WM QRS West Midlands Quality Review Service

NHS

Review of Theatre and Anaesthetic Services

The Royal Wolverhampton NHS Trust

Visit Date: 16th February 2017 Report Date: May 2017

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UKAS INSPECTION 8831

CONTENTS

INTRODUCTION

This report presents the findings of the review of Theatre and Anaesthetic Services at The Royal Wolverhampton NHS Trust that took place on 16th February 2017. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- WMQRS Theatre and Anaesthetics Quality Standards V1.6

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care, which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team that reviewed the services in The Royal Wolverhampton NHS Trust. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- The Royal Wolverhampton NHS Trust
- NHS Wolverhampton Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation, liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS Wolverhampton Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews (often through peer review visits), producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of The Royal Wolverhampton NHS Trust for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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THEATRE AND ANAESTHETIC SERVICES

General Comments and Achievements

Theatre and anaesthetic services at The Royal Wolverhampton NHS Trust were well-organised and had made progress since the previous review visit (March 2016). Teamwork was good and a relatively new theatre management team was respected by more junior staff. This team had a good understanding of the issues that still needed to be addressed and had appropriate mechanisms in place for tackling these. Communication between ward and theatre staff was also working well. Integration between the Cannock and Wolverhampton services was in progress. Some issues still needed to be addressed and anaesthetic staff had some outstanding concerns about the arrangements.

Emergency services worked well, including good emergency theatre sessions and good access to trauma lists. The overnight anaesthetic service was consultant-delivered. Portering staff were part of the theatre team which had reduced theatre delays. Reviewers were also impressed that patients walked to theatre whenever possible. List starts had been staggered based on an analysis of previous data on start times.

Reviewers did not visit Cannock Hospital or cardiac theatres and so were unable to comment on some aspects of progress since the last visit. They did note the following progress:

a. Records of checking of resuscitation equipment and anaesthetic machines were in place.
b. All staff seen by reviewers were appropriately dressed and without jewellery or very long nails.
c. Manual handing observed by reviewers was appropriate.

Reviewers commented that several aspects of this report would be addressed if clear procedures were in place and implemented throughout the theatre environment.

Good Practice

1. Emergency theatre (CEPOD) lists had an 'abscess hour' between 8am and 9am each morning for patients with abscesses who had been sent home the previous day and had come back in the morning as day cases. The 'abscess hour' also provided good experience for doctors in training.
2. The trauma theatre ran until 9pm seven days a week.
3. A supernumerary consultant anaesthetist was available to support anaesthetists in training during normal working hours.
4. The Beynon Day Case Unit was dedicated to day case work and was not used to provide additional in-patient bed capacity.
5. Coloured hats were used to display different team roles within theatres.

Immediate Risks: No immediate risks were identified.

Concerns

1. **Management of Controlled Drugs**

   Reviewers were seriously concerned that completion of the Controlled Drugs book was inconsistent with national guidance. Reviewers saw examples of the three stages of supply, administration and destruction being bracketed with one signature and one witness across all three stages. Reviewers also observed Controlled Drugs out in one theatre (theatre 4) that had not been recorded in the Controlled Drugs book. The theatre management team had undertaken a good audit of Controlled Drugs, which had identified similar problems.

2. **Medicines Management**

Other issues relating to medicines management were also observed:

a. The drugs fridge in theatre 1 contained one (non-standard) packet of drugs that was out of date by two weeks.

b. Drug security:

i. The drug storage cupboard in the Beynon Day Case Unit theatre had no lock.

ii. In both main theatres and the Beynon Day Case Unit theatre, transfer packs containing drugs such as Diazepam were freely accessible to non-clinical staff.

iii. Sugammadex was stored in a non-locked airway trolley without even a 'tamper-proof' tag for security.

c. Food items were stored in the drugs fridge in the 'robot' theatre.

