

Royal Cornwall Hospitals NHS Trust

# Royal Cornwall Hospital

## Inspection report

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## Ratings

### Overall rating for this service

Inspected but not rated ●

Are services safe?

Inspected but not rated ●

Are services well-led?

Inspected but not rated ●

# Our findings

## Overall summary of services at Royal Cornwall Hospital

### Inspected but not rated



We carried out a short notice focused inspection of the Surgical Care Groups of the trust on 15 and 16 June 2021 because at our last inspection in December 2020, we identified concerns which led to the trust being served a Warning Notice under Section 29A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The aim of the inspection was to see if the trust had made the required improvements. At this inspection, we found the trust had made a number of improvements and had met the requirements of all aspects of the S29A Warning Notice.

During this focused inspection we concentrated on specific key lines of enquiry within the 'safe' and 'well led' key questions for surgery. This meant we could assess the trust's actions and improvements in response to the Warning Notice. We did not inspect the effective, caring or responsive key questions and therefore did not change the rating for surgery which remains requires improvement overall. This is because the safe and responsive key questions were rated as requires improvement when we inspected in November 2019. As a result of that inspection the trust overall was rated as requires improvement. We will continue to monitor the performance of this service.

The trust is the main provider of acute hospital and specialist services for most of the population of Cornwall and the Isles of Scilly, about 500,000 people. The population can more than double during busy holiday periods. The trust employs about 5,000 staff.

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

The trust has seven care groups; medicine, clinical support, general surgery and cancer services, women, children and sexual health, anaesthetics, critical care and theatres, specialist services and surgery, and urgent, emergency and trauma. The Surgical Care Groups at the Royal Cornwall Hospital provide emergency inpatient surgical treatment, elective (planned) inpatient surgical treatment and day case surgery across a range of specialities. These services include acute surgery, trauma and orthopaedics, general, thoracic, ear, nose and throat (ENT), plastic, breast and ophthalmic surgery.

The trust had undertaken 30,160 elective procedures and 14,441 emergency surgical procedures from January to June 2021.

The hospital has three main theatre suites Trelawney, Newlyn, and Tower theatres.

We inspected areas of the Surgical Care Groups at Royal Cornwall Hospital. These included the Dermatology Unit, Tower Theatres, recovery areas and a surgical ward. The inspection team included a lead inspector, a second inspector and a specialist advisor.

See the surgery section for our detailed findings.

### How we carried out the inspection

# Our findings

You can find further information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

# Surgery

**Inspected but not rated**



At the last inspection in December 2020, the trust was served a Warning Notice because:

- Governance was not effective throughout the service to ensure that changes and learning supported patient safety across the trust. The response to the never events had not been managed in a timely way to ensure patient safety.
- Not all relevant audits were completed. Audits data showed varying levels of compliance. Staff were not aware of the audit outcomes and learning was not triggered by these audits.
- Staff had not received adequate training in response to the never events.
- Actions taken to mitigate further risks of never events occurring had the potential to increase the risk in the short term.

At this inspection we found:

- The trust had made significant improvements since our last inspection.
- Compliance with the World Health Organisation (WHO) Checklist had improved, and further improvements were in progress to ensure sustainable improvements. The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team to perform key safety checks during vital phases of perioperative care.
- Managers responded to incidents and shared information in a timely way.
- The programme of audits had been reviewed with a targeted audit schedule. A safer surgery group had been implemented to review audit findings and share learning with the wider hospital team.
- Compliance with training had improved with over 80% of staff having completed the WHO checklist and Human Factor training. There was an ongoing programme to ensure the rest of the workforce completed the training.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together across all hospital sites for the benefit of patients and had access to good information.
- Further improvements had been implemented to ensure actions to mitigate further risks of never events do not increase risk in the short term.
- Leaders understood and managed priorities and issues the service faced. Actions had improved communication to ensure more joined up working between Royal Cornwall Hospital, St Michael's Hospital and West Cornwall Hospital.
- Governance structures and communication within them had improved. This meant changes and learning supported patient safety across the trust.
- Staff felt respected, supported and valued. The service had an open culture where staff could raise concerns without fear.
- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and, in most cases, kept good records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

However:

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- Peri-operative documentation was not always completed fully and consistently.
- Although the trust provided assurance that the WHO checklists were being updated to include a patient safety alert, the updated documents had not been circulated yet.
- Relevant information about allergies was not written on the board in theatres.

