shared with staff and actioned as appropriate.

The service used the learning from complaints and concerns as an opportunity for improvement. Senior members of staff and leaders were involved in reviewing complaints and incidents. For example, a leader within the ED told us that there had been a complaint relating to a patient not receiving adequate pain relief. In response this was communicated to staff at handover and safety huddles that all observations should also include a pain score. Patient records confirmed this was happening.

Data showed between October 2024 and March 2025 there were 28 complaints received. The top three themes relating to complaints were communication, clinical treatment and admission and discharge.

The service had a duty of candour policy, which set out staff roles and responsibilities regarding openness, honesty and transparency if something went wrong with a patient's care or treatment. We saw learning responses which confirmed that duty of candour was completed appropriately.

Safe systems, pathways and transitions

Score

2. Evidence shows some shortfalls in the standard of care

Staff worked hard to establish and maintain safe systems of care in challenging circumstances. However, staff told us they were concerned systems and processes meant they were not always able to provide safe patient care. Crowding and the use of temporary escalation areas were identified as ongoing issues.

Most patients reported a joined-up approach to providing care and treatment that involved them and their relatives. Patients told us the initial assessment of their symptoms had been timely, and treatment initiated where needed. Patients using the temporary escalation area told us they were fully informed, understood their treatment plan.

Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Data showed that between January 2025 and March 2025 the average time a patient spent in the department was nearly 6 hours against the target of 4 hours.

Patients often spent longer than necessary in the department prior to being moved to a specialty ward. During our assessment on the 8 April at 9:15 am there were 58 patients in the department. The longest wait for a patient requiring a ward bed was 18 hours, there were 16 patients who had waited longer than 12 hours for a bed and a total of 29 patients waiting for a bed.

Data showed that between January 2025 and March 2025 the average time a patient spent waiting for admission to a ward was 5 hours 36 minutes.Data indicated in the last 12 months the hospital performed consistently worse than the England average for all patients waiting more than 12 hours from arrival to admission. The latest data available (March 2025) indicated 15% of all patients waited more than 12 hours from arrival to admission, compared to the England average of 10%.

Despite some specialities such as medical care being based in the department, patients

requiring review by a specialty service still experienced delays due to the workload elsewhere in the hospital.

At previous assessments we found ambulance crews were held at the hospital looking after patients due to the lack of beds in the emergency department. This meant ambulances were unable to get to people in the community that required their services. However, the trust and local ambulance provider had implemented Timely Handover Process (THP90) which was in place between 08:00am and 6:00pm. The ambulance staff stayed with the patients for 90 minutes, then were released and clinical responsibility for these patients was taken over by the hospital. Data showed there had been a significant reduction in ambulance delays (over 60 minutes). However, staff told us whilst THP90 worked well between 08:00am and 6:00pm significant delays could build again overnight.

Staff told us that there was no clinical engagement with THP90 and that the pace of implementation alongside other operational changes had created additional stress for staff particularly in the morning.

During the assessment we identified a theme in the quality of handovers which had affected patient safety. The trust took action to address these issues. Actions included implementing new measures to protect critical nursing time and ensure robust communication. The practice of completing the paper handover form and transferring the patient will stop and instead timely escalation and direct communication between clinical teams will occur.

There was a doctor and trained triage nurses based within the triage area who assessed and directed patients, depending on their acuity, to an appropriate clinical pathway or department. Patients could be streamed to the medical and surgical same day emergency care (SDEC) departments or Minor Injuries Unit. Children and young people were directed to the Children's ED.

The service had 24-hour access to mental health liaison and specialist mental health support for adults. There was a good working relationship with the local mental health liaison teams. There was a 4 hour target for patients requiring psychological assessment by the mental health liaison team. Data showed between January 2025 and March 2025 this was achieved on average 78% of the time.

The ED had a clear pathway for supporting people with mental health needs. During triage, nurses complete the Mental Health risk assessment, patient records we reviewed confirmed this was completed.

The Child and Adolescent Mental Health Services (CAMHS) was available 24-hours a day. Staff said they were generally responsive although there could be delays out of hours. CAMHS could refer children and young people to Multi Action RapidResponse Service (MARRS) which is a joint health and social care crisis response service for children and young people with acute mental health difficulties in Cornwall. MARRS aims to foster a health and social care culture which focusses away from each service providing care in silos and towards meeting the needs of the child.

The trust did not have an observation and engagement policy. However, staff were guided by enhanced care planning guidance. The mental health liaison service did have an observation policy and staff supported staff within the emergency department with risk assessments and care plans.

There was a twice daily nursing safety huddle where staff allocation was facilitated by the nurse in charge. Key messages were also discussed and included safety alerts, learning from patient safety events, staffing, waiting times compliance, safety checks and safeguarding.

Safeguarding

Score

3. Evidence shows a good standard of care

Patients were protected from abuse. The majority of staff had training on how to recognise and report abuse, and they knew how to apply it. Data showed that compliance with safeguarding training modules was more of less in line with the trust target (90%) for all staff groups with the exception of level 3 children safeguarding training.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm. Staff understood how to protect children, young people and their families from abuse

and the service worked well with other agencies such as police and local authority safeguarding teams, to protect them.

Staff we spoke with were aware of how to raise a safeguarding referral and knew who the safeguarding lead in the department was. The service had a safeguarding team that staff could readily access. Staff were able to tell us when they recently completed referrals.

The service worked with people and healthcare partners to understand what being safe meant to them and the best way to achieve that. Patients we spoke with told us they felt safe and that if they had any concerns or issues, they would feel comfortable to tell someone.

Staff had access to safeguarding policies, which referenced appropriate legislation and best practice guidance. Flags (identifiers) were applied to the electronic record systems to identify patients who were at risk. Safeguarding information was displayed throughout the department.

Staff had good knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and best interests decisions. The mental health trust delivered a training session on the MCA and DoLS staff told us that they found the training really helpful.

Involving people to manage risks

Score

2. Evidence shows some shortfalls in the standard of care

Some people attending the department experienced long waits and were therefore at risk of deteriorating. In March 2025, 15% of patients were waiting over 12 hours.

The department had effective processes and tools for assessing patients when they first presented. Staff used a national triage tool to triage patients. Patients with were triaged to the appropriate services. Generally most patients were quickly and accurately assessed to determine the urgency of their condition and staff prioritised care based on their need. Patients we spoke with told us their wait for triage had been timely. Data showed just over 90%

compliance with triage training.

The trust used the National Early Warning Score (NEWS 2) to assess patients at risk of deterioration in the department and enable staff to take appropriate action. In the paediatric department the Paediatric Early Warning Score (PEWS) was being rolled out at the end of April 2025. Staff were clear how to escalate patients that needed clinical review. Records we reviewed showed that staff completed the observations and scores as required by the protocol and properly escalated for review where they needed to. Audits were completed which showed variable compliance with NEWS 2. For example, there was 100% compliance in March 2025, for NEWS 2 being calculated on admission to the department but only 87.5% of patients had subsequent physical observations taken in line with their NEWS 2 score.

Most patients told us that they were informed of why they were being moved between areas in the department and waiting times had been communicated.

Leaders and staff could articulate what risk assessments they used to keep patients safe. However, only 67% of in house security staff had completed the annual refresher training in least restrictive restraint. Actions were being taken to address compliance for the 6 non-compliant staff members (33%). Restrictive restraint was only used as a last resort and was monitored by leaders.

Patients told us they felt safe and supported whilst they were in the ED. They could approach staff if they felt their health was deteriorating and they were confident staff would respond to their concerns.