3. **Disposal of Waste**

a. In most theatres, yellow bags for clinical and infected waste were used for disposal of all waste, including packaging, with no segregation of waste. This arrangement did not comply with Environment Agency requirements. Orange bags were used for disposal of waste from the recovery area, so waste from the same patients was being treated differently in different areas. Reviewers were told that some theatres did segregate waste.

b. In the orthopaedic theatre the sharps bin was on a shelf in the preparation room. Dirty sharps were therefore being taken into a clean area. Reviewers also commented that there was insufficient space to be able to access this sharps bin easily.

4. **WHO '*Safer Surgery*' Checklist**

Most of the team briefs were well organised but it was not clear that 'de-briefs' were happening in all theatres. Audit data showed only 60% compliance with *Safer Surgery* checklist requirements in urology. The theatre management team had started doing observational (qualitative) audits and so were aware of the problems that needed to be addressed. Reviewers suggested that observational audits should continue to support full implementation of '*Safer Surgery*' checklist requirements.

5. **Documentation of Policies and Guidelines**

There were no Standard Operating Procedures covering theatre management, although an Operational Policy was in draft form (but did not yet cover all the expected areas of theatre management). Several aspects were not yet documented and, for others, there was heavy reliance on national policies. The national policies were often long and not specific to the arrangements in The Royal Wolverhampton NHS Trust. Staff therefore did not have a clear set of localised guidance to which they could refer, on which training could be based and against which practice could be audited. There was no clear timescale for completing the Operational Policy or for developing other Standard Operating Procedures.

6. **Acute Pain Team**

The acute pain team (hosted within the Critical Care Outreach team) comprised one specialist nurse and only one consultant anaesthetist session. There was no cover for absences, other than the on-call anaesthetic team, and no linked pharmacist or physiotherapist. Cannock Hospital had no on-site support for acute pain management. Reviewers considered this amount of acute pain support to be insufficient for a hospital of the size of The Royal Wolverhampton NHS Trust.

Further Consideration

1. **Availability of Notes**

   Notes of operations undertaken in the Beynon Day Case Unit were kept in the Unit until scanned. They were therefore not available if patients needed re-admission after surgery. At weekends the Beynon Centre was locked and so notes were not easily available. Reviewers were unclear why surgeons did not type their operation notes directly onto the 'portal' which would avoid the need for scanning and ensure immediate availability.

2. **Staffing Levels and Training**

   Theatre and anaesthetic services were short of some staff but these issues were being addressed and staffing levels were improving. At the time of the review there were six consultant anaesthetist,15 wte theatre staff and 2.5 wte band 7 team leader vacancies. There were several gaps on anaesthetic rotas at trainee level but these were mostly being filled internally with little use of agency staff.

   An escalation policy was in place for obstetric theatres but other theatres did not have a formal arrangement for escalation if sufficient staff were not available. Reviewers were told, however, that minimum Association for Perioperative Practice (AFPP) staffing levels were always achieved and the theatres they observed were relatively well staffed.

   The management team was relatively small and consultant anaesthetists had minimal SPA (supporting professional activities) time, which may partially explain the lack of documented policies and guidelines. Allocating some consultant SPA time to lead roles across all theatres may help to achieve the documentation and implementation of expected policies and guidelines.

   Reviewers were told that staff had good access to training, but the proportion of appraisals completed and some aspects of mandatory training were still low (see compliance report for details).

3. **Equipment**

   All items of electrical equipment were regularly tested for compliance using the PAT testing regime across the department. However, at the time of the visit the stickers showing evidence of up to date safety tests for some pieces of equipment in the Beynon Centre, including Bair huggers (2014) and a Manujet (2003) was missing.