## Is the service safe?

Inspected but not rated



### Mandatory training

**The service provided mandatory training and had implemented WHO checklist and Human Factor training across the Surgical Care Groups. It encouraged all staff to complete these training packages.**

WHO checklist and Human Factor training had been rolled out to all staff who were involved with patients who underwent invasive procedures across all Care Groups, including bank staff. A trust performance report as at 15 June 2021 showed:

- 82% of applicable staff had completed the WHO checklist training.
- 89% of applicable staff had completed the Human Factors training.

This was an improvement since our last inspection where only staff working in the dermatology department had received the WHO checklist training.

For staff working in non-invasive areas, such as the surgical wards, they were required to complete patient safety training. The clinical lead for culture change and improvement told us as at 4 June 2021, 44% of staff had completed this training. They had oversight of the training record and sent out weekly reports to department leads to ensure staff who needed the training were booked appropriately.

Staff were required to complete this training annually. There was a process to restrict staff practice if they did not maintain training of these subjects.

The quality of the WHO checklist was overseen by senior team leaders, theatre managers and the WHO audit process.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, there were gaps in record keeping which the trust recognised and was addressing.**

Risks to patients were discussed daily and shared with staff across theatre suites. Daily safety huddles in theatre departments were undertaken to highlight patient risks, staffing, theatre lists, reported incidents from the previous day and infection control concerns. This meeting provided a forum for any relevant hospital updates. Minutes were taken, available to all staff and provided an audit trail for areas discussed. Staff confirmed patient handovers included all necessary key information to keep patients safe.

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As part of the five steps to safer surgery, a daily briefing in each theatre was undertaken at the beginning of each operating list. This highlighted any patient who may be deemed at risk, to discuss specific equipment requirements, and issues which may impact the list. In the eight sign-in checklists we reviewed the National Patient Safety Agency five steps to safer surgery was followed as part of the World Health Organisation (WHO) surgical safety checklist. The purpose of the checklist was to ensure all safety elements of a patient's operation before induction of anaesthesia. These checks included, for example, checking for the correct patient, ensuring the consent form had been completed and the operating site had been marked correctly. In the three cases we observed staff performed and documented checks well. For example, staff observed a "silent cockpit" approach to ensure everyone was listening and focused as each section of the checklist were completed.

The dermatology department at Royal Cornwall Hospital had made significant improvements since our last inspection, which demonstrated the trust's improvement related to the Warning Notice served in December 2020. A new process for marking surgical sites had been introduced along with a "body-map" form to ensure nurses and doctors only operated on the correct surgical site. New specialty specific WHO surgical safety checklists had been introduced and staff were now documenting surgical counts using whiteboards. Staff had been trained in this new approach and were able to explain the process to our inspectors. Regular audits had begun to monitor compliance with these changes. Extra time had been allowed for more complex surgeries. This helped staff learn the new approach and encouraged their engagement and compliance. Staff were supportive of these improvements and recognised how they could help prevent wrong site surgery never event.

Staff shared key information to keep patients safe when handing over care to others. Peri-operative care booklets were used to ensure important clinical and safety information was easily available. Staff in theatre and recovery rooms told us that information sharing between areas was good. We observed a patient's whole peri-operative journey and saw handovers that effectively communicated the patient's ongoing needs.

