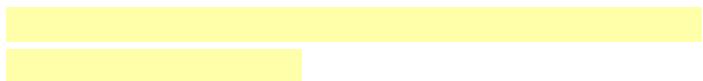


14 May 2021

States of Jersey Health and Community Services, Theatre Service Review



Executive Summary

The review found that the Health and Community Services States of Jersey are committed to providing safe and sustainable services that improve outcomes for patients and their families. This review is a testimony to its commitment to ensure that the people on its Island are in receipt of good quality and safe care. The position of The Health and Community Services States of Jersey is clear. What the review has found is that in its current arrangement the theatre service requires immediate improvements in a number of areas.

- It is my recommendation that the board sets up a Task and Finish group to set up a plan of action to draw up and agree on the best structure, process and outcome measures to use when evaluating the quality of care you provide.
- The current organisational leadership model is not in a good shape to meet the challenges of the service moving forward. Therefore, this report recommends that the organisational structure is re-designed to make it easier to identify inefficiencies and problems.
- The third recommendation which needs immediate address is an establishment review to set up specific roles and responsibilities. The focus should be on professional accountability and making sure that the staff are sufficiently competent to carry out their duties.

These are the three most pressing areas which require immediate action. A further review will be carried out in 3 months' time from the date this report is published. There are several other recommendations that have been made. It is up to the executive board to look into them and delegate responsibility on how these are going to be enacted.

I would like to thank the wonderful theatre staff of Jersey Hospital. It would not have been possible to write this report without their contribution. I was impressed by their optimism and professionalism and I am sure they truly believe in their work. I hope that this report has managed to capture in its true essence the changes they would like to see to improve patient care and their welfare.

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Background

The Health and Community Services (HCS) States of Jersey are committed to providing safe and sustainable services that improve outcomes for patients and their families. As part of this ongoing commitment, HCS wish to undertake an independent external review on the quality, safety, standard and design of the Main Theatre and Day Surgery Unit (DSU) services. Currently, HCS are not subject to inspection by an independent regulator, such as the Care Quality Commission (CQC) in England. Therefore, the external independent review aims to provide the executive team, clinicians, managers, patients and the public with external assurance that they can be confident in the quality and safety of theatre services delivered by HCS.

The process will provide a valuable objective judgement about the services and clinical performance, assessed against national standards. Advice will be given on the current model of service design and configuration and any remodelling of services required to meet future needs and the development of new ways to improve care for patients and their families. Guidance and support will be provided around quality improvement programmes and advice on the merits and means of the service in participating in wider networks.

Scope of Review

Terms of Reference

1. Examine the Leadership capacity and capability and consider whether the current systems of accountability are effective and support high quality and safe systems of work.
2. Appraise how well patient needs are assessed and if care and treatment are delivered in line with modern operating department standards and evidence-based guidance to achieve effective outcomes.
3. Assess the efficacy of scheduling within the main theatre and specifically
 - The impact of list scheduling
 - List utilisation and start and finish times
 - Speciality lists versus generic – staffing and productivity
 - What happens in turnaround times
 - Scrub and anaesthetic ratios
 - Inside and outside staffing

- Emergency lists and staffing
4. Assess the efficacy of the relationship between theatres, TSSU and the wider organisation, including maternity.
5. Consider the relationships amongst staff teams to determine if these enable them to work collaboratively, share responsibility and resolve conflict promptly and constructively.
6. Assess the culture within the service in response to incidents, establishing whether this enables openness and honesty at all levels amongst staff and patients.
7. Judge what a modern theatre service should look like for an island such as Jersey and advise on the plans for the future theatre modelling for the new Hospital build.
8. Identify how an island such as Jersey could link into a network to help enhance and support the quality and safety of the on-island services.

Summary of Findings

1. Examine the Leadership capacity and capability and consider whether the current systems of accountability are effective in supporting high quality and safe systems of work.

The following areas were reviewed :

Staff Appraisal process

The States of Jersey HCS has policies and provisions in place for managers/department leads to carry out formal appraisal meetings annually with employees to review their progress against their objectives and to identify areas of development. During these meetings, managers are encouraged to:

- Discuss work priorities
- Monitor progress against objectives set
- Monitor work activity
- Give constructive and helpful feedback
- Allow time for reflection and to measure feedback from the employee on their perception of how they are progressing
- Discuss any support, training and development needed to enable employees to carry out their daily duties

Summary of Findings

The review found that staff appraisals were not always carried out within theatres. The report acknowledges the challenges of the past year due to the ongoing Covid-19 pandemic. However, examples were sought from the periods Pre-Covid-19 pandemic and no evidence was produced. There is a consensus gained through staff interviews that this is merely undertaken as a tick box exercise. However, it has to be recognised that the majority of staff agree that when appraisals are carried out there are potential benefits. A good number of the theatre staff who were interviewed agreed that it could be a useful engagement tool to encourage employees to achieve and maintain high standards of performance and care. A few staff thought that when the process was last carried out it had been used as a tool to address long-standing disagreements, or as some put it, vendettas. Some of the conversations surrounding appraisal picked up on some issues detrimental to providing good quality care. The absence of an employee's performance feedback has affected or instilled a lack of motivation in some staff. For some staff, there are feelings of isolation and exclusion. Also, some staff highlighted a lack of training and development opportunities within the department.

Sickness and Attendance management

The State of Jersey is committed to a working environment where individuals are treated with dignity and respect. It aims to ensure that all employees maintain good health and well-being whilst at work and that absence due to sickness is minimised to maintain a high quality of service for patients.

- To manage attendance at work and minimise absence due to sickness
- To ensure that sickness absence is managed consistently and fairly across the hospital
- To ensure that employees receive prompt and appropriate support including occupational health care and advice as appropriate.

Summary of Findings

The review found that Theatres have the most number of staff on long term sickness. The cause of high sickness has been attributed to stress. The record-keeping by the management team is not always truly reflected on the electronic recording platforms reviewed. There are still some paper forms that are then passed to the senior nurse. The process fails to capture categorical data in real-time. There are some good examples of managing sickness as well as helping staff to get back to work, for example, a case was observed where staff nurses' working conditions and patterns of staff have been adjusted since returning from long term sickness. Generally, return to work meetings are said to be carried out but not recorded. The theatre senior management is aware of the process to

follow when managing long term sickness, however, the review found this is not always carried out fairly.

Annual Leave Allocation

The government of Jersey provides very clear guidelines for annual leave for both line managers and employees. Moreover, this document also provides answers to some of the most frequently asked questions.

Summary of Findings

The review found that there has been a historic carry over of unapproved leave of more than the five days which the management is permitted to approve following the annual leave guidelines. The annual leave approval is not spread across the quarters meaning some periods will leave the department short-staffed. Some staff were noted to have requested leave for more than their entitlement, the risk remains of over/under allocation because theatres are not yet fully operating using the electronic system. This is made particularly challenging in terms of an audit trail as there is the paper form that has then to be put into the electronic system. Although individual staff members are responsible for managing their leave and escalating if there is a capacity issue, some reported that the process was not managed fairly. There are reports that some are denied leave even though they have outstanding leave from previous years.

How is the leadership?

The HSC of the State of Jersey has a statement of values and behaviours that are expected of their staff. The cultural, behavioural relationship between staff and the department is underpinned by the organisation's aim to be a great place to work. It is very explicit in its expectations that the staff are required to provide the best possible care and experience for the people that use their services. The service ethos is anchored on a desire to be curious about how to improve services and patient care. This can be achieved by behaving in a way that reflects the principles and values of the organisation.