4. **Other issues**

   Reviewers also commented on the following issues:

   a. Several of the theatre lists observed by reviewers started late. Reviewers were told, however, that the Operating Theatre Efficiency Group (OTEG) work programme included improving theatre utilisation and efficiency.

   b. Feedback on 'compliments and complaints' and incidents was discussed at governance meetings attended by senior staff but it was not clear that it was shared with other staff in all areas. Some staff who met reviewers were not aware of feedback. Other issues of risk management and learning identified at the previous review visit had also not yet been fully addressed.

   c. Interpreters were available for the initial consultation but did not follow patients through their time in theatre, although Language Line was available. Reviewers suggested that it may be helpful to audit whether problems occurred in recovery and, if so, whether it would have been possible to predict which patients needed interpreters in the recovery and post-operative phase.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team		
Dr Adrian Jennings	Consultant Anaesthetist	The Dudley Group NHS Foundation Trust
Mr Simon Mills	Consultant Anaesthetist	University Hospitals of North Midlands NHS Trust
Mr Piers Moreau	Orthopaedic Surgeon	The Shrewsbury and Telford Hospital NHS Trust
Katy Moynihan	Matron Theatres	The Shrewsbury and Telford Hospital NHS Trust
Mr Steve Odogwu	Clinical Director - General Surgery	Walsall Healthcare NHS Trust
Sally Rushby	Head Nurse Surgery	Burton Hospitals NHS Foundation Trust
Claire Saunders	Principal ODP and Quality and Safety Theatre Lead	Burton Hospitals NHS Foundation Trust
Susan Smith	Theatre Manager	George Eliot Hospital NHS Trust

WMQRS Team		
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service
Jane Eminson	Director	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but' where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Details of compliance with individual Quality Standards can be found in a separate document.

Service	Number of Applicable QS	Number of QS Met	% met
Theatre and Anaesthetic Services	47	33	70

Pathway and Service Letters

XG-	Theatre and Anaesthetic Services

Topic Sections

Each section covers the following topics:

-100	Information and Support for Patients and Carers
-200	Staffing
-300	Support Services
-400	Facilities and Equipment
-500	Guidelines and Protocols
-600	Service Organisation and Liaison with Other Services
-700	Governance

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THEATRE AND ANAESTHETIC SERVICES