The trust recognised friends, and family could often see a patient's deterioration before anyone else does. Therefore, trust had a programme which enabled friends, relatives and patients themselves to make a direct referral to the critical care outreach team if they felt the clinical condition of an adult or child in-patient was actively deteriorating. There were posters and written information informing all patients and visitors of the programme.

Staff used an ED patient safety checklist outlining the clinical tasks and risk assessments needed for each patient. Data showed that in March 2025 only 79% of patients had all their risk assessments and nursing documentation completed. In addition, in March 2025 only 76% of patients had SSKIN bundle assessment completed. The SSKIN bundle is a bedside tool to help

staff monitor skin concerns and reduce the risks of developing a pressure ulcer. This meant there was a risk that patients may not always have their immediate needs met to minimise any discomfort or manage risks.

The service undertook audits of patients being cared for in temporary escalation areas to ensure their clinical needs could be met. Data showed an average of 90% compliance with these audits for the last 6 months. Following our assessment, we identified a concern regarding patients being care for in the temporary escalation areas. In response to this the number and frequency of these audits was increased.

Staff we spoke with described the processes to assess and identify patients at risk and how they assessed and documented mental capacity. Alerts on the electronic record systems enabled staff to be aware of specific risks. Staff attended a thorough shift handover where risks were communicated.

Partners, such as psychiatric liaison reported they worked well with department staff. Several members of staff commented on the fantastic support the psychiatric liaison provided, working cohesively to ensure the patient was kept at the centre.

Safe environments

Score

2. Evidence shows some shortfalls in the standard of care

Although patients experienced long waits in ambulances and waiting rooms, patients told us they were well looked after by staff.

The equipment and facilities, in the main, supported the delivery of safe care. When the department was crowded patients were held in areas not designed for long waits where there were no shower facilities available and patients did not have call bells. However, we observed staff seated in the temporary escalation area so could directly observe patients.

We identified other issues relating to equipment and facilities. These included a faulty lock on a

cupboard containing substances subject to The Control of Substances Hazardous to Health Regulation. We raised this issue with the senior leadership team following and our assessment and have seen evidence which confirmed the faulty lock was fixed the following day.

Planned preventive maintenance and electrical appliance tests were completed and recorded centrally. All electrical equipment we checked had undergone electrical safety checks within the last 12 months.

The department's fire safety equipment and emergency systems such as call bells, were tested and maintained appropriately. Fire exits were not blocked, evacuation routes were signposted. Environmental risks assessments were completed.

The department had a modern resuscitation area (built 2020). It had 6 bays 2 of which could be used for isolation and 1 was dedicated to care for children and young people. The resuscitation department had a full set of equipment for treating children and late-stage pregnant women. Each bay was large enough to easily allow for a multi-professional team to care for and treat the patient and have access to a vast range of equipment and facilities.

There was a separate area for children and their families which was safe and secure and there were toys to keep children occupied.

At our previous inspection we found the mental health assessment room which was due for updating as it did not conform to the guidance of the Psychiatric Liaison Accreditation Network (PLAN). At this assessment we found the room had been updated and now had Psychiatric Liaison Accreditation Network (PLAN) accreditation.

At the ambulance entrance, a red and green light system was in operation. If the light was green, the paramedics were able to immediately bring the patient into the department for assessment. If it was red, they needed to liaise with the team, or their hospital ambulance liaison officer (HALO) before bringing the patient through about next steps. An ambulance bay for critical patients was kept free directly outside the entrance.

In the Care Quality Commission's 2024 national patient survey the results for the hospital Urgent and Emergency Care environment and facilities was similar to other trusts.

Safe and effective staffing

Score

2. Evidence shows some shortfalls in the standard of care

There were not always enough skilled and experienced staff in the department.

There was not always the required numbers of children's nurses on each shift. According to the current establishment for paediatric nurses there were no vacancies, however some paediatric nurses had been seconded into other roles outside the Children's ED leaving a shortfall.

The lack of children's nurses was mitigated by other staff with children's nursing competencies. Data showed that between 31 December 2024 and 14 April 2025, 23% of shifts did not have two paediatric trained nurses and 9% of shifts did not have an adult nurse with paediatric competencies. All staff working in the children's ED were triage trained and updated with requirements of paediatric triage. Staff told us that the paediatric ED was short staffed at times for senior paediatric nurses and medical staff.

The consultant cover did not meet the recommendations of the Royal College of Emergency Medicine. Consultant cover was between 8am and 11pm and then on call, national guidance states consultant cover should be between 8am and midnight then on call. Additionally, the department was some distance away from the Children's ward meaning that support from the wards would take time to arrive. Consultant staffing levels were significantly lower on weekends compared to weekdays, with only 3 consultants on shift between 10am and 11pm. This was a known risk and was included on the department's risk register with a risk score of extreme, however it was unclear what mitigations were in place to reduce the risk.

The service currently had about 12 full-time consultants. Based on the current staffing establishment data showed a vacancy rate of less than 1% for all grades of medical staff, the highest vacancy rate (6%) was amongst middle grade doctors, this was still below the trust target of 10%. Data showed that nearly 13% of resident doctor shifts were covered by bank additional duty hours and nearly 25% of middle grade doctors shifts were covered by bank, additional duty hours or agency shifts. This indicates that the current staffing establishment for resident and middle grade doctors was less than it needed to be.

Data showed an overall vacancy rate of just over 10% for all staff. The vacancy rate for registered nurses was 14% just over the trust target and 6% for Health Care Assistants. The unfilled shift rate for doctors in ED for the past 3 months was nearly 3%. However, the trust advised this figure did not include consultants as their rotas were annualised so difficult to determine what was unfilled. This meant the trust did not know the number of consultant shifts that were unfilled. The average unfilled shift rate for nurses over the last 3 months was 6%.

The most recent data showed an overall staff sickness rate of 3.61% for all staff which was slightly better than the trust target of 3.75%. The highest sickness rate (4%) was for nursing staff which was slightly worse than the trust target.

There had been a significant effort in recruitment and upskilling of nurses. Administration staff vacancies and nursing shortages was included on the departmental risk register. However, it was unclear how the risks were being mitigated. This meant the trust could not be assured all reasonable actions were being taken to address risks.

There were robust and safe recruitment practices to make sure that all staff, including agency staff and volunteers, were suitably experienced, competent, and able to carry out their role. There was a suite of policies relating to safe recruitment and all new starters received a comprehensive induction.

The service used bank staff when necessary and regular agency staff, and ensured they were familiar with local systems and processes. Data showed between January 2025 and March 2025 the, 7% of all nursing shifts were filled by agency staff.

Staff appraisals were not always completed, the latest appraisal compliance was 77%. This was an improvement since the last inspection when compliance was at 65.6%, however, this still did not reach the trust's own internal appraisal target (90%). A performance appraisal can have many benefits such as to identify individual learning needs, identify continuing development needs of employees and as a tool to identify progression opportunities.

Staff did not always complete mandatory training appropriate and relevant to their role. Overall compliance for all staff was 84% which was less than the trust target (90%).

Data provided to us by the trust showed that 85% of doctors had up to date Advanced Life Support training, 56% of doctors had up to date Advanced Trauma Support Training. Fifty two

percent doctors had up to date Advanced Paediatric Life Support Training. Eighty one percent of nurses had Advanced Paediatric Life Support Training. The trust confirmed that the 2 nurses who had not completed the training were booked on the course. The compliance was below the trust target in all modules. All staff working in the Children's ED had completed paediatric life support training.