Summary of Findings

The review found evidence of the leadership turning a '*blind eye*' to some issues raised by the staff. There is also evidence that some leaders are using values to push a personal and ethnic agenda. There is sufficient evidence to suggest that some of the leadership is shying away from doing what they know is right just to prove a point. There is a proportion of misplaced stubbornness found within some specialist surgical leads. There seems to be a lack of appreciation for the unique qualities and needs of the team. There seems to be a lack of desire to provide a caring and safe

environment to enable everyone to do their jobs effectively. There are excuses for poor performance and a reluctance to take responsibility for the wellbeing of the team. Some of the responsibilities have been taken away from others and it seems there is a failure to understand the impact the leader's behaviour has on colleagues. The [redacted]

[redacted] requires support from all levels, that is the middle managers as well as the theatre senior team. The support from the senior anaesthetic team is not apparent. There is no contribution or involvement from the anaesthetic team in the day to day problem solving needed when unexpected operational situations arise. The [redacted] is left on the frontline to deal with some very difficult decisions that are sometimes not merely nursing issues. The absence of any concrete standard operating procedures makes this very difficult. The senior management's expectations are not always apparent and the direction not very clear, so that those using theatre services are unaware of the direction.

Evaluating Information

Evaluating different information is important in helping organisations generate new ideas. This in turn will provide a basis for improvement or change-making evidence-based decisions. The review looked at how well information is utilised to identify problems or issues to set criteria and standards of care. It also looked at whether any standards of performance were utilised to implement change.

Summary of Findings

The review found that data is routinely collected but not always used to inform good practice. It seems there is a reluctance to look for better ways of doing things. For example, data is available on the number of late starts and overruns. When the reviewer explored this issue with the nursing team and some middle managers, there was a reluctance to take ownership. It seems there is a culture where staff only think about their measures or experience. It appears that by ignoring the data, problems can then suddenly become invisible. There are also several opportunities being missed in collecting data to make changes to re-occurring problems. For example, the delays in getting patients to the theatre on time were noted at the time of the review. Some of the issues observed were the interpreter not booked, group and save not done, or patient cannot be located because they were sent to a different location than the originally communicated.

Orientation and Induction

The purpose is to introduce the new employee to her/his job, place of work, the Hospital and their colleagues. Its main function is to help the employee settle in quickly and create a sense of belonging. Furthermore, it will help to create and maintain high standards of working practices. This in turn will reduce the possibility of misunderstandings, bad practice and resignations. Moreover,

induction provides a supportive atmosphere and is also an opportunity to provide protected time to complete statutory and mandatory training appropriate to the role. Permanent contracts (which include fixed-term contracts) –Temporary staff i.e. bank, agency staff, locums-Honorary staff should be included.

Summary of Findings

There are currently no records to show who has completed local orientation and induction. It is non-existent for temporary staff, as they are expected to '*hit the ground*' running. The review found that the expectations of the area were not always apparent to new staff and locum staff alike. One locum mentioned that he had to just make sure that he was doing the best that he could. The [REDACTED] [REDACTED] is responsible for all assessments and signing off of all documents. The opinion of those closely working with the staff is not always sought when making judgements. There is a large amount of outstanding mandatory training that is not yet completed in theatres by all staff groups.

Clinical Responsibilities for Registered staff (Nurses and Operating Department Practitioners)

All Health Professionals have a duty of professional accountability, which makes them responsible for the outcome of their professional actions, Association for Perioperative Practice (AFPP, 2015). Health professionals are not only accountable through general law but also most importantly through their contract of employment. They are also subject to regulation through their professional bodies (NMC, 2015, HCPC, 2012). All professions must be sufficiently competent and qualified to carry out a given task.

Summary of Findings

The review found that there are no clearly defined clinical responsibilities for registered staff (both Nurses and Operating Department Practitioners). The [REDACTED] has now drafted some clinical responsibilities which have been passed to Human Resources for review. Theatre's clinical competencies were made available to the reviewer on request. In the absence of defined clinical responsibilities, it was particularly challenging to find out what standard was being aimed for. This also posed a challenge when comparing the current level of performance with that standard. There is evidence that engaging appropriate action to close the gaps in skills and knowledge is difficult in the absence of a defined structure. There were no completed records made available at the time of the review as these are not kept within the department. The assessment process is left to one named person in the department. The issue with this arrangement according to staff is that

some newly appointed staff have been deemed competent despite reservations by those who have regularly worked with the individuals. It is a situation that is causing discomfort in some groups. There is a perception that this process is carried out with one objective of bulking up staff numbers without consideration to skill sets. It inherently displaces the learning which in turn leads to achievement without understanding. This might be the reason why there have been some reported concerns by the surgical teams. Some reported feeling nervous when they walked into the room about how the operation would proceed depending on who was scrubbing for their procedure.

Skill mix

Skill mix is the combination or grouping of different categories of workers that are employed in any field of work (AFPP, 2015). In the context of health care provision, it can be applied to broad (e.g. national) macro-level planning or micro-level planning in the context of local service delivery.

Summary of Findings

The review found that generally, the theatres have a strong base of a well-experienced staff whose work is of a very good standard. The challenge however is that there is no central record to show which staff possess what level of skills. There is also no central database to identify skills needs analysis for the department and the plan of action to meet these needs. Some senior members of staff suggest that they 'mentally' hold the staff skill mix. This becomes a challenge when allocating staff in their absences as the individual skillset is not always apparent. The lack of information makes it extremely difficult to determine where staff development should be focused. Since this information is not available within the department, it seems one cannot quite pinpoint what the issues with staffing are. There are no set teams where newly qualified or appointed staff can be allocated periods of continuous close supervision with support. Therefore, developmental needs are not always adequately assessed and action plans put in place to meet the challenges of bridging the skills gap. There are no specific teams to allow for a period of supervision and support. The need to get everyone doing everything does not take into account varying learning capabilities.

Core Clinical Skills and Compliance (Mandatory Training)

2. Appraise how well patient needs are assessed and if care and treatment are delivered in line with modern operating department standards and evidence-based guidance to achieve effective outcomes.

The following areas were reviewed

Consent and Refusal of Consent

It is a general legal and ethical principle that valid consent must be obtained before commencing an examination, starting a treatment or physical investigation or providing personal care. Both the Healthcare Professional Council (HCPC) and the Nursing and Midwifery Council (NMC) provide specific guidance relating to consent.

- You must make sure that you have the informed consent of the service user or other appropriate authority before you provide care, treatment or other services (HCPC, 2016, p5)
- The NMC Code: Professional standards for practice and behaviour (2015) has the following guidance on consent:

Act in the best interest at all times

To achieve this one must :

- Balance the need to act in the best interest of people at all times with the requirement to respect a person's right to refuse or accept treatment.
- Make sure that you get properly informed consent and document before acting (NMC, 2015).

Summary of Findings

The review found the general principles of consent were followed in all observed cases during the review. There was clear documentation that indicated the proposed procedure, intended benefits and possible complications. The staff receiving patients to the theatre were observed carrying out checks to identify the patient and confirming that the patient understood the information described on the consent form. There was one particular matter of concern with the process. This relates to how a lot of abbreviations are still being used on the booking list. It makes the process of checking the consent form a little bit more challenging as some nurses are not always sure what those abbreviations stand for. Therefore, it is a situation that could potentially open up possibilities for an error to occur based on a misunderstanding. It was reported there have been incidents where the consent form has been modified during the procedure in one particular speciality. When questioned whether this was escalated appropriately the nurse sounded resigned as to what she could do.

