North East London NHS Treatment Centre

Quality Report

King George Hospital
Barley Lane
Ilford
Essex
IG3 8YB
Tel:0333 200 4069
Website:
http://www.nelondontreatmentcentre.nhs.uk/

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

North East London NHS Treatment Centre (NELTC) opened in March 2007 . NHS treatment centres are private-sector owned and are contracted to treat NHS patients free at the point of use. In 2014, the Treatment Centre was acquired by Care UK Clinical Services Ltd, the largest independent provider of NHS services in England.

The Treatment Centre provided inpatient and day case elective surgery with associated outpatient and diagnostic clinics across five disciplines: orthopaedics, general surgery, ophthalmology, oral surgery and endoscopy. It provided services to people living in North East London and Essex. The model of care focuses on treating adults who are generally healthy and who do not have significant co-morbidities. It did not provide treatment to and care to children, nor did it provide treatment for 16 – 18 year old young adults.

The Treatment Centre had 21 bed inpatient facilities and 24 day case beds. There were six theatres that operate Monday to Saturday.

We carried out a comprehensive announced inspection of North East London NHS Treatment Centre on 21 and 22 September 2016, and an unannounced inspection on 18 October as part of our second wave of independent healthcare inspections.

We inspected the following two core services:

• Surgery

• Outpatients department.

The diagnostics service is supplied by another provider and was therefore not included in this inspection.

Our key findings were as follows:

Are services safe?

- The surgery service used the Five Steps to Safer Surgery checklist; however despite this, there were three serious incidents that had occurred in theatre between April 2015 and March 2016.
- Resuscitation training compliance was low for clinical staff.
- Controlled drugs were managed appropriately, but we found medication pre-prepared was left unattended or in an unlocked cupboard within an unattended room.
- When reviewing patient records, we found some consent forms were missing patient identification details.
- In endoscopy there was currently no scope guide available for colonoscopy and no paediatric scope ready for use with narrow structures such as with diverticular disease.
- There was currently no security presence in the outpatients department during the day and a risk assessment of the situation had not been undertaken.
- Staff understood their responsibilities for reporting incidents and were confident in using the system. Learning was appropriately shared with all staff.
- Standards of cleanliness were maintained. Consultation and clinic rooms were observed to be uncluttered.
- Staff undertook mandatory training. At the time of our inspection nearly all staff were up to date with this.

Are services effective?

- There were good patient outcomes in surgical specialities.

Summary of findings

- There were short length of stay and low readmission rates.
- The hospital demonstrated effective evidence based care and treatment and published or researched guidance that related to good practice
- NELTC had achieved Joint Advisory Group (JAG) accreditation for endoscopy provision over the past three years
- All nurses and health care assistants completed job related competency frameworks as part of their induction and staff were supported to keep their qualifications and skills up to date.

Are services caring?

- We observed staff taking time to interact with patients in a respectful and considerate manner.
- Patients commented on how helpful and kind staff had been in providing support.
- Overall staff respected patients' privacy and dignity.
- The surgical service received consistent positive feedback from the Friends and Family test.

Are services responsive?

- Referral to treatment time standards were being met across the service, with the surgery service meeting the NHS standard of providing treatment for all surgical pathways within 18 weeks of referral
- One-stop clinics in outpatients enabled patients to see the consultant, have assessments, diagnostic tests and receive a date for surgery all on the same day. However, this meant that waiting times could be long, and were one of the main issues raised in patient feedback.
- Evening clinics were offered in orthopaedics, and ophthalmology and endoscopy clinics took place on Saturdays when waiting lists developed. Patients were able to choose dates and times which suited their needs.
- Leaflets were available in the waiting areas offering patient advice and information about the hospital.
- The service had not responded to more than half of all complaints within a 20 day target set out by Care UK in the last 12 months.

Are services well-led?

- There was not sufficient oversight or risk management in place for patients coming from the local NHS acute hospital for treatment. Many staff we spoke with stated this was due to unclear communication and difference in operating procedures
- Staff in outpatients were generally positive about the leadership of the service and were able to articulate the fundamentals of the strategy and vision. However, staff we spoke to in the surgery service were not aware of the future plans or strategic vision for that service.
- Risks we identified on inspection were not reflected on the risk register.
- Managers told us that staff were encouraged to be open and transparent. Staff we spoke to in outpatients felt that despite the immediate manager and head of nursing being approachable, senior managers were not visible. However, staff in surgery we spoke with stated that the senior leadership team were visible around the service and had an open door policy for any staff members needing to access them.
- Staff had felt that job security had recently been at risk following a delay in the renewal of the hospital's main contract. However, morale was improving at the time of our inspection.

Summary of findings

- Some staff we spoke with stated they had experienced or seen instances of bullying and harassment of staff while working with the service.
- All staff were encouraged to attend the monthly Quality Governance and Assurance meeting that took place one afternoon a month, and were given time away from clinic and patient duties.
- The service had a patient forum; however this group met infrequently and did not have much input from patients other than the representatives who did not gather patient feedback as part of their roles.

