Royal Cornwall Hospitals NHS Trust

St Michael's 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 St Michael's 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 St Michaels 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 February 2020 at St Michaels Hospital in the breast surgery theatre.

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 for surgery. We did not look at all domains and therefore did not change the rating for surgery which remains good overall following the last inspection dated September 2018. The trust overall was rated at that time was requires improvement. 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 which include 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 trust has seven care groups however St Michaels Hospital is managed as a separate site and does not sit within those trust care group. 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.

Our findings

St Michaels hospital has one theatre suite, this includes four operating theatres, a recovery area and two surgical wards. We inspected some of the surgical areas at St Michaels Hospital. These included all four operating theatres and one surgical ward of the hospital. A team of one manager and two inspectors, spoke with six nursing staff. We took part in one virtual interview with staff. We looked at three sets of patient notes and reviewed audit data, policies and processes. At this inspection because of the risks caused by Covid-19, we did not speak to patients and relatives.

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

We inspected this service but did not rate.

- 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. Audits 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 ensure that changes and learning supported 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 review of patient safety incidents, but responses had not been managed in a timely way to ensure patient safety.
- Mandatory WHO training for all theatre staff had been discontinued in early 2020. There was no clear and correct process for staff to follow in relation to what was needed to be counted, by whom and how this should be recorded to provide an audit trail.
- We saw that 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 the response had not been managed in a timely way to ensure patient safety.

Surgery

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 available to all staff and provided an audit trail for areas discussed.

As part of the five steps to safer surgery a daily briefing in each theatre was undertaken at the beginning of each list to highlight any patient that may be deemed at risk, to discuss specific equipment requirements, and any issues which may impact the list. In these briefings we observed notes made on the paper operating list, the questions asked were from memory. No physical prompts were used which could lead to inconsistency of the content discussed or missed information. Following the inspection, the trust told us the briefing and debriefing checklist was captured on the electronic system and there were set questions. However, this practice was not observed during our inspection.

The National Patient Safety Agency five steps to safer surgery was followed as part of the World Health Organisation (WHO) surgical safety checklist, in the one checklist we viewed. The purpose of the sign in checklist was to check all safety elements of a patient's operation before induction of anaesthesia. This included, for example, checking for the correct patient, that the consent form had been completed and the operating site marked.

During the timeout section before the start of surgery. We saw that if a new member of the team not at the original briefing joined, introductions were completed again to ensure the theatre team knew who was available and who held what role. During all stages of the 5 steps to safer surgery, staff were engaged and participating in the process, at the sign-in, timeout and sign out stages. The documentation was signed and dated to provide an audit trail.

We looked at the WHO checklist in detail for the one procedure observed and a further three records on the ward, the appropriate speciality check list was used. No debriefing at the end of the list was observed due to limited time on site.

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. We observed three swab counts as part of the WHO checklist procedure. In each case staff recorded the swab count on a paper and electronic record but each of those systems had a shortfall in information. Staff documented the swab counts on the electronic 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 therefore did not leave a full audit trail of the information, should it be needed later.

There was inconsistent practice in relation to The Association for Perioperative Practice 2016 Chapter 8 Clinical Guidelines 8.1 Accountable Items, Swab, Instrument and Needle Count and there was an inconsistency in how the standard was being met and recorded by staff. The trusts Generic Theatre Practice Standards Clinical Guideline V3.0 November 2019, stated, "Swab instrument, needle and sharps count record must be made electronically and in the patient's record."

Staff we spoke with said it was up to the scrub staff discretion regarding what was counted. Staff told us this was also based on historical practice and no updates had been provided. The Association for Perioperative Practice 2016. Accountable Items, Swab, Instrument and Needle Count Standard states, "There is a safe and consistent process in place to ensure that all items used during perioperative or interventional procedures are accounted for during the procedure and are reconciled at the end, in order to prevent items being unintentionally retained at the surgical site, in a body cavity, or within any other material (for example drapes and personal linen)." Following an investigation of the retained swab never event, an action plan was completed and learning actions included. The Quality Assurance report of 23/09/2020 noted, "There should be quarterly audit of the xxx system across all RCHT theatre suites to evidence that names of staff who conducted the count are entered and ongoing education of staff to ensure completion." No timescales were provided for completion of training or audits. At the time of the inspection there we saw no evidence that the actions indicated above were being consistently followed, in line with the relevant standards.