Safer surgery processes (Five steps to safer surgery)

The Health and Social Services Jersey has a policy in place that reflects national guidance as stipulated in the National Safety Standard for invasive procedures (NatSSips, 2015), to have local standards in place to support safe surgery. This policy applies to all staff regardless of grade or profession working in Theatres. This policy document sets out key local safety processes within perioperative care across the theatres and anaesthetic division:

- Theatre team communication briefs
- WHO safer surgery checklist
- Marking and verification process for the correct site surgery
- Process for the swabs, sharps and instrument counts
- Theatre register/documentation

Summary of findings

The review found that generally the five steps to safer surgery are undertaken by all staff following the Health and Social Services Jersey policy. The theatre communication briefs were carried out in all the observed sessions. There were a few inconsistencies noted with WHO safer surgery checklist. The relevant team members were not always attentive to the process. The process was mostly nurse-led and on some occasions, the surgical team was observed scrubbing during the process. No team debriefs were carried out in all theatres that were observed despite being opportunities to reflect and learn at the end of the list. In the majority of cases, the surgeon had left or the anaesthetist returned from recovery to find that all the team members had dispersed. The process for the swabs, sharps and instrument counts is inconsistent throughout all theatres. The count boards are not standardised leading to varying inclusion or exclusion of items that are recorded for counts. Some items placed onto the operating field are not always recorded on the counting board. Some theatres paused for the final counts whilst in some, the surgeon carried on operating. There were some inconsistencies in the manner in which the final counts were confirmed with the operating surgeon. Unnecessary activity, background noises and distractions were not always curtailed during the counting process. This meant in some of the observed cases the scrub practitioner and circulator were distracted during the process. The swab count process in its current format is a cause for concern without a multi-disciplinary approach to preventing the retention of items.

The Theatre Environment

The guiding principle is that systems are in place to minimise the risk of the surgical site being exposed to microbial contamination from the operative environment. The national standards of specifications for cleanliness issued by the (NPSSA, 2007), enables organisations to have in place a process through which ‘technical standards’ can be routinely and accurately measured. This in turn provides information by which performance may be assessed concerning standards achieved.

Summary of Findings

The review focused on very specific areas and found the following on Theatre traffic that only a specific minimum number of staff required for the case were present. There is an effective air exchange system in all currently operational theatres. All doors remained closed during operations ensuring effective ventilation. Reviewing the current arrangements of environmental cleaning found that the Day Surgery Unit has a different cleaning arrangement to Main Theatres. The cleaning between theatres is in line with current guidance. There is a procedure in place for cleaning after infected cases. However, it was observed that some equipment introduced to the operating field was not cleaned before use. Conversely, it was observed that following surgery there is a very good cleaning regimen for used equipment. The cleaning between cases was observed to be in line with national standards, operating tables and related accessories were all decontaminated between cases. The corridors are generally clean but obstructed with trolleys. A few rusty surfaces were noted dotted around theatres mainly up trolleys. The patient curtains in the Recovery room (DSU) are not disposable and there are not any clear instructions or information of when the changes take place. Yet, the Main Theatres has a dated disposable curtain in its patient areas.

Sterile Services

Re-usable medical devices should be decontaminated by following the manufacturer’s instructions and with Medical Device Directive 93/42/EEC as updated by Directive 2007/47/EC (European Commission, 2009). Health and Social Services Jersey has an offsite contracted sterile services provider. The re-usable medical device life cycle comprises the processes of cleaning, disinfection, inspection for damages, sterilisation, transportation and storage before use. The cycle is used to render a re-usable instrument safe for further use.

Summary of Findings

The review found that there are effective facilities and equipment at each location. There is a robust and traceable validation, maintenance process which takes into account the manufacturer guidelines. There is evidence that staff have an understanding of risk reduction. However, there was no evidence provided when enquired of staff training, education or qualifications. The offsite location of sterile services has not impacted the running of theatre lists during the time of the review. No issues noted with the late or non-return of instruments sets. The receiving and dispatch team are very effective in managing the sterile service to meet the needs of theatres. There are challenges with the replacement of instruments in sets. There is a requirement to complete several pieces of documentation when replacing even a single instrument. The offsite location of sterile services has not impacted the running of theatre lists during the time of the review. The turnaround time has been working well in the current arrangement. However, some issues to do with purchasing more theatre instruments, where there is frequent use of instruments were noted. The Main Theatres and DSU specific sets are not standardised meaning staff from DSU when in Main Theatre are not familiar with what additional sets are required.

Medical Devices Management and Safe Use

Incidents involving medical devices can produce unexpected or adverse outcomes that affect the safety of patients, users or other people. To minimise the risk the service providers must ensure that there are systems in place for the management of medical devices.

Summary of Findings

The reviewer inspected medical devices in both operating areas at the Main Theatres and Day Surgery Unit. Medical devices were inspected for service dates and training records for all of the medical equipment used within these areas. The staff were interviewed to ascertain if they were familiar with any policy or procedures for ensuring that they have the skills and knowledge to work safely with medical devices. The reviewer also asked to see if there was any systematic inventory of medical equipment or asset information management system. The review found that there was a system in place for the installation and next service dates. However, several medical devices were found to be out of date. Some of the challenges were attributed to the current climate of a global pandemic. There are no training records to demonstrate. This is because medical device training is carried out in the traditional oral route. Knowledge of the safe use of medical devices is passed on from one colleague to another. Therefore, the context or content of the training is not standardised,

meaning staff may not always operate the machinery in the same way as it would depend on how they were trained or who trained them. When reviewing the Datix medical devices or equipment incidents it was noted that there had been at least eighteen from the period of the 1st of January 2019 to the 26th of April 2021. The details of the incidents were not made available to the reviewer. Some challenges were noted concerning interrogating the system for details. The review notes that medical devices are a risk to patients and users in this current format. This could potentially leave the organisation exposed to litigation as the manufacturer will not take responsibility for the improper use of equipment. Moreover, if a patient got harmed in the course of treatment the absence of training records and out of date service records will not help the cause.

Datix (Reporting and Learning Culture)

‘First, do no harm.’ This principle remains central to the provision of high-quality healthcare. The mission to make care safer unites professionals and patients alike, and safety is a key component of any quality initiative. Therefore, health system leaders and policymakers should find comfort in the fact that there are already many tools available to improve patient safety. Safety is an essential component of care quality. Moreover, harm to patients is a threat to the sustainability of health systems through increased healthcare utilisation and costs. Safety is also an expectation of communities, political systems and leaders.

Summary of Findings

A review was carried of incidents by category and department. The review looked at Pre-assessment and the Main theatres from the period of the 1st of January 2019 to the 29th of April 2021. A total of 184 incidents were reported for theatres within this period and seven were reported for pre-assessment. The highest number of incidents reported related to treatment or procedure. This is followed by infrastructure or resource staffing followed closely by incidents that may or do result in personal injury. There is also a high number of incidents relating to medical devices or equipment. There are several cases reported for medication errors, anaesthesia, blood transfusion, access appointments or admission. A number of these incidences are still under review. The reviewer spoke to staff regarding reporting of incidents and found that there was a split between those that reported incidents and those that did not. For those that did not report there were several reasons identified for not doing so. The main reason was the lack of feedback and fear of being blamed. Other reasons were identified such as the lack of time, lack of belief that the reporting system will

lead to change. Some were unaware of whose responsibility it was to report. The other group was familiar with the benefits of the Datix reporting system. They knew the importance of reporting and the impact on patient safety. However, they still expressed that there was a lack of a learning culture within the hospital. There is currently no systematic approach to reduce harm that is integrated within the hospital from board-level filtering to divisions and departments. There was no evidence noted of how the organisation learns from incidence within theatres. A cohesive system based on safety strategy is absent within theatres itself and the hospital has only just set up an office to look into this through a recent appointment. There is a very low reporting culture within theatres meaning learning opportunities are being missed.

Infection control

Surgical site infections are the most important causes of healthcare-associated infections (HCAI). The recommended standard is that all personnel entering restricted areas of the operating department wear designated theatre attire to minimise the risk of infection to themselves, the patient and colleagues.