Not all staff received training on sepsis screening and management. Data showed 90% of nursing staff had completed sepsis training but only 58% of medical staff had completed the training. This had implications for missed opportunities for screening and delays in care. However, during our assessment we found sepsis screening and treatment was undertaken in line with national guidance.

The resuscitation unit had resuscitation practitioners who were dedicated to working solely in the unit, developing and maintaining a unique set of clinical skills related to trauma care

There was a positive culture around nursing education, classes and learning opportunities. We were told there was a culture of supporting staff to develop and progress.

Medical staff were supported by named supervisors. Resident doctors had protected time for teaching. Feedback from resident doctors was positive.

During the assessment, the department was busy with more patients being cared for than the department was built for. This put inevitable pressure on staff. There were nursing staff assigned to temporary escalation areas to ensure patients in this area were monitored and cared for. There was also a nurse allocated to the ambulatory decision lounge where up to four patients could be waiting and being treated so they were not left unattended.

During our assessment we observed that nursing and medical staff worked well under pressure. There was a culture of working together as a team to manage the numbers of patients in the department. We observed staff having positive interactions with patients, despite the capacity demands and patient flow. Senior staff supported junior staff, and all staff worked in collaboration with each other. For example, we saw a consultant undertaking informal teaching with resident doctors.

Infection prevention and control

Score

3. Evidence shows a good standard of care

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. Issues with defective equipment and cleanliness had been resolved since our previous inspection. The cleaning schedule set out by the service was followed. Disposable curtains labelled with the date they were last changed. Cleaning records were up to date and demonstrated all areas and equipment were cleaned regularly. Clinical waste was disposed of safely.

The service assessed and managed the risk of infection. They detected and controlled the risk of it spreading and shared concerns with appropriate agencies promptly. Staff followed infection prevention and control (IPC) guidance. Data showed that compliance with level 1 IPC training exceeded the trust target for all staff groups. However, overall compliance with level 2 IPC training was only 75% which was less than the trust target.

We observed staff maintained standards of hygiene and cleanliness. Staff washed hands in line with infection control policies and adhered to the uniform policy. We observed staff complied with 'bare arms below the elbows' policy, in accordance with National Institute for Health and Care Excellence (NICE) guidance. Personal protective equipment and handwashing facilities were mostly available. However, in the Children's ED there was not a handwashing sink. Since our assessment the trust has supplied information confirming a handwashing sink will be installed.

The service had an effective approach to assessing and managing the risk of infection, which was in line with current relevant national guidance. An IPC policy set out key information for staff to support maintaining infection, prevention and control standards. Hand hygiene, local cleaning and infection prevention and control audits were undertaken by the service. For example, between January and March 2025 hand hygiene audits showed 90% compliance.

Domestic staff were visible within the department. We observed both clinical staff and the cleaning staff diligently cleaning equipment and the environment.

Isolations rooms were designated as part of the resuscitation area of the department and a large tent was available outside of the service for any incidents requiring decontamination.

Medicines optimisation

Score

2. Evidence shows some shortfalls in the standard of care

Staff did not always store and manage medicines securely or safely. Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. However, within these areas a few of the medicine's cupboards were broken. The trust had since provided evidence which confirmed the locks have been repaired.

Medicines that had a revised expiry date once opened generally lacked, either the date of opening or the revised expiry date.

The department held To Take Out (TTO) packs. These packs were pre-labelled with standardised information including directions. However, the completeness of the pre-labelling was variable.

Whilst controlled drugs were stored securely, and records kept the trust's procedure for disposing of small volumes of part-doses was not being followed.

Concern was raised by staff in paediatric ED about the work surface they had to use when preparing medicines. It was not located in a secure clinical area and was at child height. Which meant there was a risk that if medicines were not closely monitored during preparation, for example if staff were called away to respond to an emergency, children may be able to access the medicines. This was on the department's risk register, and we saw quotes for the required changes to the environment had been obtained.

Piped medical gases were available in the emergency department. Following a national safety alert the trust had reviewed the accessibility of piped medical air. At the time of the inspection, staff were reviewing the equipment requiring piped medical air and were fitting caps to the

piped medical air outlet in areas where anaesthetic machines were unlikely to be used.

Emergency medicines and equipment were available. There were tamper evident seals in place to ensure they were safe. Staff recorded weekly safety checks on emergency medicines and equipment to ensure they were safe to use if needed in an emergency. All expiry dates checked were in date.

During triage medicine for pain relief and other symptoms were prescribed by doctors or administered by nurses via homely remedies procedures or patient group directions (PGDs). PGDs were also available for the initial treatment of suspected sepsis by the nurses.

We reviewed the e-prescribing and medicines administration records for 5 patients. These indicated medicines were administered in a timely manner.

The trust had contributed to the Royal College of Emergency Medicines (RCEM) 'Time Critical Medicines' quality improvement project work relating to time critical medicines in Emergency Departments. At the time of the inspection the pharmacy service to the emergency department had been reduced due to vacancies and was based on the medical assessment unit. The trust was reviewing clinical pharmacy staffing levels and seven day working to support hospital admissions via ED against the RCEM staffing recommendations.

Patients being discharged from ED requiring medicines in working hours would have a prescription dispensed by the on-site outpatient and ED pharmacy. Outside of working hours TTO packs were prepared by the ED nurses.

Staff described quality improvement work that had been undertaken to improve the adherence to prescribing guidelines for antibiotic and pain relief. Staff told us that not all medicines dispensed by the outpatient and ED pharmacy were collected by patients and work was being undertaken to reduce the frequency of uncollected medicines. Following a change of provider the turnaround time for the outpatient and ED pharmacy had improved.

Effective

Rating Good 

At our last assessment we rated this key question requires improvement. At this assessment the rating was changed to good. We assessed four quality statements.

Urgent and emergency services

We looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Staff comprehensively assessed people, so the care and treatment provided met their needs. This included both their mental and physical health and any personal circumstances that needed to be considered. Staff worked in a strong culture of evidence-based practice. Staff worked together and with others when assessing people's needs and shared information to maintain continuity of care. The service carried out regular audits, including monitoring against the emergency care standards.

Delivering evidence-based care and treatment

Score

3. Evidence shows a good standard of care

Staff used the trust's systems to follow the latest guidance and evidence-based practice. Staff used information given regularly in safety briefings and newsletters to implement new guidance or changes to existing procedures.

The service planned and delivered patient's care and treatment with them, including what was important and mattered to them. They did this in line with legislation and current evidence-based good practice and standards. Individual teams were assigned to the Royal College of Emergency Medicine (RCEM) 2025 Healthcare Quality Improvement Plan (QIP). QIPs are a structured approach to improving the quality of care delivered in an Emergency Department (ED). RCEM's QIPs focus on specific areas of emergency care, like mental health, care of older people, and time-critical medication.

The hospital scored similar to other trusts in the Urgent and Emergency Care Survey 2024, regarding questions such as availability of food and drinks and were patients involved enough with decisions relating to their care. The department offered patients food and drink. Patients told us that they had access to food and drink. We saw patients being supported with their dietary needs and also being assisted with drinks.

Systems were in place to ensure staff were up to date with evidence-based guidance and

legislation. Clinical records demonstrated care was provided in line with current guidance. For example, we reviewed the records of a patient who was pregnant. The Modified Early Obstetric Warning Score (MEOWS) in Detecting the Seriously ill and Deteriorating Woman Clinical Guideline was followed.