We spoke with a senior staff member who told us that they had instructed staff to ensure two staff checked the swab count and signed and dated the paper document. She was not sure if staff had maintained this practice as no audits of surgical paperwork had been undertaken. We also asked if an audit of the input of theatre information on the computerised system was undertaken, no audits had been undertaken.

Mandatory WHO training for all theatre staff had been discontinued in early 2020. As part of never event learning updated WHO training we were told by governance leads for the surgical care group, that this was to start being rolled out again. We found during this visit that dermatology staff had received this updated training but not all other theatre staff had started the training, and this could create a risk to patient safety. The trust staff told us there was currently no formal training for the WHO checklist in the trust. New staff had been trained by staff within theatres during their local induction. The quality of the WHO checklist was 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 of completion. Evolving plans were that all staff involved with the WHO checklist would undergo annualised training. This had commenced and will be monitored through Electronic Staff Record and staff 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.

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.

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. 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.

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.

Surgery

Staff told us they reviewed five WHO records per theatre each month. This was completed by theatre staff reviewing their own practice and so lacked any external or independency oversight. This was a very low percentage of the total surgeries performed. Staff also confirmed they were not aware of the audit outcomes and learning was not triggered by these audits.

Consent was not managed in line with good practice guidance. During the inspection we reviewed four patients' records and saw patients' consent for surgery was obtained on the day of surgery. This was not in line with recommendations from the Royal College of Surgeons: Consent, Supported decision-making: A guide to good practice 2016, which recommends consent should be obtained prior to surgery to ensure patients have sufficient time and information to make an informed decision. The recommended practice also ensures additional consideration is given to those patients who lack mental capacity, have learning disabilities and to children and young people. As part of the WHO checklist, we observed during timeout that the scrub staff would read the consent form out loud and seek verbal confirmation from the surgeon.

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.

Staff reported incidents and near misses using the trust's electronic incident reporting system.

There was a clear understanding of incident reporting among staff and a no blame culture. Staff demonstrated the incident reporting process and told us they could request feedback. Staff told us the trust promoted incident reporting as a positive action. Information provided by the trust showed there has been a rise in incident reporting, overdue incidents and serious incidents and concise actions since July 2020.

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.

Surgery

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.

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 this a full investigation and final report was produced with recommendations and an action plan. The action plan identified allocation of responsibility and timescale for action. Effective sharing of learning across other specialties did not occur. Although some staff we spoke with were able to tell us about the never events that had occurred in their speciality, some could not. Staff were not aware of the never events in other specialities or other theatres within the trust. Safety briefings were provided by the trust, but no evidence was provided to support that the information had been disseminated down. This meant we were not assured the learning from never events had been shared effectively to ensure similar incidents did not occur in other specialities.

Staff were encouraged to be open and honest and to report incidents. All staff we spoke with told us they were encouraged to raise incidents and there was a no blame culture. Staff we spoke with said they could request feedback following an incident being raised.

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.

Surgery

- The governance structure 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 St Michaels 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.

Staff told us speciality leaders in the surgical care groups were approachable and they felt more listened to in recent months. Theatre staff were not aware of who most members of the trust board were, except for the Chief Executive. Staff referred to her by first name and several staff spoke positively that the CEO had visited theatres and spent time with them. Staff told us that as a result of the CEO visiting and discussions at that time, a new process for dealing with the red tag around the swabs had been identified (swabs were bundled in packs of five secured with a red tag and incorporated into the swab count). The changes had been made at theatre level but when speaking to staff they told us that this had not been recognised by any policy or standard operating procedure. The trust sent us the Surgical Practice Standards Clinical Guidelines V4.0 December 2019 which included information in relation to dealing with the red tags in a count. It was clear that staff were unaware of supportive guidance in relation to this.

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 groups and trust locations. Staff we spoke with 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.