Summary of Findings

The review found that the general principles of infection control were followed. There is an appropriate arrangement for the laundering of theatre attire. Suitable footwear and headwear are also provided and observed to be visibly clean with no apparent bloodstains. However, some staff were observed to be wearing wristwatches and having long fingernails. No visitors were observed entering the clinical environment. The reviewer was not able to obtain any statistics on surgical site infections. It was noted that a regular observational audit of personal protective equipment is carried out weekly. A copy of the last environmental audit was also made available to the reviewer.

The impact of list scheduling utilisation and start and finish times

The human and physical resources should be utilised effectively through proactive coordination, to facilitate the delivery of high-quality care to patients admitted for elective scheduled surgery (AFPP, 2015). The effective use of theatre time and resources is one of the fundamental levers for ensuring timely patient access to high-quality healthcare. The operating theatres are also one of the most expensive resources in any hospital, and Health and Social Services Jersey is committed to ensuring optimal use of operating theatre capacity and maximising surgical performance. There is a system in

place that supports effective management of the perioperative environment. Presently, there is a 6-4-2 theatre operational procedure that has recently been put in place for managing elective surgery. The hospital also provides a responsive emergency service that also covers maternity and is managed by trained and competent out of hours and day staff.

Summary of Findings

The review found that there is no consensus on what the session start times are, varying from 08:30 am to 09:00 am. The nursing staff and auxiliary workers report for work usually at 07:50 am. The anaesthetic and the surgical team arrive anytime from 08:30 am to whenever they get there due to various plausible reasons. There are scheduling teams for the different specialities that are responsible for populating the theatre list. The [REDACTED] chairs the list review meetings weekly. An update of actions from the previous meeting was not available in the first observed meeting. However, subsequent meetings have now gone on to include an update as well as actions from the previous meetings. The [REDACTED] has been present at all meetings. An absence of theatre nursing representation was noted at the first meeting. Nevertheless, the succeeding meetings have now had a theatre coordinator attend the theatre planning review. This is particularly invaluable to ensure that all theatre lists have the correct patients, equipment and staffing. However, it was noted that they have not yet developed a voice or that the purpose of the meeting has not been adequately explained to them. There are currently no systems in place through an audit process to determine whether theatre scheduling has been effective. There is also an issue of overuse of medical abbreviations. This is particularly challenging from the nurses planning perspective.

What happens in turnaround?

The most senior nurse/operating department practitioner is in charge of the theatre team on a particular shift. They are responsible for liaising with the wards and sending for patients as well as allocating breaks. In addition, where lists have been identified as potentially overrunning it is the responsibility of the coordinator to ensure that they are staffed adequately. Efficient turnaround requires all staff involved to understand their roles to ensure the time interval between patients is kept to a minimum. Patient turnaround can determine whether the whole theatre session runs smoothly and finishes on time, an important factor affecting staff experience.

Summary of Findings

The review found that whilst it is a good practice to have the coordinator as the designated person to authorise the collection or sending of patients, it is not always the most efficient way of using resources. The coordinator should be able to update that information in real-time to the teams or have that information displayed on a visual board for all to see. The nurses in theatres felt that they are not empowered to manage their list as they have to run everything past the coordinator. Even a simple thing such as arranging breaks has not been left to individual teams to manage. This has a very negative impact on how the teams perform as there is also no incentive to work through the list efficiently because of the constant threats of interference. It was also noted that when teams worked efficiently to get through their list, they were then redeployed to other areas. This is having a very negative impact on efficiency and it seems some are dragging the lists till their shift officially ends for fear of being punished for being efficient. Other challenges relating to turnaround time were noted in the facilities available to consent patients. The patients are not always in the same place making it particularly challenging to locate them. It is one of the biggest challenges the surgical teams face every morning. Its impact on their well-being and patient safety is not yet fully appreciated. If there was a plan in place to avoid delays this would, in turn, reduce late starts of lists which ultimately lead to potential overruns. The review also found that patients were not always ready when theatres sent for them due to many ward reasons. The reviewer found that the absence of team performance had a negative impact on patient turnaround. There is a sense of 'us' and 'them' which is palpable at all levels within theatres. The nursing staff feel that they are not well supported by their immediate managers (Grade 5s) and the Grade 5s feel the middle managers have no clue how they are doing. This, in turn, has an impact on efficiency. *It is almost as if some staff want things to fail so they can say I told you so.* Changes put in place by middle managers are often positive, but the reasons for making those changes are not being explained to staff, leading to the feeling that countless changes are being made to their working lives for no reason. This is on every level affecting not only nursing staff but other theatre staff (currently employed as manual workers) as well as health care assistants.

Scrub and Anaesthetic ratios

It is the responsibility of the coordinator to make sure that all lists, elective or emergency, are staffed by a team of appropriately trained and competent staff. The hospital has recently introduced a staffing model that is in line with the (AFPP, 2014).

Summary of Findings

The review found that although the ratios are in line with the (AFPP, 2014) recommendations, there are still challenges with the skill mix. There are reports that sometimes lists are staffed with people without the required skills and experience in managing these lists. The complex cases and heavy lists and some of the high turnover lists are not always appropriately staffed. For example, some orthopaedic revision cases require at least 10 or more heavy instruments sets per case. This review found that staff working in these areas were more likely to go off sick due to musculoskeletal problems or sometimes through stress. The 2 plus 1 staffing ratios on some fast turnover lists like urology can impact patient safety. The number of specimens required to be correctly labelled and recorded requires additional staffing resources. The theatre schedule has not yet evolved to look at these issues and plan for resources accordingly. Ophthalmology (If well-populated) and the injection list for pain management are some of the other lists that would benefit from a review by these staffing ratios. There is evidence that given the required numbers of staff and skills some of these sessions would be able to turnaround more cases safely and efficiently.

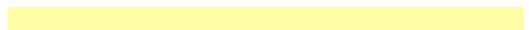
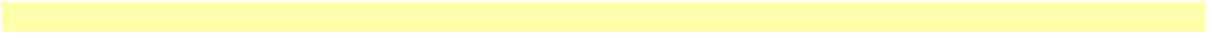
Inside and outside staffing (Theatre Support Services)

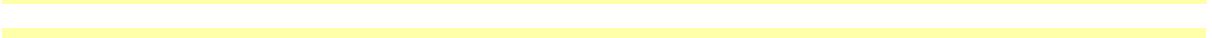
Theatres require several support services to run smoothly. These may vary from porters, cleaners, stores and procurement services. Consumables and equipment are two of the main resources that are managed by theatres. The management of both of these resources involves complex systems. Problems within these systems can have a significant impact on the daily operational running and the financial performance of theatres. Theatre teams can face a number of issues relating to consumables and equipment during their working day. These issues have the potential to increase clinical risk and significantly increase the amount of financial and process waste that occurs. Good management of consumables and equipment will improve the quality, safety and reliability of both of these systems and help reduce staff frustration. Importantly, it can go a long way to improving patient experience and outcomes.

Summary of Findings

The review found that there are no dedicated porters, cleaners, stores and procurement services for theatres. Instead, theatres dip into the hospital pool of porters when requiring patients to be moved to and from hospitals. This arrangement is not always appropriate for theatres as at times patients on the ward are not always ready meaning the porter is then called elsewhere. This then results in delays which in turn affects theatre utilisation. In some cases, it leads to overruns which in turn increase cost as the staff is then paid overtime. Theatres have now only recently since the review

employed a dedicated cleaner. The biggest issue with outside staffing is relating to stores and procurement. The role is currently not filled in by a permanent person. There are several members of the nursing and support workers who are pooled in to manage stores and procurement. The workload can be very demanding and complex at times.