The trust audited practice against evidence based research. For example, between January and March 2025 nearly 90% of patients had intravenous (into a vein) antibiotics started within 1 hour for the management of sepsis in line with sepsis guidance. This was an improvement since our last assessment when in April 2024, when data showed 72% of patients who met the criteria received antibiotics within an hour. Sepsis is an extreme reaction to an infection.

How staff, teams and services work together

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always work well across teams and services to support people. They did not always share their assessment of people's needs when people moved between different services. There were not robust processes and dedicated time to support effective handover between clinical teams.

Due to operational pressures and challenges, informal processes had been developed and had become acceptable. This included staff completing the Situation, Background, Assessment, Recommendation, and Decision (SBARD) paper form prior to transferring a patient to another department without giving a verbal handover. SBARD is a structured communication framework used to facilitate clear and concise information sharing. We heard of instances where patients had come to harm because crucial safety information was not handed over between teams. We raised our concerns with the trust. This resulted in a rapid change to the handover processes which included additional time allocated for staff to complete handovers and the ceasing of the practice of not giving a verbal handover and arrangements to monitor compliance with the new process. Audits for April and May 2025 showed there was still variable compliance. For example, in April 2025, 96% had a nurse-to-nurse handover completed, 80% had a transfer form acceptably completed and 70% had a handover form signed and completed

by receiving nurse. In response to the audit results, the trust was taking further actions. For example, reinforcing the responsibility of the receiving nurse to complete the form and arranging refresher training for teams with recurrent non-compliance.

Staff did not always have access to the information they needed to appropriately assess, plan, and deliver care, treatment and support in line with people's individual needs. There were multiple IT systems used for accessing patient records, blood test results, and ordering other investigations. Clinical notes were paper based. This meant staff had to access several different systems to gather the information they needed, therefore, there was a risk that important information could be missed. Staff told us that it was time-consuming to use all the different systems. The trust was due to role out an electronic patient record system bringing all the different systems into one by the end of the year.

Care was not always coordinated well with different teams. Despite some specialities such as medical care being based in the department, patients requiring review by a specialty service still experienced delays due to the workload elsewhere in the hospital. Whilst specialty staff reviewed patients following referral, this regularly took longer than 30 minutes which delayed specialist care and slowed admission to a ward area. Between October 2024 and March 2025 the average time from referral to review by the acute medical team was over 20 hours. However, the trust told us that there may be data quality issues with the data provided.

The multidisciplinary team were all involved in assessing people's needs. We observed plans being made for a discharge from the emergency department. For example, joint planning between the mental health trust and staff working in the emergency department.

Staff were noticeably very busy in the department, but staff were positive about support and relationships in the department. We saw good multidisciplinary working which demonstrated mutual respect amongst staff.

Monitoring and improving outcomes

Score

3. Evidence shows a good standard of care

Staff told us treatment plans were evidence based and monitored for outcomes. The patient records we reviewed confirmed that care was evidence based. For example, we reviewed the records of a patient who attended who was having a heart attack. The records showed that care and treatment was in line with National Institute for Health and Care Excellence Guidance in the management of acute coronary (heart) syndromes.

Having senior decision makers working alongside triage trained nurses in the same location was an effective pathway. Senior decision-makers can quickly assess patients, initiate necessary tests, and start treatment earlier in the process, potentially preventing delays.

Patients care was reviewed and updated, and appropriate referral pathways were in place to make sure that needs are addressed. For example, there were specific pathways for patients who had sustained a broken hip or a heart attack. Data showed for March 2025, 100% of patients were started on the broken hip pathway.

The trust percentage of patients reattending the ED within 7 days of the original attendance was slightly worse than England percentage between January 2025 and March 2025.The percentage of patients leaving the department before treatment was completed was less than the than England percentages between January 2025 and March 2025.

Patients were supported to manage pain or discomfort during waiting times. Patients we spoke with reported they had received help to manage their pain. The Urgent and Emergency Care Survey 2024 showed that the response to ‘Do you think the hospital staff helped you to control your pain?’ was about the same comparing with other trusts. The trust pain audit for adults found good compliance with assessing pain at the time of triage, the latest data for March 2025 showed 100% compliance and just over 90% compliance with administering pain relief at the time of triage. However, only 43% of patients had their pain assessed hourly.

There was a full audit plan in place for the department with clear audit leads and timetable in place. Leaders could describe the outcomes of audit and actions taken in response to them.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

Patients understood their rights around consent to the care and treatment they were offered. Patients received information about care and treatment in a way they understood and had the appropriate support and time to make decisions.

Staff had access to the trust consent policy and understood the relevant consent and decision-making requirements of legislation and guidance. Staff knew who to contact for advice.

Staff had access to the mental health team 24 hours a day to support them and patients. We were told the team were responsive and supportive. We observed the mental health team in the department supporting patients and offering advice to staff and most people seen within an hour by a specialist clinician.

We observed staff gain consent from patients for their care and treatment in line with legislation and best practice guidance. Staff received training on the application of the Mental Capacity Act for staff who would need to assess patients to give consent.

Staff understood specific requirements of taking consent from children. They had received training and knew how to apply it, for example Gillick competence.

When patients did not have capacity to consent, staff made decisions in their best interests and documented them.

Caring

Rating Good

At our last assessment we rated this key question good. At this assessment the rating has remained good. We assessed 3 quality statements.

We looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

We observed staff offering compassionate care to patients. Most patients we spoke with told us they were treated with kindness and respect when receiving care. Patients told us they felt reassured by their care. Staff reported the workload still negatively impacted their wellbeing. Staff worked in a highly pressured environment. However, workforce wellbeing was recognised by the leadership team who were trying to develop initiatives to support the staff.

Most staff felt supported by their managers and colleagues due to a strong team culture. However, staff did not feel engaged or involved in operational decision making. Leaders were sighted on the risks to the workforce and the support required.

Maintaining patients' privacy and dignity in the department was challenging. The crowded nature of the department meant that escalation areas were in use. The use of the temporary escalation areas did compromise privacy and dignity. However, we did not observe incidents of privacy and dignity not being maintained.

Kindness, compassion and dignity

Score

3. Evidence shows a good standard of care

The department was crowded, patients were being held and looked after in one of the corridors of the department. We observed patients in the corridor being treated with compassion and kindness although it was difficult to be able to maintain privacy in conversations due to this being an open area. There were portable screens which could be used, and we observed staff taking patients to a private area for any tests or procedures to maintain their dignity.

Although privacy and dignity were difficult to maintain for patients receiving care and treatment in the corridor, the patients we spoke with did not voice any concerns and acknowledged the difficult circumstances staff were working in.

Staff and leaders acknowledged the difficulties in ensuring that dignified care was always upheld for patients in temporary escalation areas and acknowledged the time other patients waited for treatment.

Friends and family survey results from April 2024 indicated 85% had a very good or good experience and 9% had a poor or very poor experience. Performance was slightly better than at our last assessment.

Staff at all levels sought to accommodate patients' needs despite the challenges with over crowding. The IT systems allowed for transparency in patient needs and cultural preferences.

Staff were able to access interpretation services to communicate with patients.

Chaplaincy staff and facilities were available to support patients, carers, and staff in response to cultural, religious, or unexpected needs such as a death. There was a room available for private conversations.

The hospital had a rehabilitation and sensory garden for critically-ill patients. The Critical Care Healing Garden was located immediately below the Critical Care Unit. It has been filled with sensory plants, two outdoor hospital bed spaces, a rehabilitation bridge, and peaceful seating areas for families, carers and staff.

Patients said that staff listened and communicated with them appropriately, and in a way they could understand. Patients told us that they received kind and compassionate care. Patients described being as involved in their care as they wanted, and up to date with all plans.