However, documents and information on theatre boards were not always completed fully and consistently. For example, information about allergies was recorded in notes and shared during the "sign in" and "time out" parts of the WHO checklist. However, we observed in the theatre we visited, these were not recorded on the whiteboard. We also found information was not fully completed in the three peri-operative care booklets we reviewed. For example, the pre-operative checklist had not been fully completed to indicate the questions asked within this section of the checklist had been answered. The trust told us they recognised this problem and had redesigned the surgical care documents. They had collated information from different care groups to understand why some sections were not always completed and whether it was necessary to have these. They aimed to streamline and standardise these documents where possible. Senior managers would be monitoring whether the changes improved compliance through their monthly audits.

At this inspection we looked at how changes and improvements were managed between all of the trust's hospital sites across Cornwall. For example, at West Cornwall Hospital we saw a newly updated peri-operative care booklet in use. This had additional boxes on the "patient care in theatre" page where the theatre scrub practitioner and circulating practitioner signed and printed their names. This demonstrated that the trust had met the requirements of the Section 29A Warning Notice issued on 21 December 2020, which required the trust to maintain a written record of two signatures for the scrub count. However, in St Michael's Hospital and The Royal Cornwall Hospital these documents had not been updated. We were told this change was being implemented trust wide and updated care booklets were approved for issue and would soon be in use. We noted in the minutes from the Quality Assurance Committee on the 23 June 2021 (one week after our inspection), this had been discussed and confirmed that five out six perioperative care booklets had been updated and were published. The one outstanding was in relation to cataract surgery where additional changes were being made following a further revision to the WHO checklist.

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Theatre staff had to add the names of the scrub and circulating practitioners to the electronic record of care before the record could be closed. These records were monitored and if staff had failed to enter their names, a notification would be sent to theatre managers the following morning prompting them that a record was incomplete and to review these. This was an improvement since the last inspection where records could be closed without staff adding their names to it and did not provide an audit trail if the information was needed later.

Daily reports were circulated to ensure governance leads were sighted on issues and concerns in real time. The trust had also updated their Scrub Practice Standards Clinical Guideline in February 2021 indicating that the perioperative document must be fully completed and signed, naming the scrub and circulating practitioners. This was to be retained in the patients' medical record.

An audit process had been implemented since March 2021 to understand areas of improvement in completing peri-operative booklets throughout the patient's journey in surgical care. A first audit had been undertaken which looked at the quality of record keeping in 50 sets of notes across the different care groups. This audit had identified several areas of improvement in the quality of record keeping between wards to recovery areas. The actions from these audits were on the agenda to be discussed at the Safer Surgery Group meeting planned for the following day of our inspection. There were plans to re-audit within three months to check the actions were effective. The purpose of the Safer Surgery Group was to ensure learning and actions were shared across the different care groups. This audit process had improved as the information was gathered by the governance lead for Anaesthetics, Critical Care and Theatres which ensured independent oversight, compared to our last inspection where we identified this was lacking.

We reviewed results of the WHO checklist audit from March to May 2021 which demonstrated improvement in practices. The quantitative compliance (measured by the quantity of something rather than its quality) ranged from 90% to 100% in that period. Compliance in relation to the qualitative compliance (measured by the quality of something rather than its quantity) increased from 61% to 100% between March and May 2021. This was an improvement from the same period in 2020. This audit was to help assure the trust Executive Team that standards were being met across all theatres. The audit areas included the safety huddle, operating list briefing and debriefing. This audit relied on information being gathered by the nurse or matron in charge from each theatre. This audit was a peer assessment within clinical areas overseen by the Theatre Manager or Nurse in Charge. Leaders told us the additional WHO checklist training and Human Factor training had provided staff working in the Surgical Care Groups refreshed understanding on the expectations of peer assessments. The trust had implemented further spot audit checks on those areas of the WHO checklist peer assessment to ensure independent oversight. We were told by leaders that eventually both audits would be brought together to provide a clearer view of assurance. We noted action plans were drawn from the independent process to ensure actions were implemented and learning was shared.