There are a lot of backorders sometimes due to poor receipting or orders being sent to the wrong departments. This work covers both the Main Theatres and the Day Surgery Unit. The administrative aspects of the job alone are of significance let alone the manual handling and managing stocks. The absence of a clear system of reporting stocks makes it also a challenge in keeping on top of requirements. It has to be said that the current climate of the pandemic has made it difficult due to disruptions of some supply chains. The question of consumables is also affecting the provision of good quality care in patients under an anaesthetic. One observed surgical list in which a patient required a surgical forced-air warming device was a classic example of one of these challenges. It was reported by the anaesthetist that this was an ongoing issue with a lot of the consumables. Post-operative hypothermia can lead to prolonged recovery periods, therefore, affecting the theatre flow by blocking recovery.

Emergency lists and staffing

The hospital has a designated emergency service that is staffed 24 hours a day, managed by trained and competent staff. This is also used to cover maternity services by making available on-demand theatre nursing staff. There is currently a Consultation Proposal for Theatre Staff Change of Theatre Shift Patterns taking place. The rationale to review the theatre shift patterns was to ensure the hours that staff worked reflected what the service needed to deliver, there were a plethora of shifts. The on-call shifts also needed to be reviewed and the ability to have a private list every Saturday within core hours established.

Summary of Findings

The review found that the service is responsive to the needs of those that require emergency service as in line with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD, 2003)

classification of interventions to respond to immediate, urgent and expedited care. The review found that the capacity allocated for maternity was adequate but habitually underutilised for the number of sessions allocated to them. There are variable start times mainly attributed to job plans that have not factored in theatre start times. The proposed nursing cover is adequate for the service needs. However, there are reservations from the nursing staff about how safe this is. This has been previously looked at for a period of three months in July 2020 in a document titled Staffing Levels for the Safety of Perioperative Patients by [REDACTED] This trial showed that there was a large percentage of hours of no activity. It also showed that at no point from 20.00 to 08.00 hours were any two theatres open at the same time. The reviewer found no evidence to sustain the reservations on safety there are no Datix entries to highlight the patient safety issue. Enquiries were also made to the management to find out if any concerns were raised in writing and what nature these were. No official concerns from the nursing staff have been officially raised so far.

Value and efficiency

In the current operational format, it is difficult to measure value because of the absences of matrixes on the Island. Regarding the length of time, a patient is likely to wait for a procedure, the median is the closest to accurate information available. However, this is problematic because it is impacted by the way the waiting lists are managed on the Island. For example, if a routine patient is brought in out of order (i.e. too early) the median will drop and provide an incorrect impression of how long one will wait for an operation. Having spoken to the team managing this data the reviewer is assured that considerations are being explored to fix as well as improve on this. Currently, data is only able to provide a median time patients waited by speciality and priority. Unfortunately, in its current format, there is no way of knowing in detail the procedure the patient is waiting for. This according to the data office is a potential development but currently not available. The data system is difficult to interrogate for simple queries such as how many overruns or underruns the theatres experienced in the last week. The reviewer was provided with numerous sheets of paper in order to look through individual sessions for that information. The reviewer made contact with the informatics team requesting details but is still awaiting a response.

Summary of Findings

The efficiency of theatres was looked at in terms of utilisation. At the time of the review, it was noted that several of the allocated Private patient lists were under-booked. Currently, theatre planning meetings have not yet been exploring opportunities to offer these free slots to other

surgeons. There is a good example noted within one of the specialities where the surgeon still uses his private lists to operate on public patients. The majority of the surgeons have clearly stated that their position is that they will not use their spare time to carry out unpaid work. There is flexibility within the current format to accommodate emergency private patients on the public lists. The underutilised lists have the potential to reduce the public patients waiting list.

Patient experience and outcomes

The National Patient Safety Agency (NPSA, 2009) argues that patients and staff should be actively involved in designing solutions to the problem of harm rather than providing surface level or superficial input. Ensuring a safe care environment with minimal harm to patients is an indispensable component of high-quality care. Together with the provision of a positive patient experience and the delivery of effective care, ensuring patient safety is one of the domains in the measurement of care.

Summary of Findings

A review of patient experience and outcomes was a challenge for the reviewer. The patient experience office was not able to provide any patient experience feedback for patients using theatre services. Whilst there was some feedback from the Day Surgery Unit the data was a year old and only one patient feedback was documented for the current year. Of the patient experience, feedback for the Day Surgery Unit reviewed that patients generally felt they were happy with the care they received. The reviewer contacted the patient experience office to find out if any data had been captured through their office. There has been no response since.

Speciality lists versus generic – staffing and productivity

The review found no differences in staffing and productivity in speciality lists versus generic.

Safety and reliability

Reliability is very difficult to measure in the current hospital model. Issues with safety were addressed in **Terms of Reference (2) Appraise how well patient needs are assessed and if care and treatment are delivered in line with modern operating department standards and evidence-based guidance to achieve effective outcomes.**

Team performance and staff wellbeing

This will be looked at previously under **Terms of Reference (5)** under the subheading **(5) Consider the relationships amongst staff teams to determine if these enable them to work collaboratively, share responsibility and resolve conflict quickly and constructively.**

4. Assess the efficacy of the relationship between theatres, TSSU and the wider organisation, including maternity.

The proximity of Theatre Sterile Services Unit and turnaround time

This has been looked at previously under **Terms of Reference (2)** under the subheading **(Sterile Services).**

Emergency Theatre Cover for Maternity

This has been looked at previously under **Terms of Reference (3)** under the subheading **(Emergency lists and staffing).**

5. **Consider the relationships amongst staff teams to determine if these enable them to work collaboratively, share responsibility and resolve conflict quickly and constructively.** Assess the culture within the service in response to incidents, establishing whether this enables openness and honesty at all levels amongst staff and patients.

Some staff groups voluntarily came to speak to the Reviewer. Some were concerned that the terms of reference had not been made available to them beforehand. The reviewer explained to the staff the purpose of the review and its context. There was no specific format for these conversations. Staff were encouraged to express their feelings and thoughts and permission sought to take down notes. All staff were told that the conversations would be anonymised with no identifiable information reported. The reviewer spoke to Surgeons, Anaesthetists, Nurses, Healthcare Assistants, Theatre Assistant Practitioners, and Theatre Attendance. The reviewer picked up the common themes within the various groups to determine the impact of these relationships on staff culture. Observations were also carried out to look at how the staff interacted. The reviewer was particularly interested in finding out whether the social relationships were warm and caring. The review also wanted to see if people were treated fairly, whether they took pride in their work and the presence or absence of teamwork.

Current Organisational Climate and Culture

Organisational culture could be described as the social glue that holds the organisation together. It is not always immediately clear but thought to be the personality of the organisation. In England, the National Health Service (NHS) has a constitution that puts the patients at the heart of what it does. It is committed to working together for patients. Staff are expected to show compassion, respect and dignity, making sure that everyone counts to improve lives. At the heart of this constitution is a very strong commitment to providing quality care. Similarly, Health and Community Services (HCS) are committed to providing safe and sustainable services that improve outcomes for patients and their families.

Summary of Findings

This review has been undertaken following an extremely challenging year for both the theatre staff and the medical professionals in Health and Community Services Jersey. The effect of the pandemic and post-pandemic recovery phase on the health, wellbeing and morale of front-line workers is profound. A number of changes to the working arrangements and terms have been made following the reset from the pandemic. Some of the changes are historical and had been in the pipeline before the pandemic, such as the changes to theatre staffing levels and the consultation proposal for change of shift patterns. For the surgical teams, the events surrounding the resumption of elective surgery at the hospital following the pandemic has also been particularly challenging. Wholesale changes to the elective and private lists have been received with mixed feelings amongst the surgical communities. How the changes have been introduced is a source of resentment for a good number of the staff the reviewer spoke to. Although some of the surgeons the reviewer spoke to are managers within their disciplines, there is consensus that the quality of the senior leadership is poor within the hospital. The main issues highlighted are to do with the amount of trust bestowed or not bestowed to specific areas to manage their workloads. Almost everyone interviewed felt that communication upwards and downwards was very poor if any at all. They all felt that there is not much in terms of employee involvement and participation. The staff felt that a lot of things were now being done to them and not with them. A lot of staff stated that they no longer make suggestions as these are not valued. Some members of staff stated that they felt useless. All the responsibility has been taken away from them and there are no opportunities to show initiative as this is not welcome. The reviewer spoke to staff who thought that over the last three years they had experienced a steady but also continuous decline in morale. One thing that was unanimous was the need to be acknowledged, valued and respected.

