Royal Cornwall Hospitals NHS Trust

West 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 West Cornwall Hospital

Inspected but not rated

We carried out a short notice announced focused inspection of the surgical care group of Royal Cornwall Hospitals NHS Trust (RCHT) on the 9 and 10 December 2020.

We inspected one surgical area of West Cornwall Hospital on the 10 December, as part of that inspection. The aim of the inspection was to see if the trust had taken the necessary action and made the required changes following six never events between February 2020 and September 2020, within the surgical care group and one never event in medical services. The trust had a further incident in September 2020 which did not meet the never event criteria but was declared as a never event by the hospital. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, these are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

The never events happened over three locations, with one never event taking place in May 2020 Wrong site surgery, Dermatology West Cornwall Hospital.

During this focused inspection we concentrated on specific key lines of enquiry within the 'safe' and 'well led' domains for surgery. This meant we could assess the trust's learning and changes to practice in response to the never events. We did not inspect the effective, caring or responsive domains. We did not look at all domains and therefore we did not change the rating for surgery which remains requires improvement overall. This is because the safe and well led domains were rated as requires improvement in September 2018. We will continue to monitor the performance of this service. With the risks relating to Covid-19 still present, we'll draw from the best of our existing methodologies and adapt them to work in the current environment. We are clear that our focus will continue to be on services where we have concerns about quality and/or safety, and we'll continue to take appropriate action to protect people if necessary.

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, approximately 500,000 people. The population can more than double during busy holiday periods. The trust employs approximately 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 & the Isles of Scilly. The trust has seven care groups however, West Cornwall Hospital is managed as a separate site and so does not sit within those trust care groups. Elective surgery is provided at St Michaels Hospital and West Cornwall Hospital.

The Royal Cornwall Hospital Trust has undertaken approximately 51458 elective procedures and 24496 emergency surgical procedures from January 2020 to November 2020, including West Cornwall.

We visited the outpatient and day case unit. A team of one manager and two inspectors, spoke with seven nursing staff. We took part in one interview with staff. We reviewed audit data and policies and processes. At this inspection because of the risks caused by Covid-19, we did not speak to patients and relatives.

Our findings

Following the inspection, we took regulatory enforcement action as a result of our findings in surgical care services. We issued a Warning Notice under section 29A of the Health and Social Care Act 2008. This means that we asked the trust to make significant improvements in the quality of healthcare it provides. Further details can be found at the end of the report.

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

- Compliance with World Health Organisation (The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases of perioperative care). We found that the checklist had improved following a review of safety incidents, but the actions required in response had not been managed in a timely way to ensure patient safety.
- Not all relevant audits were completed such as observational audits of staff practice around the WHO checklists and checking of information on electrical systems. Audit data showed varying levels of compliance and staff were not aware of the audit outcomes and learning was not triggered by these audits.
- Staff had not received adequate training in a timely way in response to the never events.
- Safety systems which had been implemented as part of never event learning did not always consider the impact on staff and the wider safety implications.
- Managers had not identified the gaps in learning between the specialities and across the trust and had not ensured that actions from incidents were implemented and monitored for effectiveness in a timely way.
- Governance procedures were not effective throughout the service to guarantee that changes and learning ensured patient safety across the trust. Quality Improvement processes had been implemented but were in their infancy.
- Staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff followed current national practice to check patients had the correct medicines.

Is the service safe?

Inspected but not rated

- Compliance with World Health Organisation (WHO) Checklist had improved following a safety review of safety incidents, but responses had not been managed in a timely way to ensure patient safety.
- When safety systems had been implemented as part of never event learning, the trust did not always consider the impact on staff and the wider safety implications.
- Staff followed current national practice to check patients had the correct medicines.

Assessing and responding to risk

Compliance with World Health Organisation (WHO) Checklist had improved following review of safety incidents, but response had not been managed in a timely way to ensure patient safety.

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

Surgery

We spoke to a senior member of the theatre team who explained, as part of the five steps to safer surgery a daily briefing in each theatre was undertaken at the beginning of each patient surgery list to highlight any patient that may be deemed at risk, to discuss specific equipment requirements, and any issues which may impact the list.