Leaders had undertaken an internal thematic review of the never events to determine if there were additional trends or learning which could be gained. A review of staff skills had taken place and training had been provided firstly within the dermatology team, but with plans for further roll out of training for ophthalmology and cardiology teams. We were advised this was taking a lot of logistical planning as it involved training a whole team for half a day. Theatres and all interventional spaces teams would also be provided with this training.

The review of staff skills had been a self-assessment format which did not provide assurance of a consistent benchmark of skills had been used. Leaders had not recognised this as a risk, but staff were clear about the risks of this process but did not confirm they had raised it as an issue within the trust.

Culture

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

Surgery

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

The Board were fully aware of the never events and were supportive of the actions taken by the trust. We looked at the minutes of three public board meetings from July 2020, October 2020 and November 2020, and found reference to the never events.

Staff told us 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.

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 who. They recognised change was needed as a result of the never events to ensure patient safety

Governance

Governance structures and the communication within them were not effective to ensure that changes and learning supported patient safety across the trust.

The governance structure did not always ensure information and learning was shared effectively between surgical specialities and locations in the trust. Theatre staff were managed by theatre managers as part of a triumvirate of a general manager, head of nursing and clinical director. They were answerable to the operations lead, who reported in turn to the trust board.

The Board were fully aware of the never events and were supportive of the actions being taken. We looked at the minutes of three public board meetings from July 2020, October 2020 and November 2020, and found reference to challenge from the board in relation to the never events.

There were governance structures at each location, which enabled the never events to be reported and escalated in each location. St Michaels hospital had been enabled to manage itself separately from the main site in October 2019. At St Michaels Hospital going forward there were three heads of department meetings each week and one business meeting each week for issues to be raised and discussed. Any minutes from governance meetings were forwarded to Royal Cornwall Hospital to ensure linked learning with the main hospital.

At St Michaels Hospital there was one staff member allocated 15 hours each week to cover governance for the hospital, this was alongside their substantive role. St Michaels triumvirate leaders explained that as part of the care group re-structure crossing of different care groups, had created 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.

Surgery

All current actions were reported to and reviewed by 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 St Michaels Hospital would become part of the central governance team at the Royal Cornwall Hospital and work directly across all three locations of the trust.

Information about incidents was not shared across surgical specialities or locations through governance processes or any staff communications. There is a governance structure for the trust which does not consistently incorporate West Cornwall Hospital and St Michaels Hospital.

There was a disconnect between staff in theatre 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 theatre safety huddles from September 2020 to December 2020 and these did not evidence any communication or learning from never events across the Trust. These huddles were attended by all theatre staff.

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

Senior governance meeting minutes demonstrated incidents and shared learning were discussed. However, we reviewed weekly governance huddle meeting minutes from October into November 2020 and saw that the never events were not included and so could not demonstrate that learning had been received and understood and acted upon across the trust.

Staff we spoke with had limited knowledge of the never events and the actions being taken to address them. We were not clear as to the assurance the senior teams were receiving about actions being put in place as a result of the never events, particularly in relation to training and audit. We spoke with staff in the surgical areas visited and they consistently confirmed that they were not aware of never events in other surgical specialities and learning taken from those events was not used to support safety practice in other parts of the trust.

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 had been 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 the use of the WHO checklist, human factors and scrub practice. It had been recognised that the WHO checklist and the practice of questioning and raising concerns about the WHO checklist had, in some places, previously been poor and staff had recognised the risks of this. Staff spoke positively about the training provided and one member of staff described the WHO checklist training as “an eye opener” and other staff told us patient safety had improved as a result.

Surgery

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.

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 were held in the department to enable staff not on that shift to be able to access the information. A further governance huddle was held each Monday afternoon.

Processes had been developed to train staff in human factors. Human factors training focused on optimising performance by better understanding the behaviour of individuals and the environmental factors involved. This training had not yet been implemented in all areas of practice and at the time of the inspection had only been completed by the dermatology team on the Royal Cornwall Hospital site. There was a risk that if not all staff completed this training, they may not have the correct knowledge and skills, potentially increasing the risk of errors occurring.

Areas for improvement

MUSTS

St Michaels Hospital - Surgery

- 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 audits 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, inspection manager 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