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-101	**Service Information** Patients should be offered written information about: a. Services provided, location and hours of opening b. Visiting hours and visiting arrangements c. How to contact the service d. Staff they are likely to meet	Y	
XG-102	**Procedure Information** For each procedure, patients should be offered written information, and the opportunity to discuss this, covering: a. Preparation for the procedure b. Types of anaesthesia available c. Staff who will be present at or who will perform the procedure d. Any side effects	Y	Relevant information about procedures was available. This covered all aspects of the QS except that it was not clear which staff would be present at and perform the procedure.
XG-103	**Privacy, Dignity and Security** Patients' privacy, dignity and security should be maintained at all times, including security of clothes, dentures, hearing aids and personal belongings during examinations and procedures.	Y	Privacy and dignity were maintained at all times and Appleby Ward had won a patient dignity award. Security of belongings in Appleby Ward may benefit from review. Patients' property was put in bags in an unlocked cupboard.
XG-104	**Communication Aids** Communication aids should be available to help patients with communication difficulties to participate in decisions about their care.	Y	
XG-196	**General Support for Service Users and Carers** Patients and carers should have easy access to the following services. Information about these services should be easily available: a. Interpreter services, including access to British Sign Language b. 'Compliments and complaints' procedures	Y	See main report (further consideration) in relation to use of interpreters.
XG-199	**Involving Patients and Carers** The service should have:a. Mechanisms for receiving feedback from patients and carers about their treatment and care b. Mechanisms for involving patients and carers in decisions about the organisation of the servicesc. Examples of changes made as a result of feedback and involvement of patients and carers	Y	A 'Creating Best Practice Steering Group' was in place. Patients with dementia and their carers had been involved in this group. Other patients and carers had not yet been involved although this was planned for the future.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-201	**Leadership** Theatre and Anaesthetic Services should have a Clinical Director, Lead Nurse, Lead Operating Department Practitioner and Lead Manager with responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services.	Y	
XG-202	**Service Leads** Leads for, at least, the following areas should be identified: a. Critical care, including high dependency care and outreach b. Acute and non-acute pain services c. Obstetric anaesthesia d. Care of children e. Major incidents f. Admissions and day care g. Pre-operative assessment h. Recovery i. Equipment management	Y	
XG-203	**Staffing Levels** The service should have sufficient staff with appropriate competences to deliver the expected number of assessments and procedures for the usual case mix of patients within expected timescales (QS XG-602). An escalation policy should be in place which ensures flexibility of staffing in response to fluctuations in demand and availability of staff. Staffing levels should be based on a competence framework covering staffing levels and competences expected (QS XG-206), and should ensure an appropriate skill mix of consultant anaesthetists, other anaesthetic medical staff, physicians assistants, operating department practitioners, theatre assistants, theatre nurses and porters. In Major Trauma Centres the trauma anaesthetic team should be separate from other emergency and elective teams. In hospitals with obstetric units the obstetric anaesthetic team should be separate to enable elective work to continue uninterrupted by emergency work and a named consultant should be responsible for each elective caesarean section list.	Y	See main report (further consideration) in relation to staffing levels.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-204	**Obstetric Anaesthesia Duty Anaesthetist** A duty anaesthetist competent to undertake duties on the delivery suite should be: a. Immediately available for emergency work on the delivery suite 24/7 b. Resident on-site in units offering a 24 hour epidural service c. Able to delay other responsibilities should obstetric work arise All duty anaesthetists should have completed an initial assessment of competence in obstetric anaesthesia (IACOA) or have equivalent competences before undertaking unsupervised obstetric work.	Y	A consultant anaesthetist was not always allocated to elective obstetrics.
XG-205	**Acute Pain Team** An acute pain team should be available including: a. Consultant anaesthetist with sessional commitments to the team b. Specialist nurse with specific competences in the management of acute pain c. Other medical, nursing and operating department practitioner staff as required for the number of patients and the complexity of their needs d. Pharmacist with sessional commitments to the team e. Physiotherapist with sessional commitments to the team	N	See main report (concerns section).