The National Patient Safety Agency five steps to safer surgery was followed as part of the World Health Organisation (WHO) surgical safety checklist, however, during this inspection we observed the practice but as the surgery was underway no documentation was seen. No debriefing at the end of the list was observed due to our limited time on site.

We spoke to a senior member of the theatre team who explained, some actions relating to the never events had not been implemented. For example, the updating of the peri-operative care plan to include two signatures for the swab count was considered but no action was taken. The Association for Perioperative Practice 2016 Chapter 8 Clinical Guidelines 8.1 Accountable Items, Swab, Instrument and Needle Count Recommendation 8.1.62 states, “A copy of the count sheet should be retained in the patient’s notes indicating the names of the scrub and circulating staff responsible for the final count. Where electronic records are utilised, the record should indicate the names of the scrub and circulating staff responsible for the final count.”

The current electronic learning for staff provided by the trust, does not state that the swab check requires two staff signatures of the scrub and circulating staff responsible. Staff documented the swab counts on the paper record. The only field which was mandatory for staff to complete was if the count was correct or incorrect. The record did not require the names of staff completing the checks to be added to the system. Therefore, the record could be closed without including staff names and so would not provide an audit trail if the information was needed later. The written record enabled only one signature, despite two staff having competed the checks, and so again did not leave a full audit trail of the information, should it be needed later.

Mandatory WHO training for all theatre staff had been discontinued in early 2020 and updated training was being rolled out, staff had not received this updated training, and this could create a risk to patient safety. Timescales for staff to receive the training were not yet formalised. The trusts staff told us there was currently no formal training for the WHO in the Trust. New staff have been trained by the current staff within theatre during local induction and the quality of the WHO checklist has been overseen by senior team leaders, theatre managers and the WHO audit process. Following the never events in 2020 it had been recognised by governance leads that this needed to be improved to provide further assurance, the evolving plans would be that all staff involved with the WHO checklist would undergo annualised training. This had commenced and was to be monitored through ESR and the performance reviews. Electronic learning for the WHO safer surgery checklist had been created in November 2020 and so there was a time lapse between mandatory and updated training being available for staff.

From November 2017 audit processes changed to an electronic audit completed at the time of surgery and recorded completion of the WHO process in all areas apart from Endoscopy and Cardiac Catheter Laboratory. There was a disconnect between identifying safety concerns, making action plans and ensuring those actions had been successfully implemented. Monthly audits of the WHO checklist were undertaken looking at five steps to safer surgery. We were told by staff that the audits only looked at a small number of records.

We reviewed the results of the WHO audit from January to October 2020. The quantitative compliance ranged from 100% to 88% in May 2020. However, compliance in relation to the qualitative declined from 99% to 49% between April and May 2020. This picked up in June and July. However, it did not break down the areas within the WHO checklist to enable clarity of what had been audited and the areas identified as requiring improvement.

Surgery

This audit was to help assure the trust Executive Team that standards were being met across all theatres. Audit data showed variable levels of compliance and did not state how many records were reviewed and if paper records used in theatres were audited. The areas included for audit were the safety huddle, the operating list briefing and debriefing. From November 2017 audit processes changed to an electronic audit completed at the time of surgery and recorded completion of the WHO process in all areas apart from Endoscopy and Cardiac Catheter Laboratory.

Medicines

Staff were unaware of the medicine never event which had occurred in the emergency department on the Royal Cornwall Hospital site

There was a lack of information sharing across the different sites in relation to the medicine never event which occurred in the RCH site.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The surgical care group took appropriate action in response to significant incidents, but the action taken was not immediate and could have been taken sooner to ensure patient safety. For example, updates in training and practices to prevent reoccurrence. In accordance with the Serious Incident Framework (NHS England, 2015), the trust reported seven never events, which met the reporting criteria set by NHS England. A further incident which did not meet the criteria had been considered significant by the trust and so treated as a never event.

Senior member of staff explained that staff reported incidents and near misses using the trust's electronic incident reporting system, and staff had seen some changes and improvements as a result.

Never Events

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

The trust has had seven never events which happened over three locations.

February 2020. Retained swab, Breast Surgery theatres at St Michaels Hospital.

May 2020. Wrong site surgery, Dermatology West Cornwall Hospital.