Responding to people's immediate needs

Score

2. Evidence shows some shortfalls in the standard of care

There were delays in responding to people's individual needs. Data showed long waits in the department. Patients were offered meals three times a day. Hot food could be ordered from the main kitchen within the hospital. Staff offered hot drinks to patients and carers during the day. However, data showed in March 2025 only 76% of patients had been offered a drink within 2 hours of arrival which was the departments target.

The trust scored better than expected for the question on patients being told why they had to

wait with the ambulance crew. However, scores for patients being told how long they would wait to be examined or treated, and updated on how long their wait would be, were particularly low for the trust, as well as for England. The trust scored better than expected for patients saying they were told who to contact if they were worried about their condition after they left department.

The department had effective processes and tools for assessing patients when they first presented to the department. Staff used a nationally recognised tool to triage patients. Staff we spoke with knew the process for referral to emergency support, including mental health crisis teams.

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs. Staff gave patients and those close to them help, emotional support and advice when they needed it. The service undertook audits which monitored compliance with staff informing the patient's next of kin that they were in hospital. For example, the latest data available for March 2025 showed 93% compliance.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patient feedback posters and actions taken by the trust to act upon concerns were displayed in the department and waiting areas.

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment. Staff talked to patients in a way they could understand, using communication aids where necessary.

Staff introduced themselves and established a good rapport with patients. Staff across all professions demonstrated caring and attentive attitudes towards patients.

Workforce wellbeing and enablement

Score

2. Evidence shows some shortfalls in the standard of care

Staff told us they were unable to influence change and contribute to decision-making in the department which impacted them. There was a disconnect between the clinical teams and operational corporate decision making and staff felt a loss of autonomy and influence. Frontline staff delivering the service did not feel empowered to drive initiatives to improve quality and safety. Staff described the pressure they felt in the morning to move patients out of the department, and this had a negative impact on their wellbeing. Staff felt their voice was often unheard. This was reflected in the 2024 NHS staff survey results. Only 46% of Acute and Emergency Medicine (including ED) staff either agreed or strongly agreed that they were involved in deciding on changes introduced that affect their work area. This was worse than the trust average (50%).

The majority of staff told us that they felt supported and valued by their immediate line managers. However, in the 2024 NHS staff survey only 34% of Acute and Emergency Medicine (including ED) staff were either satisfied or very satisfied in relation to the extent of which the organisation valued their work. This was worse than the trust average (40%).

Leaders tried to foster a culture of promoting of equality, diversity and human rights to prioritiorise safe, high quality compassionate care. However, there was mixed results in the Workforce NHS Workforce Race Equality Standard (WRES) Survey 2024. For example, 56% of white staff (working in ED) believed that there are equal opportunities for career progression / promotion compared to 45% of ethnic minority groups. Twelve percentage of white staff in the last 12 months personally experienced discrimination from any of the following: Manager / team leader or other colleagues compared to 30% of ethnic minority groups.

Senior leaders voiced concerns relating to their wellbeing and having no time protected time. For example, meetings ran until late in the evening. Senior leaders told us that they were worried the current pace of change was not sustainable for staff wellbeing. Senior leaders worked hard to provide wellbeing support to staff. For example, they arranged a summer ball for staff.

Staff we spoke to valued the yearly session with their team members to undertake required training and attending the governance meeting in the afternoon.

The service supported staff with an induction programme when they joined the department including a period of supernumerary status and time to gain experience in different parts of the

department. There were opportunities to undertake training relevant to the emergency department as well as simulation training. There was a “train to retain” staff culture by supporting staff to develop. New staff were assigned a mentor for support and guidance. There were initiative ideas to support staff in training, wellbeing and development. For example, “Turbo Tuesday” which was a quick 10 minute teaching session open to all staff and Thursday Learning Club (TLC). Training sessions focused on relevant areas. For example, acute illness management, mental health and non invasive ventilation.

There was an inclusive organisational culture which enabled staff to have a sense of belonging. This was reflected in the Trust Strategy 2023-2032, which included “We Are Royal Cornwall Health Trust” Operational Development programme for 2024/25 as a key pillar. The review of Year 2 and next steps paper which was recently presented at sub board committees outlined progress to date. For example, the initial targets in leadership and values-based training had been met. However, phases focused on Equality, Diversity & Inclusion and Wellbeing have been delayed due to staff capacity challenges.

There were support mechanisms in place to support staff in the event of catastrophic events including a Trauma Risk Management (TRiM) debrief and the chaplaincy team. Sixty six clinical staff trust wide had completed TRiM training staff were encouraged to complete a TRiM referral for any potentially traumatic event. TRiM is a trauma-focused peer support system

Leaders were aware of the demands of the department and staff wellbeing. The majority of staff told us that although they were very busy, they could take their breaks.

Responsive

Rating Requires improvement 

At our last assessment we rated this key question requires improvement. The service was in breach of legal regulation safe care and treatment due to crowding and waits in the emergency department. At this assessment the rating has remained the same. We assessed 3 quality statements

We looked for evidence that the service met patient’s needs.

Staff tried to provide equity in access to care and treatment. However consistent with our previous assessment, we found patients who attended the emergency department who needed admitting as an inpatient, experienced long waiting times in the department.

Due to challenges with flow in the hospital patients did not always have access to care and treatment in the emergency department when they needed it.

Patients continued to wait long periods for admission. There were examples of long stays in the department whilst patients waited for an appropriate place of care. This included extended waits in environments that not designed for patient care.

Staff were committed to making reasonable adjustments where required and listened to people's concerns to improve the service. However, this was not always possible due to overcrowding in the department.

However, the service generally delivered person centred care. Patients were involved in decisions about their care. The service provided information people could understand. Patients knew how to give feedback and were confident the service took it seriously and acted on it.

Person-centred care

Score

2. Evidence shows some shortfalls in the standard of care

The majority of patients we spoke with told us that they felt they were at the centre of their care and treatment. Patients felt involved in planning and making shared decisions about their care and treatment. In the UEC Survey 2024, in relation to the question, were you involved as much as you wanted to be in the decisions about your care and treatment', the hospital scored similar to other trusts.

Patients told us they had had an appropriate assessment of their health needs and they were consulted about their treatment plan. Patients were very understanding of the pressures faced by the staff. Patients told us they had their tests completed and treatment plan explained to them, and they were satisfied with the standard of care.

Staff generally considered patients individuals needs and preferences. They did not always complete risk assessments to identify specific needs such as nutrition, hydration, and pressure

ulcers. Staff we spoke with were aware of the need to undertake risk assessments, how to undertake them and who to contact for support. However, staff said due to the operational challenges they did not always have time to complete them.

Patients were provided with food, blankets, pressure relieving equipment and additional pillows.

Specific patients' needs were flagged on the electronic systems. For example, there was a specific tag for patients living with dementia. Patients living with dementia were often placed near the nursing station to enable good oversight of their needs.

Staff were committed to trying to make reasonable adjustments to help patients access services. However, due to overcrowding this was not always possible. The department had access to translation services. There was a multi-faith room on-site for staff and patients with a chaplain team available to visit bedside upon request.

We saw positive interactions between staff and patients with complex needs to ensure they remained settled in the department. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to try and meet all their needs. Staff told us that resources were available for patients living with dementia including a twiddle sleeve provided by volunteers. There were also link workers available to provide additional support and advice to staff for supporting patients with learning and mental health difficulties.

The department had hearing loops for people with a hearing impairment. A hearing loop delivers the sound from a sound source such as a microphone, direct to a user's hearing aids.