XG-206	**Competence Framework and Training Plan** A competence framework should cover expected competences for roles within the service. A training and development programme should ensure that all staff have, and are maintaining, these competences. The competence framework and training plan should cover all staff identified in QS XG-203, including at least: a. Moving and handling in the theatre environment b. Drug administration c. Plastering d. Resuscitation e. Use of equipment f. Care of children and young people	N	Staff were actively encouraged to undertake training. Data available on the day of visit showed, however, that appraisals had been completed for 30 to 70% of staff in different areas and completion of Basic Life Support (BLS) training ranged from 40 to 80%.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-207	**New Starters, Agency, Bank and Locum Staff** Before starting work in the service, local induction and a review of competence for the expected role in assessments and procedures should be completed for all new starters, agency, bank and locum staff.	N	A lot of induction information was available but it was not clear how this information was expected to be used, who the target audience was, or what individuals who received a pack were expected to do with it. Some information was replicated. A clear pack and process for new starters, bank and external locum staff was not yet in place.
XG-208	**Emergency Service** Staff with appropriate competences should be available outside planned sessions including: a. On call consultant anaesthetist b. On-site anaesthetist of grade CT3 or above (or equivalent) c. Emergency theatre service Competences for emergency work should be maintained through appropriate Continuing Professional Development and / or daytime job-planned work.	Y	
XG-209	**Staff monitoring** Arrangements should be in place for monitoring and reviewing staff sickness, vacancy and turnover levels.	Y	A robust policy was in place in the Beynon Centre. The main theatres policy seen by reviewers did not include the appendices detailing monitoring arrangements but these appeared to be working in practice.
XG-210	**Team building** The service should encourage a range of activities to develop team building and multi-professional working.	Y	Multi-professional meetings were held on an individual specialty basis. A range of other meetings was also in place and project work was organised on a multi-professional basis.
XG-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available during working hours to support all aspects of theatre and anaesthetic services, including the acute pain team.	Y	Consultant anaesthetists had limited administrative support, but implementation of the new theatre system should help to reduce the administrative burden on consultants.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-301	**Support Services** Timely access to the following services should be available: a. IT support b. Hospital porters c. Patient transport d. Security e. Cleaning f. Linen supplies g. Logistics and sterile services h. Pharmacy, covering advice and supply of drugs and medical gas testing i. Infection control advice j. Medical records k. Pathology l. Imaging m. Plastering (if not part of theatre and anaesthetic service) n. Electronic and Bio-Medical Engineering	Y	Portering staff were part of the theatre team.
XG-302	**Blood and Transplant** Appropriate arrangements should be in place for: a. Supply and storage of blood products b. Other NHS Blood and Transplant storage requirements (if applicable)	Y	
XG-401	**Facilities and Equipment** The service should have appropriate facilities and equipment to deliver the expected number of assessments and procedures for the usual case mix of patients within expected timescales (QS XG-602). Facilities and equipment should comply with all relevant Standards and should ensure: a. Appropriate privacy, dignity and security for patients (QS XG-103) b. Appropriate separation of children and adults c. Immediate availability of resuscitation equipment for children and adults which is checked in accordance with Trust policy d. Availability of specialist equipment when required e. In-theatre imaging when required	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-402	**Equipment Management** The service should have arrangements for equipment management covering: a. Procurement and management of equipment and consumables b. Installation assurance c. Calibration, operation and performance of equipment d. Equipment maintenance (service contracts and maintenance schedules) covering planned maintenance and 24/7 breakdown or unscheduled maintenance e. Contingency plans in the event of equipment breakdown f. Monitoring and management of equipment failures and faults g. Ensuring safety warnings, alerts and recalls are circulated and acted upon within specified timescales h. Programme of equipment replacement and risk management of equipment used beyond its replacement date	N	See main report (further consideration section).