June 2020. Wrong site surgery, Dermatology Unit Royal Cornwall Hospital.

May 2020. Partial retained wire, Cardiac Catheter Laboratories Royal Cornwall Hospital.

September 2020. Incorrect lens fitted, Ophthalmology Theatre Royal Cornwall Hospital.

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September 2020. Wrong medicine given, Emergency Department Royal Cornwall Hospital.

October 2020. Wrong site surgery, Dermatology Unit Royal Cornwall Hospital.

There was an investigation of each incident and debriefs were undertaken in each department to gain a better understanding of what had gone wrong. An investigation lead was appointed to carry out the investigation and an initial 72-hour report was produced. Following the full investigation a final report was produced with recommendations and a subsequent action plan to identify allocation of responsibility and timescale for action. The investigating officer for the dermatology never events also reviewed a previous never event in 2013 for comparison.

There was some learning from the never events and some changes to practice as a result. During our inspection, we were advised that the standard operating procedure for dermatology was being updated as a result of the never events.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust's investigation process included confirmation that duty of candour had been applied.

All staff we asked demonstrated a clear understanding of the duty of candour and their own responsibility to be open and honest.

Is the service well-led?

Inspected but not rated

- Leaders had not identified the gaps in cross care group and trust wide learning. They had also not ensured that actions from incidents were implemented and monitored for effectiveness in a timely way.
- The governance structures did not always ensure information and learning was shared effectively between surgical specialities and other locations in the trust.
- Staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.

Leadership

Leaders understood and managed the priorities and issues the service faced, however, had not identified the gaps in cross speciality and trust wide learning. Leaders did not recognise the risks of the self-assessment review of the training needs of staff.

Leaders recognised the challenges surrounding the never events and that changes were required to ensure further patient safety. A new Culture and Improvement Lead role had been implemented to drive change across all locations including West Cornwall Hospital. The staff member in this role had already started to make inroads into identifying the issues and the directions needed for leadership but this work was in its infancy.

Surgery

Trust leaders had not identified the gaps in cross speciality and trust wide learning. There was no clear insight by leaders into the gaps in shared learning. Not all managers had shared the never events and the subsequent changes to the wider care group and trust locations as staff had limited knowledge of the never events. Safety briefings were provided by the trust, but no evidence was provided to support that the information had been disseminated down. This was a missed opportunity for learning and safety development.

Culture

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

Staff felt supported, respected and valued. Staff felt positive and proud to work in the hospital and staff told us they felt they were a good team and benefitted from excellent clinical skills.

Staff told us that they felt morale was low, mostly caused by the impact of Covid-19 and increased workloads, but they considered that a culture change seemed to be happening with staff starting to feel more empowered and able to speak up. Freedom to Speak up Guardians and safety champions were available in the trust to support staff. There was evidence of team working and cooperative, supportive and appreciative relationships among staff.

There was a culture which encouraged openness and honesty at all levels within the organisation. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. Staff we spoke with said they felt comfortable raising concerns felt they were listened to.

Governance

Governance structures and the communication within them were effective to ensure that changes and learning supported patient safety across the trust.

The trust governance structure did not always ensure information and learning was shared effectively between surgical specialities and locations in the trust. The senior team at West Cornwall Hospital, explained at the time of the inspection there was no link to central trust governance. Theatre staff were managed by theatre managers as part of a triumvirate of a general manager, head of nursing and clinical director. They are answerable to the operations lead, who reported in turn to the trust board.

There were governance structures at each location, which enabled the never events to be reported and escalated in each location. West Cornwall hospital was able to manage its own service separate from the main hospital site in October 2019. At this location there were three heads of department meetings each week and one business meeting for issues to be raised and discussed. Following this change the triumvirate have seen a more positive shift, however senior team members had not been invited to audit days, and meetings. Any minutes from governance meetings were forwarded to Royal Cornwall Hospital to ensure linked learning with the main hospital.

At West Cornwall Hospital there was one staff member funded 15 hours each week to cover governance for the hospital. This was alongside their substantive role. West Cornwall Hospital triumvirate leaders explained that as part of the care group re-structure crossing of different care groups was a convoluted arrangement with too many people from different groups. A full-time governance post for both West Cornwall Hospital and St Michaels Hospital had been created and the post holder was due to start in January 2021. It is anticipated by the trust that this would provide strong governance links with the main site.