Is there a positive or negative organisational climate?

The reviewer found sporadic elements of learning from mistakes as well as opportunities for making improvements. Although staff generally reported that they were not involved in planning and decision making, several opportunities were identified where they could be in a position to make a meaningful contribution as to how the service is run. However, some of the managers have failed to maintain some level of clinical experience, making it difficult for them to fully comprehend what this should look like. According to a good number of the staff interviewed, achievements are not being celebrated, not even a simple thing such as completing an operating list. Some reported that it has been years since anyone came and said to them well done for your hard work. There are several conversations with very senior members of the surgical team which seem to suggest that those underperforming are not dealt with directly. Instead, the approach of senior management is to tarnish everyone with the same brush. Similarly, changes aimed at managing these poor behaviours or performances are the main reasons why change is being enforced and not welcomed. This, according to a lot of the surgeons interviewed and a good number of nurses, is also leading to some bureaucratic processes being put in place which in turn stifle innovation. Having interviewed some members of the same surgical team, there is evidence that conflict is also present within even small teams. So, as the senior management has been identified as the source of the negative organisational culture, there are also small pockets within some departments that have also been infiltrated by this culture in the organisation. There are reports that this is starting to affect innovation, as some good ideas to improve services are being overlooked. This culture is also widespread within the theatre nursing community with only a few senior people having a voice in how the department runs.

Is Conflict resolved quickly and constructively (Nursing)?

The reviewer found that there was conflict affecting all levels of the department and sometimes reaching other parts of the organisation. Of particular concern is that some unresolved conflict has also found its way to a regulatory organisation because of a lack of belief in the internal systems. There is a very high number of unresolved bullying and counter bullying allegations within the nursing and support staff groups. These unsettled allegations have now started to impact patient care on various levels. The grievances that the nursing staff have are starting to impact the quality of care they provide because of low morale. Firstly, some of the staff relationships have broken down so irreparably that the staff concerned can now not be allocated to work in the same theatre. For

those that are, the communication between them is not conducive for a harmonious working relationship. The theatre department has lost all confidence in the Human Resources department on some issues. The view from the staff is that it is non-existent and elements of it that are remaining are viewed as incompetent. There is a worrying trend of prolonged investigations and a lack of updates as to where the issues are. Nurses reported to the reviewer that there is a lack of transparency and they generally feel undervalued hence no action is taken to address bad behaviour. There is a toxic gossip culture festering within theatres and staff repeatedly reported that they are ignored by the front desk. The reviewer found that there is an issue of role modelling within theatres. Some senior nurses have been observed engaging in negative conversations with junior staff. The senior teams are also not spending enough time in theatres. This means that opportunities are being missed to address grievances and disputes in real-time. That means team building prospects are non-existent in the absence of visible leadership. There are reports of significant acts of incivility within the department and no assessment of their impact on both staff and patients.

Is Conflict resolved quickly and constructively (Surgeons and Anaesthetist)?

A very good number of Surgeons and Anaesthetists reported that the clinical management was failing dismally to address issues with performance. They felt that there was no open and transparent communication between them and senior management. One surgeon reported that the management had no faith in the process of raising concerns. They described the situation as one-way communication. Some described the management as an '*invisible lot*' who constantly fail to address the real issues. Currently, there is some conflict regarding what most describe as a total disregard. The recent changes to the private and public list are said to have been put in place with no consultation with the staff the decision would affect. Most surgeons approached reported that they were not asked how such a move would affect their specialities or patients. There is a constant referral that the decision had been taken already at a senior level without consultation. The main source of conflict according to the staff, rests with the fact that they believe there was no transparency surrounding this major decision. They reported that not a single person was offered any documents surrounding how this decision was reached or what alternatives, if any, were considered. This has been a source of what seems like an ongoing conflict between surgeons and the senior management. From listening to both sides of the argument one gets a sense that there is a conscious decision by some sections to ensure that the new way of working is seen to be failing.

6. Judge what a modern theatre service should look like for an island such as Jersey and advice on the plans for the future theatre modelling for the new Hospital build.

Summary of Findings

7. Identify how an island such as Jersey could link into a network to help enhance and support the quality and safety of the on-island services.

The following areas were reviewed :

Audit/Research Office

Auditing in the healthcare business plays a vital role in cultivating the quality of patient care and services, as well as keeping healthcare organisations in compliance with the necessary legal requirements and regulations. It is a multifaceted process that can help improve the quality of care, provide cost savings in specific areas, improve patient satisfaction and avoid unnecessary redundancies. The benefits are well documented, when carried well they can provide observations and recommendations that will address ways to control costs, improve the quality of services and ensure compliance with the latest regulations.

Summary of Findings

Currently, Health Community Services (HCS) are not subject to inspection by an independent regulator, such as the CQC in England. In the latest major strategic document from England (NHS), the first set of ambitions stated are to improve healthcare quality and reduce variations in the safety of care. Although HCS policies and protocols are very similar to those in England, their applications or lack of are not very clear. There are no clear measurements to determine how well and effectively the services are run. The review found no evidence of how the health service involves patients and staff in safety as part of its everyday business. The patient experience department was not forthcoming with details of how patients experienced their care through the services reviewed. There are no set mechanisms of feedback to the area reviewed; it is unclear how the service would act upon incidents that emerge from this source. The current patchwork of information systems does not adequately meet the needs of the hospital that wants to know how well it is doing. The review found that at the moment the systems and the data contained within them are highly inaccessible, making it difficult to identify how to improve and how to use the data effectively. Beyond technology which is very useful in capturing data, the organisation has not yet adopted behavioural insights to understand the gap between intended behaviours around incident reporting. Speaking to some senior clinicians one gets a sense that they are aware of the value. What remains particularly perplexing is the lack of strategy to incorporate these into everyday work.

Network Memberships

There is a desire in some quarters to join networks and the benefits are well known to the teams.

Summary of Findings

The review found that some clinicians were aware of other networks that could help enhance and support the quality and safety of the on-island services. They reported that the issue is to do with funding and not having a readily available audit office to help with the cause.