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-403	**Delivery Suite Equipment** The following facilities and equipment should be available within the Delivery Suite: a. At least one fully equipped obstetric theatre b. Blood gas analysis and the facility for rapid estimation of haemoglobin and blood sugar c. Monitoring equipment for the measurement of non-invasive blood pressure and invasive haemodynamic monitoring d. Equipment for measuring ECG, oxygen saturation and temperature e. Rooms should have oxygen, suction equipment and resuscitation equipment, including a defibrillator. All equipment must be checked in accordance with Trust policy. f. Rooms should have active scavenging of waste anaesthetic gas to comply with COSHH guidelines on anaesthetic gas pollution. g. Supply of O rhesus negative blood available 24/7 for emergency use h. Blood warmer allowing the rapid transfusion of blood and fluids. i. Access to cell salvage equipment. j. Patient controlled analgesia equipment and infusion devices for post-operative pain relief k. Ultrasound imaging equipment for central vascular access, transversus abdominis plane (TAP) blocks and epidural cannulation of patients as well as high risk and bariatric women l. Intralipid, Sugammadex and dantrolene with their location clearly identified.	Y	Compliance based on self-assessment.
XG-404	**IT system** IT systems for storage, retrieval and transmission of patient information should be in use. Theatre and anaesthetic staff should have access to: a. Pre-assessment information b. Theatre management system c. Trust Patient Administration System d. Emails and the Trust intranet and policies e. On-line medical and other relevant information System connectivity should be sufficient to ensure that patient details are entered once only.	N	At the time of the review, the theatre IT system and the PAS system did not communicate. As a result, staff relied on printed theatre lists, which were produced relatively late. A new theatre system was being introduced which will address this issue.
XG-405	**Moving and Handling Aids** Moving and handling aids should be available and appropriately maintained.	Y	Appropriate moving and handling was observed. A hover mattress was available.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-406	**Specialist Equipment** The service should have access to appropriate equipment, moving and handling aids and patient gowns to meet the needs of: a. Bariatric patients b. Adults and children with physical disabilities	Y	
XG-501	**Referral Information** Guidelines on information to be sent with each referral should have been agreed and circulated to all referring GPs and referring hospital clinicians.	N/A	The only service to which patients were directly referred was the chronic pain service.
XG-502	**Patient Pathway Guidelines** Guidelines should be in use covering: a. Pre-assessment, including antenatal referrals b. Pre-operative care c. Assessment prior to anaesthesia and procedure d. Range of anaesthetic techniques normally offered for each procedure e. Use of WHO Safer Surgery Checklist f. Anaesthetic assistance throughout the procedure. g. Monitoring during anaesthesia and recovery h. Post-operative care i. Post-surgery review j. Recognition and treatment of complications, including involving other services as required k. Anaesthesia in the CT and MRI environment l. Use of ultrasound during anaesthesia m. Anaesthesia in the plaster room n. Wrong site block tool kit o. Handover to post-anaesthetic care These protocols should be explicit about responsibilities at each stage of the assessment and procedure and about handover between stages of the patient pathway. Protocols should be specific about indications and arrangements for day case and short-stay surgery and enhanced recovery.	Y	
XG-503	**Consent** The Trust consent procedure should be in use.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-504	**Clinical Guidelines** Clinical guidelines should be in use covering at least: a. Management of patients with allergies b. Post-operative management of epidural anaesthesia and peripheral nerve catheters c. Blood transfusion including blood component therapy, intra-operative cell salvage and management of massive haemorrhage d. Management of suspected anaphylaxis during anaesthesia e. Peri-operative management of bariatric patients f. Management of patients with diabetes g. Management of malignant hypothermia h. Management of post-operative nausea and vomiting i. Management of patients with trauma j. Management of sepsis k. Management of acute unplanned surgical care l. Conditions requiring antenatal referral to an anaesthetist (available to both obstetricians and midwives) m. High risk surgical care for patients with a predicted hospital mortality of ≥10%	N	Guidelines were available in each theatre. See main report in relation to heavy reliance on national guidelines that had not been localised.
XG-505	**Transfer** Guidelines on transfer of patients should be in use covering, at least: a. Transfer to and from critical care services within the hospital b. Transfer for critical care or other specialist care outside the hospital Guidelines should be specific about communication, staffing, equipment and transport during the transfer and governance responsibility.	Y	
XG-506	**Pain Management** Guidelines should be in use covering management of: a. Peri - and post-operative acute pain b. Chronic pain	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-507	**Infection Control** Guidelines on infection control should be in use, including: a. Care of patients with suspected or confirmed contagious and communicable diseases and/or suppressed immune systems, including patient care before, during and after their procedure b. Decontamination of equipment and environment, including before and after use by patients with suspected or confirmed contagious or communicable diseases c. Use of single-use, disposable equipment	Y	
XG-508	**Resuscitation Policy** The Trust resuscitation policy should be in use.	Y	
XG-509	**Network and More Specialist Services** Guidelines should be in use covering arrangements and agreed timescales for: a. Access to procedures available at other hospitals b. Access to specialist advice or procedures not available within the hospital c. Arrangements for theatre and anaesthetic staff and equipment to transfer to carry out procedures at another hospital (if required), including governance responsibility.	Y	Guidelines covering vascular surgery were in use.