Surgery

All current actions were reported to and reviewed by the Incident Review and Learning Group through to the Quality Assurance Committee. However, there were gaps in governance structures which did not ensure that communication between all surgical specialities and all locations of the trust were enabled. As part of the new governance structure the governance lead for West Cornwall Hospital would become part of the central governance team at the Royal Cornwall Hospital and work directly across all three locations of the trust.

This would make sure they were aware of any never events or incidents. For example, a never event occurred on the West Cornwall Hospital site in May 2020 (undertaken by a Royal Cornwall Hospital team), the senior team at West Cornwall Hospital were not made aware of the never event until the internal summit held November 2020. Another example, a never event took place at Royal Cornwall Hospital in September 2020. We were told the team at West Cornwall Hospital were made aware of the ophthalmology never event by a visiting doctor and not by the trust governance structures. Information could have been shared and learning implemented earlier to prevent the risk of reoccurrence.

There was a disconnect between staff on the ground and the senior leadership teams. Governance and management interacted with each other appropriately but information about incidents while shared with managers through weekly speciality/business meetings, care group governance meetings and speciality governance meetings, was not disseminated to staff working in theatres and surgical areas.

We reviewed minutes from the daily safety huddles from June 2020 to November 2020 and they did not evidence any communication or learning from never events across the trust.

We looked at staff meeting minutes across the surgical care group and they did not demonstrate incidents and shared learning.

Senior governance meeting minutes demonstrated incidents and shared learning were discussed. We reviewed weekly governance huddle meeting minutes from October into November 2020 and saw that the never events were included.

The trust senior staff told us that “critical friends” were to be used to visit theatres and review practices using an external perspective, for scrutiny and challenge. Critical Friends are staff from other departments of the trust with some surgical insight which enabled them to observe practice and provide an external perspective.

Quality Improvement processes had been implemented but were in their infancy. Some information gathering had taken place and a substantial action plan was completed. The trust was using quality improvement methodology to support the spread and sustainability of learning. A training session had been held in December 2020 which had looked at World health Organisation (WHO) practice, Human Factors and scrub practice. Human factors training focusses on optimising performance by better understanding the behaviour of individuals and the environmental factors involved. It had been recognised that the WHO checklist and the practice of questioning and raising concerns about the WHO had in some places been poor and staff recognised the risks of this.

The quality summit was also held in November 2020 to further support the development of a substantial action plan. The internal quality summit saw representation from across all care groups, including those where a never event occurred. From this meeting, further cross cutting themes were identified, and a paper presented to board.

An incident review and learning group which had looked at information sharing and shared presentations across some of the care groups.

Surgery

Staff recognised the difficulty with having a large action plan and were looking to manage the changes effectively rather than be overwhelmed with the task.

We were told by senior staff that never events and serious incidents learning was disseminated to staff through daily huddles across wards and theatres. These huddles were recorded, and notes held in the department to enable staff not on that shift to be able to access the information and so that it was available for reference the next day. A further governance huddle was held each Monday afternoon, which the theatre manager had recently started to attend. At the time of the inspection minutes were not available. Theatres undertook never event debriefs to look at what could be improved, an example of this was an increased focus on the WHO checklist, this was used to embed safe and positive learning. A monthly governance audit half day meeting was held to review audit data. We were told a newsletter was being launched to circulate the positives to celebrate good work and share the information more widely. This had not yet been completed.

Areas for improvement

MUSTS

West Cornwall Hospital

- Ensure that actions taken to mitigate further risks of never events occurring do not have the potential to increase risk.
- Ensure that staff receive timely and adequate training in response to the never events
- Ensure that there is a system and process whereby there is a complete programme of theatre audit which includes sharing outcomes and learning across the multi-disciplinary team.
- Ensure that there is a clear governance structure to enable learning to be shared more widely across the trusts and to its other locations to guarantee patient safety.
- Ensure that actions taken in response to the never events are actioned in a timely way to ensure patient safety and to prevent re occurrence.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one other CQC inspector. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	S29A Warning Notice