Importantly, the provider must ensure that:

- Identified risks are reported and reviewed within the agreed timescales; and there is clinical oversight, governance structures, and risk management of patients coming from other healthcare providers that utilise the theatre services. (Regulation 17) (2) (b)

The provider should also ensure that:

- All clinical staff are competent in basic life support and have the required level of resuscitation training for their role
- Proposed changes to Resident Medical Officer working patterns comply with the European working time regulations.
- Structures which support staff learning from incidents are reviewed.
- The Workforce Race Equality Standard (WRES) is effectively implemented, and there is continued work towards improving culture within the service.
- Temperature checks on medicine fridges are routinely carried out on the weekend to help maintain safe levels.
- All staff are aware of the major incident management and escalation procedure, and business continuity plans.
- Current security systems in place to protect staff and patients are reviewed, and make improvements where gaps have been identified.
- Adequately risk assess the need for a continuous daytime security presence in outpatient areas.
- Provision and additional support available for patients with learning disabilities are reviewed, and develop a policy to formalise any arrangements.
- There is a scope guide available for colonoscopy and that a paediatric scope is available for use with narrow structures such as with diverticular disease.
- That equipment failure in ophthalmology is logged and responded to.
- That staff in Barley Court cannot be overheard through a shutter that separates the waiting area and the staff kitchen.
- Audits and quality monitoring is appropriate for the service and actioned accordingly.
- Continued progress is made on increasing the number of Friends and Family responses it receives.
- Ways of reducing waiting times during the one stop clinics are explored, and that patients are kept fully informed of waiting times when they attend.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	The surgery service used the Five Steps to Safer Surgery checklist, however despite this, there were three serious incidents that had occurred in theatre between April 2015 and March 2016. There was a low compliance for resuscitation training for clinical staff. We found an instance of controlled drugs left unattended in an unlocked cupboard. Patient's own controlled drugs were also not always recorded or accounted for. There was not sufficient oversight or risk management in place for patients coming from the local NHS acute hospital for treatment. Staff we spoke with stated this was due to unclear communication and difference in operating procedures. Staff we spoke to were not aware of the future plans or strategic vision for the service. Some staff we spoke with stated they had experienced or seen instances of bullying and harassment of staff while working with the service. However, there were good patient outcomes across surgical specialities. The service performed well on most national audits, and care was delivered in line with relevant national guidelines. The service was also meeting the NHS standard of providing treatment for all surgical pathways within 18 weeks of referral. The feedback from patients we spoke with regarding the care they received was positive. Patients stated that staff were friendly, helpful, and professional. The service also received consistently positive feedback in the Friends and Family test. Staffing levels in wards and theatres were generally good with low use of agency staff. Staff knew how to report concerns and most staff felt that they received good and timely feedback about reported incidents. There was good multidisciplinary team (MDT) working between doctors, nurses and allied health professionals.

Summary of findings

Outpatients and diagnostic imaging

Good

There were systems in place to report and learn from incidents, standards of hygiene were maintained and clinic rooms were well equipped. Risks were appropriately identified during assessment and communicated back to the patient's GP. A large amount of risk was automatically excluded by the referral criteria, picked up in the triage process.
The department was running at a high nursing vacancy rate which was being managed, and caused minimum service disruption. Staff underwent a formal orientation programme and induction when they joined the service and completed job related skills as part of induction. Patients and staff spoke highly of doctors and other clinical staff.
Effective evidence based care and treatment was demonstrated. Accreditation for endoscopy provision had been achieved for the past three years. Patient consent was collected routinely. Patients were treated with dignity and felt involved in decisions about their own treatment. Patients also spoke highly of medical and nursing staff.
The hospital was meeting its referral to treatment time targets. A 'one stop' clinic enabled patients to see the consultant, have diagnostic tests and receive a date for surgery all on the same day. However, this meant that waiting times during clinic appointments could be long and the hospital had no audit for monitoring waiting times but provided information regarding the one stop clinic waiting times in the helpful information pack sent to patients. There was adequate space and seating areas for patients.
Staff identified patient's individual needs and put in place support where necessary. We found a number of examples where people with additional needs had been taken in to account and their support needs met.
There was a clear leadership structure within outpatients. There had been a period of instability due to staffing and job security issues that were now resolved following the renewal of the main contract. Staff we spoke with felt very much part of a team with the head of nursing described as visible and supportive. Staff were given time away from clinic and patient duties to attend the

Summary of findings

hospital wide governance meetings. Staff also attended monthly team meetings. Heads of departments met monthly and took issues from their departmental meetings.
We identified a number of actions the provider should take to improve the service.
There was no scope guide available for colonoscopy and a paediatric scope was not available for use with narrow structures such as with diverticular disease.
There was currently no security presence in the outpatients department during the day and a risk assessment of this situation had not been undertaken.
The monitoring of the quality of contracted provision through service level agreements had recently received a renewed focus by the leadership team which should continue. Uptake of patients completing the Friends and Family survey had been low and the focus on improving this should also continue.
The only audits that currently took place in outpatients were in infection control and venous thromboembolism. It was acknowledged that the service would benefit from further quality monitoring. Waiting times during 'one stop' clinics, wound clinics, privacy from conversations being overheard and security provision were examples of this we encountered.