## Never events

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

When we inspected in December 2020 the trust had reported seven never events across its three locations between February and October 2020. Since we last inspected, the trust had reported two further never events, both at its Royal Cornwall Hospital site:

- One in February 2021 which was a wrong site surgery carried out in the interventional radiology department. (Interventional radiology refers to minimally invasive, image-guided medical treatments).

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- June 2021 was an overdose of insulin administered due to the use of an incorrect device in anaesthetics.

Nearly all staff we spoke with knew about a recent never event and all staff knew about those which related to their own role or specialty.

The trust had improved communication of never events with staff. We saw evidence that the trust made sure learning from never events were communicated quickly across all staff grades and sites. For example, a trust wide briefing was issued on the safer administration of insulin by clinical staff within a week of the reporting of the latest never event.

At this inspection we looked at how changes and improvements were managed between all of the trust's hospital sites across Cornwall. For example, staff in St Michael's Hospital and West Cornwall Hospital told us about the recent overdose of insulin never event, which occurred at the Royal Cornwall Hospital. Staff in the Post Anaesthetic Care Unit (PACU) showed us how 'pop ups' on trust computers communicated safety information, such as never events. A theatre sister at the Royal Cornwall Hospital showed us how they recorded information from daily theatre department meetings through a cleaning logbook. Staff would see the latest news when they recorded the daily cleaning of theatre.

Staff at all sites confirmed they also received safety information through management emails and leader 'vlogs' but they expressed concern that they did not always have time to log in to see these. (Vlog stands for a video blog or video log and refers to a type of blog where most or all of the content is in a video format). Trust managers would soon be placing new electronic communication screens throughout theatre departments. The screens would be linked and could be updated remotely to show the latest safety messages.

There was an investigation of each incident and debriefs were undertaken to gain a better understanding of what had gone wrong. Investigation leads were appointed and after initial investigations 72-hour reports were published. Following a full investigation into the wrong site surgery never event, a final report was produced with recommendations and an action plan to identify allocation of responsibility and timescale for actions. The final investigation report for the insulin never event was being written, as it only happened 18 days before our inspection.

There was learning from these never events and changes to practice as a result. For example, following the interventional radiology never event, five learning points were identified:

- Clinicians undertaking the procedure to prepare together so key information is reviewed prior to starting the procedure.
- When concerns are raised, for everyone to pause and check information before proceeding.
- Ensuring clinicians taking written consent capture sufficient information for the patient and the team to validate the procedure, site and, when specifically required, the side.
- Consent form to be seen and procedure confirmed verbally in the room as part of WHO final checks.
- Referral information to be seen and procedure confirmed verbally in the room as part of WHO final checks.

We saw one instance where trust guidelines were not followed in relation to COVID-19 and management of patients, according to COVID-19 status. We observed one case where a medium risk patient at the Royal Cornwall Hospital was initially incorrectly treated as low risk. This was raised at the time of inspection and a rationale was provided as to why the team had not acted in accordance with the guidelines. This was because the procedure was an urgent case and the patient had tested negative on the morning of the surgery. The clinical team involved in the surgery had reflected on their practice to ensure they clearly understood the guidelines and were able to communicate their rationale if deviating from it.



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## Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Systems had been improved to ensure correct syringes were available to administer medicine for the treatment of diabetic patients. This was in response to a never event and had been implemented across all sites. The communication was an improvement since the last inspection when key information about a medicine never event had not been shared across the trust.

The service had systems to ensure staff knew about safety alerts and incidents. This meant patients received their medicines safely. Staff followed current national practice to check patients had correct medicines.

## Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. However, managers had not ensured that actions from a patient safety alert were implemented and monitored in a timely manner.**

Staff knew what incidents to report and how to report them. All staff were able to describe systems and processes to report incidents. They told us the trust encouraged them to report incidents and there was a no blame culture.