The environment of the Children's ED was child-friendly including a variety of toys available. There was not a dedicated play specialist within the Children's ED. Staff could request support from play specialists from the Children's ward if required. Staff had undergone training in distraction techniques to minimise stress and anxiety in children. Staff working in the Children's ED had access to "Don't Forget The Bubbles" (DFTB) an online educational resource for paediatric medicine, particularly emergency medicine. It's a platform created to share knowledge and insights related to caring for children, aiming to improve patient care and support the learning of healthcare professionals.

The trust had Butterfly Companion Volunteers Offering companionship to patients at the end of life. The team was recruited and trained with support from, a national charity.

Patients were encouraged to use a hospital passport which helped inform hospital staff about the needs of the person with a learning disability and how to support them. Staff told us they had used them previously and were familiar with their use.

Providing information

Score

3. Evidence shows a good standard of care

The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

There was information available on what to expect and the process within the emergency department. There were posters and leaflets written to advise patients. Leaders had written an information sheet to advise those patients were residing in temporary escalation areas to apologise that a room was not available on a ward, why this happened and how patients should expect to be treated.

The service provided real time waiting information for patients arriving in the ED Digital displays reporting wait times were available to patients who had not yet been treated and regularly updated. In addition, the trust's website clearly displayed current wait times at the 10 minor injury units within Cornwall.

Patients could expect information to be tailored to individual needs. This included making reasonable adjustments for disabled people and interpreting and translation.

The trust's IT systems did not link up with system partners such as 111 so information could not be shared easily. However, the emergency department's IT system did link with the minor injury units so information could be shared easily if a patient was redirected to one of the minor injury units.

The Urgent and Emergency Care Survey 2024 showed the trust scored similar to other trusts for questions relating to the time they spent waiting and being involved in their care.

The majority of patients we spoke with considered they had received enough information about their condition, care and next steps.

Patients were informed as to how to access their care records. The patient had Patient secure online portal (secure website) which allowed access to all hospital outpatient appointment information in one place, by using a smartphone, tablet, or computer. Patients could rebook, or cancel hospital appointments online and access supporting information, including appointment letters.

There was a variety of information available in relation to health care, either displayed publicly on walls or screens or as part of leaflets and other materials. Information was provided in different languages and large print if required.

Discharge letters were sent electronically to GPs and other professionals if required (for example community nursing). Patient paper records were stored securely.

Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always provide care in a timely way. The whole hospital as well as the emergency department was exceptionally busy as had been the case for many years. Data showed that between January 2025 and March 2025 the average time a patient spent waiting for admission to a ward was 5 hours 36 minutes.Data indicated in the last 12 months the hospital performed consistently worse than the England average for all patients waiting more than 12 hours from arrival to admission. The latest data available (February 2025) indicated 12.6% of all patients waited more than 12 hours in the department.

Leaders and staff acknowledged that people could not always access support and treatment in

a timely manner due to patient flow and capacity issues.

The emergency department was worse than the regional and national average for patients waiting less than 4 hours from arrival to admission, discharge or transfer. Data showed between October 2024 and March 2025 on average 46% of patients had a decision to admit, discharge or transfer within 4 hours of arrival. Performance had improved since the rate of 39% in October 2024. Between January 2025 and March 2025, the average time a patient spent in the department was nearly 6 hours against the standard of 4 hours.

Staff told us long delays in these areas were common. During our assessment on the 8 April at 9:15 am there were 58 patients in the department. The longest wait for a patient requiring a ward bed was 18 hours, there were 16 patients who had waited longer than 12 hours for a bed and a total of 29 patients waiting for a bed.

Lack of beds available to admit patients impacted on ambulance handover times as additional patients were in the department. Data showed between January and March 2025 on average ambulance handover took more than 1.5 hours which was more than the national target of 1 hour. The trust and local ambulance provider had implemented Timely Handover Process (THP90) to address this.

The national standard is that patients should have their first initial assessment within 15 minutes of arrival. Data showed variable compliance with this standard. Between January 2025 and March 2025 this standard was met on average 70% of the time.

The service had policies and procedures for escalation and care of patients in temporary escalation areas to mitigate the main risks from crowding. The hospital had processes to monitor performance and quality against national targets and standards.

There was a constant focus by staff on the issues with crowding and capacity pressures in the department. We were told by all those staff we met that the pressure they were under and how this affected their ability to provide safe and quality care was a constant worry. There was recognition and support from the wider health and social care community who understood the pressures and the need to respond as a system. At the time of our assessment the trust was participating in a system wide “Perfect Fortnight” in the run up to Easter which ran between 7 and 17 April 2025. The trust had 5 pledges to reduce pressure on the department when there

was an increase in the number of visitors to Cornwall. There was a “wash up” exercise completed for feedback and key learning points followed by a debrief.

The department was fully accessible to patients with disabilities or who used a wheelchair.

Well-led

Rating Requires improvement

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. We assessed six quality statements. We looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

There was not a clear system of risk management based around delivering safe and good quality care and treatment.

There was an inclusive and positive culture of continuous learning and improvement. Leaders were capable, compassionate and inclusive and supported their staff in challenging and stressful times. There was a strong desire to meet the needs of the whole population and to provide safe, integrated person-centred care. However, we had concerns regarding the fragility and sustainability of those leading the service to deliver the significant changes at the current pace.

Leaders felt they did not have the autonomy to lead and make decisions about changes that impacted their services. Staff told us they were unable to influence change and contribute to decision-making in the department which impacted them. There was a disconnect between the clinical teams and operational corporate decision making and staff felt a loss of autonomy and influence.

Most staff were aware of the freedom to speak up service and were confident in raising concerns. The service worked in partnership with stakeholders and communities.

Shared direction and culture

Score

2. Evidence shows some shortfalls in the standard of care

The trust board approved the trust strategy in November 2022 for 2022-2032. The strategy described their overarching vision as a Trust of Outstanding Care for One and All, and this was underpinned by 3 key strategic objectives: Safe, High-Quality Care, Supported and Valued People and Journey of Improvement. The trust had recently undertaken a refresh of the strategy to provide an opportunity to ensure the strategic priorities continue to reflect their current operating environment and the opportunities and challenges faced.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The service had emergency department (ED) strategy 2022-2027. There were different mechanisms for staff to feedback on the proposed strategy.

There was mixed feedback from staff regarding culture and implementation of the vision and strategy alongside other changes. Some staff describing a difficult culture in the context of operational decision making and pressure to place patients on the ward. Staff described the negative impact it had on staff wellbeing and morale. Some staff told us that they were not engaged in changes that were made that impacted them. Not all staff were aware of the vision and strategy of the service and how this fitted into the overarching trust strategy. There had been work undertaken to improve this including increased senior oversight and presence, professional role modelling and increased staffing and support as well as engagement. This had improved the culture though senior staff were aware there was still more to do to embed the change.

There was a good safety culture where events were investigated, and learning was embedded to promote good practice. Staff said raising concerns was encouraged and valued. In the 2024 staff survey results 87% of staff working in the ED either agreed or strongly agreed that the organisation encourages staff to report errors, near misses or incidents.

The trust values of respect, compassion, honesty and teamwork, were displayed around the trust and department. We saw staff lived these values.

Leaders had a shared purpose and strived to deliver and motivate staff to succeed. However, we were concerned about the negative impact it had on their wellbeing. Generally, there were high levels of satisfaction amongst staff, despite the challenges they faced. However, in the 2024 staff survey results only 50% of staff working in the ED agreed or strongly agreed that if a friend or relative needed treatment they would be happy with the standard of care provided by this organisation.