Recommendations

Terms of Reference	Recommendations
<p>1. Examine the Leadership capacity and capability and consider whether the current systems of accountability are effective and support high quality and safe systems of work.</p>	<p>Staff Appraisal process</p> <p>Senior management should establish a robust monitoring process for compliance with the process.</p> <p>Management should ensure that everyone has an opportunity to discuss performance and development needs with line manager.</p> <p>Utilise the process to ensure that staff understand their role and responsibility, and how they contribute to the performance of the organisation.</p> <p>Review individual performance at least once a year and identify any training or development needs to undertake role to improve performance.</p> <p>Immediate performance concerns should be acted upon sooner rather than wait for the appraisal process.</p> <p>Appraisals should not be used to pursue personal vendettas instead the process should be used to support and encourage.</p> <p>Sickness and Attendance management</p> <p>Re-establish consistent management of sickness absence in line with the hospital's policy.</p> <p>Senior managers should regularly monitor and evaluate the process for its application and compliance.</p> <p>Utilise the policy to find ways on how to support staff well-being.</p> <p>Work related stress should be acknowledged and alternatives sought to support staff.</p>

	<p>Move the recording of sickness from paper to electronic Health Roster to enable accurate monitoring.</p> <p>Managers should always seek advice from occupational health</p> <p>Hold regular Human Resource meetings to seek advise on ongoing department sickness management.</p> <p>Annual Leave Allocation</p> <p>All annual leave management and allocation should be moved to the Electronic Health Roster.</p> <p>There should be monitors in place to make sure that it is done so fairly.</p> <p>No application for annual leave should be refused without good reason.</p> <p>If annual leave is refused then reason must be recorded.</p> <p>How is the Leadership?</p> <p>The senior management needs to be visible and provide an authoritative but caring presence.</p> <p>The management team needs to be all-encompassing making sure equality and opportunity for promotions follow a transparent process.</p> <p>The nursing management needs to establish a culture of caring and continuous improvement through clear standards of behaviour and zero tolerance to gossiping and tolerance of poor care.</p> <p>Provide a clear organisational chart and empower all staff grades to be part of the decision making process.</p> <p>Give independence to individual theatres to manage their workloads, including sending for patients and allocation of breaks.</p> <p>Give individual teams a voice and the professional independence to ensure they take ownership of the care they provide.</p> <p>The coordinator's role should be rotational to allow others to develop.</p> <p>Incorporate visual management to make performance and problems visible and to enable effective team communication.</p> <p>Place large, clear and highly visual displays of daily targets and</p>
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	<p>performance.</p> <p>Establish a problem solving standard approach used to deal with issues that affect performance, systematically eliminating the barriers to progress.</p> <p>Evaluating Information</p> <p>Use information you are currently collecting to find out current trends/what needs improvement to make effective plans for future.</p> <p>Examples are:</p> <ul style="list-style-type: none"> • Waiting list • Patient experience /lack of it • Late theatres starts • Incidents reported investigated/not investigated • Staff absences reasons/causes • Underutilised theatre sessions • Seek opportunities to collect information <p>Clinical Responsibilities for Registered staff (Nurses and Operating Department Practitioners)</p> <p>Establish clear clinical responsibilities for all staff from the theatre attendant to Divisional lead.</p> <p>Consent and Refusal of Consent</p> <p>There should be zero tolerance to intra-operative altering of consent forms.</p> <p>Encourage reporting of discrepancies between listed procedures against consent forms.</p> <p>Safer surgery processes (Five steps to safer surgery)</p> <p>Carry out regular audits to monitor compliance</p> <p>Establish staff educational programmes to raise awareness</p> <p>Monitor all incidents (near miss no harm/low harm related to non-adherence to the process).</p> <p>Theatre Environment</p> <p>Replace rusty equipment.</p> <p>Replace Day Surgery Unit Recovery room multi-use curtains with disposable curtains.</p>
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	<p>Get a fire safety inspection to review the storage arrangements of the trolleys in the corridor for reassurance.</p> <p>Sterile Services</p> <p>Standardise instruments sets for day surgery and main theatres.</p> <p>Review the process for replacing instruments to make less bureaucratic.</p> <p>Medical Devices Management and Safe Use</p> <p>Review your medical devices management policy.</p> <p>Establish a process for Reviewing Medical Devices Management</p> <p>Put in place process for Monitoring Compliance and Effectiveness</p> <p>Provide medical devices training to all staff and keep accurate records</p> <p>Put in place a medical device checklist user responsibility</p> <p>Make sure all equipment has clearly labelled</p> <ul style="list-style-type: none"> • Service due dates • Organisation's equipment number <p>Datix (Reporting and Learning Culture)</p> <p>Resources and readiness relook at the organisation's purpose of incident reporting.</p> <ul style="list-style-type: none"> • Allocate appropriate financial and staff resources • Objectives must be clearly articulated • Establish a culture around safety <p>Uptake and Usage should focus on the user experience with the reporting system.</p> <ul style="list-style-type: none"> • Provide training for staff • Clear definitions of what should be reported • Direct feedback loop • Make sure that anonymity is guaranteed for staff <p>Information Capture should be meaningful to the relevant departments.</p> <ul style="list-style-type: none"> • Establish regular reports that show actual number of reports and categories • Make sure reports are done in a timely manner • Collaborative reporting to ensure data supports action
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	<p>Analysis and Publication</p> <ul style="list-style-type: none"> • Making sure data is analysable • Data must be understood by staff responsible for acting on it • Managers should have immediate access to data • All staff encouraged to participate in the analysis <p>Generating learning and Improvement through effective feedback mechanisms.</p> <ul style="list-style-type: none"> • Prioritisation of efforts prior to designing improvements • Establish system for monitoring improvement • Innovative approaches to engaging staff in improvement <p>Infection control</p> <p>Put in place a process of monitoring surgical site infections.</p> <p>Challenge bad practices such as the wearing of wrist watches and bands in the clinical areas.</p> <p>The impact of list scheduling utilisation and start and finish times</p> <p>The review recommends that the theatre planning meeting agenda should focus on;</p> <ul style="list-style-type: none"> • Review of sessions that are being used / released / awaiting surgical cover • Confirm any changes to be made to lists, who will action these and the associated deadlines • Review of lists that are empty or significantly underutilised, in order to clarify whether or not they will still run. • Discuss and agree any requests for extensions or additional ad-hoc sessions • Review of the cancellations data from the previous week and look into the reasons why • Discuss any estates or equipment issues <p>Additionally, the review recommends that a further list review meeting should be established to look at the following:</p> <ul style="list-style-type: none"> • To review lists for the next two weeks to ensure full bookings
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- Review x-ray requirements to avoid clashes
- Review HDU/ Bed requirements
- Review equipment and implant queries

The issue with the high number of under-filled private lists

What happens in turnaround?

Establish a surgical arrivals lounge for on the day anaesthetic review and consenting.

Alternatively, share the 4 consultation rooms on Reynar ward for the first part of the morning with obstetrics.

Establish a definitive start session start time and monitor reasons for late starts.

Give individual teams control over how the list are run, sending for patients managing breaks.

Scrub and Anaesthetic ratios

The current staffing ratios are in line with recommended guidance on theatre staffing.

However, a list planning review should be put in place to determine staffing requirements based on clinical need.

It is recommended that a skills need analysis is carried as matter of urgency to determine the department needs.

Following that a clear staff development and rotational programme should be put into place to address the skills issues.

Senior staff should take an active role in the training and development of staff.

The role of the coordinator should be re-evaluated and clearly defined.

The recovery start times need to match the activity, therefore staggered start times are recommended in order to provide cover for the later part of the day.

Inside and outside staffing (Theatre Support Services)

Establish a theatres stores team to manage consumables and loan equipment.