Managers shared learning about incidents and never events with staff and across the trust. We saw evidence of this in minutes of meetings and “pop-ups” on computer screens.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Staff received feedback from investigation of incidents both internal and external to the service.

Staff met to discuss the feedback and identify where improvements could be made to patient care. There was evidence changes had been made as a result of feedback. For example, in dermatology, processes had been improved to avoid the need for doctors to leave their clinic and check surgery sites. More time had been allocated for procedures to ensure clinical staff completed all safety checks prior to, during and post-surgery.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident.

However, two of the three hospitals (Royal Cornwall Hospital and St Michael’s Hospital) we visited had not included specific questions around a national patient safety alert issued in 2017 on their checklists. These questions were asked to ensure that patients’ intravenous cannula were free from residual anaesthetic medicines before they leave theatre. An intravenous cannula is a thin tube that healthcare staff insert into a person's vein. Healthcare staff use them to administer medicine. NHS England required all theatre departments in England to add these questions to their surgical safety checklists by 9 August 2018. In theatres, cannula flushing was recorded on the electronic system but not on the checklist. While the trust had advanced plans to issue new surgical safety checklists, these were not fully implemented at the time of our inspection. They explained this was due to using the opportunity to review and improve existing

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documents. The safer surgery group signed off the improved checklist on 18 June 2021 and the minutes from the Quality Assurance Committee on the 23 June 2021 (one week after our inspection), confirmed that five out of six perioperative care booklets had been updated and were published. The one outstanding was in relation to cataract surgery where additional changes were being made following a further revision to the WHO checklist. Further evidence sent by the trust showed that the documents were available to all departments and there was a two-week turnaround for all departments to update their stationery.

## Is the service well-led?

Inspected but not rated



### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.**

Leaders recognised the challenges surrounding never events and the changes required to ensure patient safety and comply with the Warning Notice we served at the last inspection. The role of the new Clinical Lead for Culture Change and Improvement was embedded, and they were driving improvement in invasive procedures across the Royal Cornwall Hospital, including the Surgical Care Groups.

Staff told us there was a notable positive change in communication shared across the Surgical Care Groups and hospital sites. This was an improvement since our last inspection where staff could not demonstrate they were aware of information about never events and learning from these.

A monthly quality assurance committee was attended by executive and non-executive directors. Actions from our previous inspection and never events were reviewed and discussed. Documented meeting minutes showed leaders challenged actions overdue and encouraged accountable teams to focus on these. This gave the leadership team oversight of actions and their progress.

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.**

Staff we spoke with said they were encouraged to raise concerns and to speak up. They told us that Human Factors and the WHO checklist training had increased their confidence to speak up if they had a concern. We saw posters and messages were sent to staff by the trust, to encourage them to speak up if they had concerns.

There was evidence of team working and cooperative, supportive and appreciative relationships among staff. Staff felt comfortable in asking for help. We observed friendly and professional relationships amongst staff. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. They recognised change was needed as a result of the never events to ensure patient safety.

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The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust's investigation process of the recent never events confirmed that duty of candour had been applied.

## Governance

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

The governance arrangements had improved since our last inspection. Leaders could demonstrate oversight of issues and actions.

Gaps in training, skills assessments and sharing of information had been addressed since the last inspection. We saw evidence the trust had prioritised the WHO checklist and Human Factor training, and significant improvements had been made in this area.

Skills assessment had improved and competency packs for staff had been reviewed and developed. At our last inspection staff skills were assessed using self-assessment tools. At our current visit we found the practice education team were implementing systems to independently assess staff skills. Leads monitored staff compliance and we saw 67 out of 73 staff members working in theatres had completed the revised competency assessments. We were told by the theatre management team there were plans to recruit one additional member of staff to support this team with skills and competency assessment.

Oversight of audit results had improved since our last inspection. Governance leads monitored audits and ensured the annual audit programme was completed. They used this information to review practice and identify where improvements were needed.