Capable, compassionate and inclusive leaders

Score

2. Evidence shows some shortfalls in the standard of care

Staff told us they felt supported by managers and had opportunities for development. Managers were visible and approachable. Leaders of the service were knowledgeable about the issues and priorities of the service and worked for change and improvement when needed. They recognised where the service needed to be improved and were working to make improvements. They focused on staff wellbeing and ensured a culture promoting good practice, good quality and aspired to give safe care and treatment.

There was a triumvirate leadership structure with medical, nursing, and operational leads. There was a strong, committed and capable leadership team in the department. The leadership team had the skills, experience and knowledge to lead the department effectively and with credibility. They were open, honest and willing to learn and improve. However, the Emergency Department and medical care services were in the same care group and was therefore the same leadership team. We were concerned that, whilst they had capability, they might not have capacity and the wellbeing of the triumvirate leadership team was impacted given the number of significant changes being made at pace.

There was a disconnect between clinical decision making and operational decision making. Senior clinical staff told us that they were not engaged or involved in decisions that directly

impacted them.

Staff told us leaders in the service were approachable and responded to any concerns raised. Staff also told us leaders modelled the values of the practice. The leadership team worked with other departments and also the ICS the development of emergency care services within the region.

The leadership in the department included the clinical director, the head of nursing and general manager. They described a positive working relationship and were well sighted on the demands and challenges of the department. They recognised the risks in the department and shared strategies and plans to address these. However, the biggest risk they identified was over crowding in the department and it was not clear how the risk was being mitigated. They could not be assured all reasonable actions were being taken to address risks.

Senior leaders were aware of the impact that the crowded department has had on staff and that this increased stress. There were support services in place and actions to support culture had been implemented. However, leaders acknowledged there was still more to do.

Leaders were able to demonstrate how they worked as part of a multidisciplinary team within the service and how they collaborated with partners such as local NHS ambulance and mental health trusts. They told us they worked well together and there was regular engagement to review performance and identify improvements to services. Leaders had various initiatives to aid flow, virtual wards, community assessment and treatment units, urgent community response services and minor injury units.

Leaders had effective support and opportunities to develop and maintain their skills. The roles of staff and leaders were clear, and they understood their responsibilities and accountabilities. The trust had processes to encourage talent management, career progression and succession planning. The Safe and Compassionate Leadership programme formed part of the trusts commitment to support and equip leaders and make positive steps towards culture improvement. This programme aims to support leaders in their challenging roles.

Freedom to speak up

Score

2. Evidence shows some shortfalls in the standard of care

The service had established Freedom to Speak up arrangements. Staff were aware of how to raise concerns. However, the Freedom to Speak up annual report covering the time period between April 2024 and March 2025, showed trust wide the experience of staff raising concerns had declined. The report showed that just over 70% of staff felt secure raising concerns about unsafe clinical practice which was in line with the national average. However, only 51% of staff felt confident that their organisation would address their concerns which was worse than the national average of 56%.

In the same report there were 81 speak up cases raised in total trust wide. Of these cases 47 were raised direct to the Freedom to Speak Up Guardian (FTSUG) and 34 via the anonymous app. The numbers of anonymous concerns had continued to fall, this may suggest staff are feeling safer to speak more locally in their care groups and to champions and the Guardian. However, the number of anonymous concerns raised was 42% which was much higher than the national average of 9.5%. The greatest number of cases raised related to behaviours and relationships. Nurses were raising the largest number of concerns in this time period followed by administration staff. The Acute & Emergency Medicine care group raised 6 concerns.

Leaders encouraged staff to raise concerns and promoted the value of doing so. However, not all staff felt empowered to speak up or that their concerns would be listened to.

Call 4 Concern was available to staff, patients and those close to them to raise concerns and these were listened to and addressed by the team.

Patients knew how to make a complaint or raise concerns. The service clearly displayed information about how to raise a complaint. Managers investigated complaints, identified themes and shared feedback with staff. Learning from these was used to improve the service. Staff understood the policy on complaints and were able to give examples of learning from complaints.

When something went wrong, people received a sincere and timely apology and were told

about any actions being taken to prevent the same happening again. We reviewed learning responses which showed Duty of Candour was completed appropriately.

Governance, management and sustainability

Score

2. Evidence shows some shortfalls in the standard of care

The service did not always have effective systems to enable oversight of risk. The department risk register was monitored and included risks for adult and paediatric emergency departments. However, the ED specific risk register did not include timelines for review or mitigations. This meant we could not be assured all reasonable actions were being taken to address risks. An additional risk register provided by the trust which included medical care services risks included some risks relating to the ED but were not on the ED specific risk register. For example, on the joint risk register there was a risk pertaining to overcrowding and the use of the corridor as a temporary escalation areas but this risk had not been reviewed since 15 March 2023.The ED specific risk register included a similar risk relating to overcrowding but did not include mitigations and when the risk was reviewed.

There was a good range of accurate and timely data and information available to understand performance and quality and improvements were made as needed. For example, the service compared itself to national published research in relation to the increased risk of patient's dying by experiencing delays in the ED crowding.

Audits undertaken included clinical effectiveness and compliance with guidance from the National Institute of Health and Care Excellence (NICE). Performance against national guidance was shared with staff to highlight areas of improvement. For example, the April 2025 ED Governance newsletter included performance against national guidance for the management of patients having a stroke.

There were regular and effective meetings for safety, audit, quality, and governance. These discussed and addressed key areas of performance, risk, audit, culture, and workforce. Minutes recorded areas of concern were identified and actions were taken to learn and improve. Once a

month, the team reported and presented a summary of their incidents and staffing metrics to the care group for the wider group to be aware of the departmental pressures and emerging risks.

Information on governance was shared via a newsletter emailed to all staff; a poster was also displayed. Staff received feedback from incident reporting and risks during handover and safety huddles.

Staff were part of the emergency preparedness network, and they had the strategies and guidance to respond to major incidents. Good practice was recognised and celebrated.

Staff understood their role and responsibilities, what they were accountable for, and to whom. Leaders mostly operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, we had concerns around the challenges for the department leads and staff around the increased pressures and the impact this may have on patients.

Partnerships and communities

Score

3. Evidence shows a good standard of care

Staff and leaders worked in partnership with key organisations to support care provision, service development and joined-up care.

A range of Improvement training courses were available via the QI website and were delivered in both virtual & face to face settings. The trust invited external stakeholders such as Integrated Care Board (ICB) colleagues to join to provide and foster engagement with improvement, science education and shared peer to peer learning.

The trust held bi-monthly Learn and Share events which were open to Cornwall System-wide stakeholders and provided an opportunity to showcase improvement endeavours at varying

stages, drive the improvement mindset and provide networking & collaborative opportunities.

People's views and experiences were gathered and acted on to shape and improve the services and culture. This included people in a range of equality groups. People who used services, those close to them and their relatives were actively engaged and involved in decision-making to shape services and culture. For example, the accessibility advisory group which had a range of stakeholders including iSight Cornwall, Mobility and DisAbility Cornwall were engaged with developing the hospital estate.

Leaders understood their duty to collaborate and work in partnership, so services worked seamlessly for people. They shared information and learning with partners and collaborated for improvement. For example, the Cornwall Partnership NHS Foundation trust, intermediate care service provided a Mental Health Crisis Assessment Hub, which incorporated Acute hospitals, GP's, Urgent Treatment Centres and Same Day Emergency Care units. The service was available 24 hours a day 7 days a week for patients in experiencing a mental health crisis with no acute medical need. This was an alternative to an attendance at the emergency department.