Emergency lists and staffing

Keep the current arrangement however, identify and only allocate

	<p>staff with the right skills to these shifts.</p> <p>Bring back the theatre attendance on the on-call roster to cover shortfalls as they possess the right skills.</p> <p>Value and efficiency</p> <p>Establish metrics and measures to determine value.</p> <p>The focus should be quality, collect data to demonstrate your clinical outcomes.</p> <p>It is recommended that an economical component to these metrics is also put in place.</p> <p>Currently, the political perspective is very clear and in the absence of a patient voice this may be the closest you could get to patient representation.</p> <p>Patient experience and outcomes</p> <p>Measures should be put in place to ensure that there is an improvement of patient experience and to ensure positive outcomes of care.</p> <p>The service needs to adopt a model that puts at the centre both private and public patient engagement and starts capturing patient experiences.</p>
2. Appraise how well patient needs are assessed and if care and treatment are delivered in line with modern operating department standards and evidence-based guidance to achieve effective outcomes.	<p>Consent and Refusal of Consent</p> <p>There should be zero tolerance to intra-operative altering of consent forms.</p> <p>Encourage reporting of discrepancies between listed procedures against consent forms.</p> <p>Safer surgery processes (Five steps to safer surgery)</p> <p>Carry out regular audits to monitor compliance</p> <p>Establish staff educational programmes</p> <p>Monitor all incidents (near miss no harm/low harm related to non-adherence to process</p> <p>Theatre Environment</p> <p>Replace rusty equipment.</p> <p>Replace Day Surgery Unit Recovery room multi-use curtains with</p>

	<p>disposable curtains.</p> <p>Get a fire safety inspection to review the storage arrangements of the trolleys in the corridor covered with highly combustable sheets.</p> <p>Sterile Services</p> <p>Standardise instruments sets for day surgery and main theatres.</p> <p>Review the process for process for replacing instruments to make less bureaucratic.</p> <p>Medical Devices Management and Safe Use</p> <p>Review your medical devices management policy.</p> <p>Establish a process for Reviewing Medical Devices Management</p> <p>Put in place process for Monitoring Compliance and Effectiveness</p> <p>Provide medical devices training to all staff and keep accurate records</p> <p>Put in place a medical device checklist user responsibility</p> <p>Make sure all equipment has clearly labelled</p> <ul style="list-style-type: none"> • Service due dates • Organisation's equipment number <p>Datix (Reporting and Learning Culture)</p> <p>Resources and readiness relook at the organisation's purpose of incident reporting.</p> <ul style="list-style-type: none"> • Allocate appropriate financial and staff resources • Objectives must be clearly articulated • Establish a culture around safety <p>Uptake and Usage should focus on the user experience with the reporting system.</p> <ul style="list-style-type: none"> • Provide training for staff • Clear definitions of what should be reported • Direct feedback loop • Make sure that anonymity is guaranteed for staff
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	<p>Information Capture should be meaningful to the relevant departments.</p> <ul style="list-style-type: none"> • Establish regular reports that show actual number of reports and categories • Make sure reports are done in a timely manner • Collaborative reporting to ensure data supports action <p>Analysis and Publication</p> <ul style="list-style-type: none"> • Making sure data is analysable • Data must be understood by staff responsible for acting on it • Managers should have immediate access to data • All staff encouraged to participate in the analysis <p>Generating learning and Improvement through effective feedback mechanisms.</p> <ul style="list-style-type: none"> • Prioritisation of efforts prior to designing improvements • Establish system for monitoring improvement • Innovative approaches to engaging staff in improvement <p>Infection control</p> <p>Put in place a process of monitoring surgical site infections.</p> <p>Challenge bad practices such as the wearing of wrists watches and bands in the clinical areas.</p>
<p>3. Assess the efficacy of scheduling within the main theatre and specifically. The impact of list scheduling</p> <ul style="list-style-type: none"> • List utilisation and start and finish times • Speciality lists v generic – staffing and productivity 	<p>The impact of list scheduling utilisation and start and finish times</p> <p>It is recommended that the theatre planning meeting agenda should:</p> <ul style="list-style-type: none"> • Review sessions that are being used / released / awaiting cover • Confirm any changes to be made to lists, who will action these and the associated deadlines • Review of lists that are empty or significantly underutilised, in order to clarify whether or not they will still run.

<ul style="list-style-type: none"> • What happens in turnaround • Scrub and anaesthetic ratios • Inside and outside staffing • Emergency lists and staffing 	<ul style="list-style-type: none"> • Discuss and agree any requests for extensions or additional ad-hoc sessions • Review of the cancellations data from the previous week and look into the reasons why • Discuss any staffing or equipment issues <p>Additionally, it is recommended that a further list review meeting should be established to look at the following:</p> <ul style="list-style-type: none"> • To review lists for the next two weeks to ensure full bookings • Review x-ray requirements to avoid clashes • Review HDU/ Bed requirements • Review equipment and implant queries <p>The issue with the high number of under-filled private lists</p> <p>What happens in turnaround?</p> <p>Establish a surgical arrivals lounge for on the day anaesthetic review and consenting.</p> <p>Alternatively, share the 4 consultation rooms on Reynar ward for the first part of the morning with obstetrics.</p> <p>Establish a definitive start session start time and monitor reasons for late starts.</p> <p>Give individual teams control over how the list are run, sending for patients managing breaks.</p> <p>Scrub and Anaesthetic ratios</p> <p>The current staffing ratios are in line with recommended guidance on theatre staffing.</p> <p>However, a list planning review should be put in place to determine staffing requirements based on clinical need.</p> <p>It is recommended that a skills need analysis is carried out as a matter of urgency to determine the department needs.</p> <p>Following that a clear staff development and rotational programme should be put into place to address the skills issues.</p> <p>Senior staff should take an active role in the training and development of staff.</p> <p>The role of the coordinator should be re-evaluated and clearly defined.</p>
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	<p>The recovery start times need to match the activity therefore, staggered start times are recommended in order to provide cover for the later part of the day.</p> <p>Inside and outside staffing (Theatre Support Services)</p> <p>Establish a theatres stores team to manage consumables and loan equipment.</p> <p>Emergency lists and staffing</p> <p>Keep the current arrangement however, identify and only allocate staff with the right skills to these shifts.</p> <p>Bring back the theatre attendance on the on-call roster to cover shortfalls as they possess the skills.</p> <p>Value and efficiency</p> <p>Establish metrics and measurements to determine value.</p> <p>The focus should be quality, collect data to demonstrate your clinical outcomes.</p> <p>It is recommended that an economical component to these metrics is also put in place.</p> <p>Currently, the political perspective is very clear and in the absence of a patient voice this may be the closest you could get to patient representation.</p> <p>Patient experience and outcomes</p> <p>Measures should be put in place to ensure that there is an improvement of patient experience and to ensure positive outcomes of care.</p> <p>The service needs to adopt a good model of patient engagement and start capturing patient experiences.</p>
4. Assess the efficacy of the relationship between theatres, TSSU and the wider organisation, including maternity.	<p>The proximity of Theatre Sterile Services Unit and turnaround time</p> <hr/> <p>This has been looked at previously under Terms of Reference (2) under the subheading (Sterile Services).</p>

	<p>Emergency Theatre Cover for Maternity</p> <p>This has been looked at previously under Terms of Reference (3) under the subheading (Emergency lists and staffing).</p>
<p>5. Consider the relationships amongst staff teams to determine if these enable them to work collaboratively, share responsibility and resolve conflict quickly and constructively.</p> <p>Assess the culture within the service in response to incidents, establishing whether this enables openness and honesty at all levels amongst staff and patients</p>	<p>Establish clear and specific performance goals for people's jobs.</p> <ul style="list-style-type: none"> • Communicating is the link between a team's daily work and the organisation's strategy. • Set challenging yet realistic goals for others to inspire peak performance by connecting people to their work emotionally and intellectually. • Regularly review overall individual performance. • Encourage people to initiate tasks and projects. • Recognising superior performance helps employees grow and obtain their career goals. • Conduct team meetings that serve to increase trust and mutual respect.
<p>6. Judge what a modern theatre service should look like for an island such as Jersey and advise on the plans for the future theatre modelling for the new Hospital build.</p>	<p>The future theatre modelling should take into account the patient journey.</p> <p>Admissions lounge should be on the same floor and the first point of arrival.</p> <p>This should include enough assessment rooms to cater for the number of theatres.</p> <p>The sterilisation unit should ideally be situated within the same complex.</p> <p>A consultation of the current users view would be useful in contributing to the theatre design.</p>
<p>7. Identify how an island such as Jersey could link into a network to help enhance and support the quality and safety of the on-island services.</p>	<p>It is recommended that all specialties connect to networks on the mainland.</p> <p>Individual leads need lead on the process.</p> <p>The hospital management create an office to look into needs and the benefits.</p> <p>Allocate resources to promote the cause.</p>

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References

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