The service used a range of meetings to manage current risks, issues and performance. These included weekly governance huddles, monthly safer surgery group meetings and quality assurance committee meetings.

## Management of risk, issues and performance

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

The clinical lead for culture change and improvements had clear plans to ensure staff maintained training and skills. They had delivered the majority of the Human Factors training and told us they were now starting to implement Train the Trainers courses to ensure there were sufficient trainers available throughout the trust.

Weekly governance huddles were held. This meant there was oversight of risks, actions and performance. A Safer Surgery Group had been implemented with representation across the care groups including governance leads to keep oversight of required improvements and actions.

# Surgery

To help assure the trust's executive team that standards were being met across all theatres, audit processes had been implemented. For example, an audit process had been introduced since March 2021 to understand areas of improvement in completing peri-operative booklets throughout the patient's journey in surgical care. A separate monthly WHO checklist audit was undertaken.

In the dermatology department, the reviewed systems and processes around the WHO checklist enabled staff to be more confident in managing risks. For example, when staff stated they found it difficult to do swab and equipment counts before suturing of a surgery site, consultants and staff worked together to implement a solution. This included pausing before the final step in the surgical procedures so that the necessary counts could be undertaken. Staff we spoke with told us there were further improvements planned to develop the service further. This included the implementation of electronic consent forms.

## Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.**

The Governance Lead for General Surgery and Cancer had identified a need to check knowledge and understanding of high-profile incidents, and governance information across wards and clinical areas. As such a spot audit check was being developed to then be shared across further Care Groups for development. At the time of our inspection, the criteria for this audit was awaiting sign off. This had been highlighted at weekly governance huddles as a concern for several months and had been delayed due to Covid-19 pressures. However, this was now back on track and was due to be implemented as soon as the sign off process had been completed.

The dermatology department was short of two consultants and had been unable to recruit into vacancies, despite several adverts for the position. To keep up with demand, a large volume of dermatology work was outsourced to other providers. However, there was an increasing waiting list and the trust was rarely meeting the referral to treatment time standards.

The dermatology department took one of the suggestions from the "Getting It Right First Time (GIRFT)" programme to consider creating a "nurse registrar" post (GIRFT is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change). Following an approved business case, and a job plan being developed, a candidate was appointed. This was for a training post which included a progression to advanced nurse practitioner through a funded university course. The nurse who had been appointed had been supervised in a structured apprenticeship and logged every patient contact.

The establishment of this role had supported and contributed to the trust achieving the two week wait standards. Data from NHSE/I for March 2021 showed that out of 698 patients referred for suspected skin cancer, 682 (97%) were seen within two weeks of referral.

We were told by the Trust Associate Specialist in dermatology the patient cases seen by this nurse were audited and compared favourably with audits of senior clinician's two week wait activity in the department. (two week wait is the time between referral from a GP and to be seen by a hospital specialist where patients shows symptoms of cancer)

# Surgery

## Areas for improvement

We told the trust that it should take action because there were areas where it should make improvements to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

### SHOULD

#### **Surgical care service**

- The trust should ensure their new peri-operative documentations are implemented across all the Surgical Care Groups immediately to include the patient safety alert, “confirming removal or flushing of lines and cannula after procedures 9 November 2017.” (Regulation 12).
- The trust should ensure it reviews the COVID-19 guidelines for “amber” and “green” patients so that it can be followed consistently in all urgent cases. (Regulation 12)

This is required as part of Regulation 12 on managing risks to patients, but we considered that it would be disproportionate for these two findings to result in a judgement of a breach of the regulation overall at the location.

- The trust should continue to review and implement improvements so that information is recorded consistently. This is relation to peri-operative documentation packs and information about allergies on white boards in theatres.
- The trust should continue to encourage uptake of the WHO checklist and Human Factor training, to improve compliance.

# Our inspection team

The team that inspected the service comprised a CQC lead inspector, a second CQC inspector and a specialist advisor. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.