The trust had a West Cornwall Hospital development group. This group brings together representatives from the public, clinicians and managers, primary care network and other organisations as partners in the restoration and further development of West Cornwall Hospital. The group hosted a number of events including an outpatient workshop and developed a booklet addressing concerns and identifying improvements regarding West Cornwall Hospital.

The trust's strategy aligned to local plans in the wider health and social care economy, and services were planned to meet the needs of the relevant population. The ICB recommended that all Cornwall Isle Of Scilly providers held regular provider to provider meetings to address the challenges across the system given the degree of interdependencies. Seven pillars or Urgent and Emergency Care priorities were developed and the ICB transformation support hub supported the coordination / oversight of each 7 pillars for action plan development and exception reporting. Four of the pillars were the responsibility of the trust. There was a performance dashboard aligned to key performance indicators to monitor the impact. There were weekly ICB clinically led oversight meetings, each pillar had accountable leads, was clinically driven, had clear governance, a designated action plan and trajectory.

Partners from the Cornwall system, such as the local community trust, GP's and the local ambulance trust met monthly to ensure the system was working together and safe for patients. Policies and pathways such as same day emergency care were aligned with other key partners to drive improvements for patient care and treatment.

Partners we spoke with advised there were no concerns in relation to staff working together, inclusivity and partnership working.

Alerts on the IT system enabled staff to be aware of and follow specific care plans if a patient had needs that required additional support. There was a frequent and high intensity users lead. They led monthly multi agency meetings. This was in line with The Royal College of Emergency Medicine (RCEM), Best Practice Guideline.

The emergency department had regular meetings other stakeholders such as the mental health trust to improve shared learning, oversight of clinical issues and performance and to enable joint service development and provision to progress in collaboration.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

Staff focused on continuous learning, innovation and improvement across the organisation and the local system. They encouraged creative ways of delivering equality of experience, outcome, and quality of life for people. The service actively contributed to safe, effective practice and research. The trust have a Quality Improvement (QI) team and hub (QIdeas) on the staff intranet where staff could submit ideas for improvement programmes via a short form and received a response usually within 48 hours. It was expected that staff raised small-scale improvement ideas directly to their line manager and teams for action. Through these suggestions, the leadership identify themes. For example, food availability for staff.

Staff told us that the trust was building QI into the culture with the understanding that in the future, they will not need a QI team as each staff member will be empowered to take on QI

initiatives. The trust offered positive opportunities for staff to discuss QI including QI cafes, let's talk monthly sessions with executive team with one session focusing on QI, and an annual QI conference.

As part of the response to ongoing operational pressures, an improvement project was to expand the range of pre packed to take out (TTO) medications within ED to facilitate faster discharges was implemented. This included use of pre-packs ‘in hours’ to help patients be discharged from ED faster. A piece of work was undertaken to identify the most commonly prescribed items in ED that would be useful to hold as TTO packs. Feedback following implementation of the packs included: reduced the amount of medicines given to patients that could be bought cheaper by patients, increased stock levels of high frequency TTO's and a wider range of medicines as TTO’s.

There was a Clinical Vision for Flow Improvement programme recently established. This programme focussed improving operational and clinical performance within the department. For example, achieving the average ambulance handover time to under 40 minutes by September 2025 and improve performance in the management of patients with sepsis.

A new triage system supported by a new standard operating procedure had commenced shortly before our assessment. The principle aims were reduced triage times as well as ensuring patients had early clinical review and oversight. Staff had been involved in the development and an evaluation was planned.

The service had strong external relationships that supported improvement and innovation. Staff and leaders engaged with external work. There was a trust wide flow improvement programme with 4 workstreams: ED, sick frail patients, sick general patients, and short stay patients. Each workstream had an action plan.

The department’s senior nurse was developing a chart for patients to provide information for them and their families on what was happening and the next steps. This would be updated by staff and form a ‘live’ and personalised source of information.

The trust implemented a ward accreditation program called Aspire (named voted for by staff). It was developed and implemented by the trust and aimed to improve the quality of care by evaluating and accrediting wards based on specific standards. The program was revised and expanded to incorporate evidence-based metrics and new elements, like direct registered

nurse care time and ward climate, to ensure a more robust and reliable assessment of patient safety and quality. The program was seen as a tool for continuous quality improvement at the ward level, encouraging staff ownership and pride in their work, while also reducing variation and improving team working.

Regulation 10: Dignity and respect

Service

Medical care (Including older people's care)

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

- Temporary escalation spaces in Tintagel ward and boarding beds in the Acute Medical Unit did not have curtains. This meant patient' dignity and respect was not maintained.
- There were multiple examples of mixed sex breaches on medical wards.

Regulation 12: Safe care and treatment

Service

Medical care (Including older people's care)

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

- Staff did not always assess the risks of venous thromboembolism (VTE) on admission and re-assess the risks within 24 hours.
- Staff did not always consistently re-assess National Early Warning Score 2 (NEWS2).

- The stroke pathway did not always manage risks or provide care in an effective and timely manner.
- Incidents and mortality reviews were not always reviewed and completed in a timely way.
- Medicine was not always administered and disposed of in line with guidance.
- Medicine was not always reconciled within 24 hours of being admitted.
- There was poor infection prevention and control management across the hospital.
- Temporary escalation chairs and temporary beds did not always have call bells for patients.

Regulation 12: Safe care and treatment

Service

Urgent and emergency services

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

- Staff did not always complete nursing assessments in a timely manner, including National Early Warning Score 2 (NEWS2).
- Patients did not always receive care in a timely manner including time from arrival to admission and waiting for specialty referral.
- Staff did not always fully complete handover documentation.

Regulation 15: Premises and equipment

Service

Medical care (Including older people's care)

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

- Two beds in the hyper-acute stroke unit did not have monitors available.
- There was a shortage of equipment for patients in the physio stroke unit.
- The environmental layout of equipment and furniture blocked exits.
- Control of Substances Hazardous to Health (COSHH) and medical equipment were not always securely stored.

Regulation 17: Good governance

Service

Medical care (Including older people's care)

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

- Audits were not always completed, including compliance of Mental Capacity Act assessment.
- Patient records were not always completed fully.
- Efforts to mitigate risks to patients were not always effective or completed in a timely manner.

- Patient records were not always kept secure.

Regulation 18: Staffing

Service

Medical care (Including older people's care)

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

- Staff mandatory training did not always meet the trust target or national guidance, including Basic Life Support training, Paediatric life support training, and Oliver McGowan Mandatory Training on Learning Disability and Autism (Tier 2).
- Staff appraisals did not meet the trust target.
- Staff were not always able to access clinical supervision opportunities when needed.
- Staff were not always able to take breaks.
- Allied Health Professionals for stroke patients were below operational need for patients on the stroke pathway.
- There was a strong reliance on temporary agency and bank staff.
- Vacancy rates were higher than target for two staff groups, including resident doctors .

Regulation 18: Staffing

Royal Cornwall Hospital

Action plan requests

Service

Urgent and emergency services

Regulated activities

- Treatment of disease, disorder or injury

How the regulation was not being met

- Paediatric nursing cover was not in line with national guidance.
- Consultant cover was not in line with national guidance.
- Staff appraisals did not meet the trust target.
- Staff mandatory training did not always meet the trust target or national guidance, including Advanced Paediatric Life Support training and Advanced Trauma Support training.
- Staff were not always able to access clinical supervision opportunities when needed.