XG-510	**Management of Drugs and Anaesthetic Agents** Guidelines on the management of drugs and anaesthetic agents should be in use covering at least: a. Roles and responsibilities b. Security and storage c. Prescription, including prescription of unlicensed medicines and controlled drugs d. Preparation and administration e. Identification and management of extravasation f. Identification and management of patients at risk of adverse reactions g. Management of continual infusion and patient-controlled analgesia h. Prescribing of drugs to take home for day case patients i. Control of waste anaesthetic gases	N	See main report (concerns section).
XG-511	**Hazardous Substances** The service should have an up to date report showing compliance with Control of Substances Hazardous to Health (COSHH) Regulations.	Y	Compliance based on self-assessment.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-512	**Health and Safety** The Trust Health and Safety Policy should be in use, including specific reference to the response to clinical incidents.	Y	Compliance based on self-assessment.
XG-601	**Operational Policy** A Theatre and Anaesthetics Service Operational Policy should be in use covering at least: a. Availability of services, including 24/7 availability b. Visitors and visiting by relatives and others c. Staff clothing d. Professional behaviour in the theatre environment e. Management of staff who are new or expectant mothers f. Safe handling and positioning of patients g. Communication and liaison with Trust bed management, surgical teams, obstetrics, imaging and pathology services h. IT security i. Management of clinical waste j. Safeguarding children and vulnerable adults in the operating theatre k. Death of patients in the theatre environment and organ donation l. Arrangements for obtaining feedback from hospital clinicians and for involving referring GPs and hospital clinicians in decisions about the organisation of the service m. Response to a Major Incident	N	A draft Operational Policy was in development but did not yet cover all aspects of the QS. A policy on death of a patient in the theatre environment was in place. See also main report (concerns section).
XG-602	**Capacity Management** The service should have a capacity management plan covering: a. Expected timescales for response to emergency, urgent and planned demand b. Response to unexpected fluctuations in demand c. Response to delays in surgery and recovery d. Medical arbitration on priority of theatre cases (Major Trauma Centres only) e. Daily access to theatres for reconstructive microsurgery (Major Trauma Centres only)	Y	Six, four and two weekly planning meetings were in place. Capacity was generally being well-managed.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-603	**Risk Assessment and Management** A system risk assessment and risk management should be in use covering risk assessment, risk management and review of risks. Risks and actions should be recorded in an up to date Divisional Risk Register. The risk management system should include feedback to staff about risks identified and action taken.	Y	
XG-604	**Service Improvement** The service should have systems for ongoing review and improvement of quality, safety and efficiency, including at least: a. Theatre utilisation b. Staff utilisation c. Review of clinical pathways with referring GPs and hospital clinicians	Y	The Operating Theatre Efficiency Group (OTEG) was working well to improve theatre efficiency.
XG-605	**Service Development Plan** The service should have a development plan or strategy which brings together the staffing, training, equipment and facilities plans for the next five years in support of the Trust's business plans.	N	This was in development through the OTEG and specialty staffing review.
XG-701	**Data Collection** Regular data collection and monitoring should cover: a. Theatre utilisation, theatre session over-runs and under-runs b. Activity levels c. Timed clinical events along the patient pathway d. Achievement of agreed timescales for responding to emergency, urgent and planned demand e. Operations on 'high risk' surgical patients carried out under the direct supervision of a consultant surgeon and consultant anaesthetist f. Operations on patients with a predicted mortality of >5% where the consultant surgeon and consultant anaesthetist are present for the operation	N	Data on theatre utilisation was available but data on other aspects of the QS were not seen by reviewers. In practice, a high proportion of operations on high risk surgical patients was carried out under direct consultant supervision.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
XG-702	**Audit** The service should have a rolling programme of audit of compliance with guidelines and protocols [QSs XG-500s] and related outcomes.	N	An audit plan was available for 2016 but not for 2017. Reviewers did see evidence of audit, including a good Controlled Drugs audit tool. Signatures were, however, not routinely considered as part of this audit and audit of signatures had to be specifically added. WHO *Safer Surgery* audits were quantitative although one qualitative audit had been completed.
XG-703	**Quality Assurance System** The service should have a system to ensure analysis and feedback on the quality of: a. Equipment management (QS XG-402) b. Cleanliness of theatres c. Preparation of clinical areas d. Implementation of WHO Checklist Feedback to individual members of staff should be linked with appraisal and re-validation arrangements.	N	See main report in relation to equipment management. All areas were clean but reviewers did not see evidence of systematic analysis and feedback of cleaning. There was no evidence in relation to quality assurance of preparing of clinical areas (i.e. opening up and preparing theatres).
XG-704	**Monitoring of Key Performance Indicators** Key performance indicators (QS XG-701) should be reviewed regularly with Trust management and with commissioners.	Y	
XG-798	**Multi-Disciplinary Review and Learning** The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from: a. Positive feedback, complaints, outcomes, incidents and 'near misses' b. Published scientific research and guidance relating to theatre and anaesthetic services	N	Multi-disciplinary review and learning meetings were not yet in place although a plan to alter the governance meeting structure to enable the inclusion of more staff was being considered.
XG-799	**Document Control** All policies, procedures and guidelines should comply with Trust document control procedures.	N	A 'policy on policies' was in place but this was not yet being followed. The NCEPOD policy was out of date. Few other local policies had been created.

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