Summary of findings

Contents

Requires improvement

North East London NHS Treatment Centre

Services we looked at
Surgery; Outpatients

Summary of this inspection

Background to North East London NHS Treatment Centre

North East London NHS Treatment Centre (NELTC) opened in March 2007. NHS treatment centres are private-sector owned and are contracted to treat NHS patients free at the point of use. In 2014, the treatment centre was acquired by Care UK Clinical Services Ltd, the largest independent provider of NHS services in England.

NELTC is located on a large campus that also contains an acute NHS hospital, a NHS community and mental health trust and a large care home. NELTC provided inpatient and day case elective surgery with associated outpatient and diagnostic clinics across five disciplines:

Orthopaedics, general surgery, ophthalmology, oral surgery and endoscopy. It provided services to people living in North East London and Essex. The model of care focuses on treating adults who are generally healthy and who do not have significant co-morbidities. It did not provide treatment to and care to children, nor did it provide treatment for 16 – 18 year old young adults.

The Treatment Centre had 21 bed inpatient facilities and 24 day-case beds. There were six theatres that operate Monday to Saturday.

Our inspection team

Our inspection team was lead by:

Inspection Manager - Max Geraghty, CQC

The team included CQC inspectors, supported by specialist advisors, including a consultant surgeon and specialist nurses.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider;

- **Is it safe?**
- **Is it effective?**
- **Is it caring?**
- **Is it responsive to peoples' needs?**
- **Is it well led?**

Before visiting we reviewed a range of information we held about the hospital and spoke to the local clinical commissioning group. Patients were invited to contact CQC with their feedback.

We visited the treatment centre to undertake an announced inspection on 21 and 22 September 2016 and undertook an unannounced inspection on 18 October 2016.

As part of the inspection process we spoke with members of the senior leadership team and individual staff of all grades. We met with staff working within the surgical and outpatient areas.

We spoke with inpatients, day-case patients and people attending the outpatient's clinics. We looked at comments made by patients who used the services of North East London NHS Treatment Centre when completing the hospital satisfaction survey and reviewed complaints that had been raised with the hospital.

We inspected all areas of the treatment centre over a two day period, looking at outpatients and surgical care. We did not inspect the diagnostics service as that is supplied by another provider.

We did not inspect the core areas of urgent and emergency care, medicine, critical care, maternity, care of children and young people, or end of life care, as these services were not provided at North East London NHS Treatment Centre.

Summary of this inspection

We spent time observing care in day and overnight stay wards, operating theatres and the outpatients department. We reviewed policies, procedures, training and monitoring records, as well as patient's records where necessary.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experience of the quality of the care they received at North East London NHS Treatment Centre.

Information about North East London NHS Treatment Centre

Activity (April 2015 to March 2016)

- Inpatient activity/overnight inpatients – 747
- Day case attendances – 7807
- Visits to theatre – 8283.
- Outpatients activity
  - Ophthalmology – 15.9%
  - General Surgery – 18.0%
  - Orthopaedics – 50.2%
  - Gastroenterology – 5.6%
  - Oral – 10.4%

Safe

- Never events reported in this period – 2
- Serious injuries – 3
- Clinical incidents – 111
- Non-clinical incidents – 37
- Incidents of hospital acquired venous thromboembolism (VTE) – 2
- Infection control: No reported incidents of Clostridium difficile (C.diff) or Meticillin resistant staphylococcus (MRSA)

Effective

- Incidents of unexpected mortality during the reporting period– NIL
- Number of unplanned returns to theatre during the reporting period- 6
- Number of unplanned transfers during the reporting period– 2
- Number of unplanned readmissions within 28 days of discharge during the reporting period - 17

Caring

- NHS Friends and Family test (FFT): scores between 91% and 97% between Jan 2015 and Jan 2016, and with a consistently high response rate –

Responsive

- 18 week RTT – NELTC meeting national waiting times.
- Cancelled by NELTC for non-clinical reasons- 193
- How many offered an appointment within 28 days - 166
- Complaints received – 153 (Not all complaints were managed within formalised Care UK Complaints Policy timescale of 20 working days)

Well-Led

- Turnover – moderate inpatient nursing staff turnover Apr 2014 to Mar 2015 at 33.33%. Between Apr 2015 and Mar 2016 it was 18.75%. Theatre/ODP staff in same periods 4.55% and 18.75% respectively.
- Higher rates of sickness occurred in this reporting period amongst theatre and nursing staff, fluctuating between 4% and 36%.
- Bank and agency staff usage, as share of total staff, fluctuating between 20% to 92% across the reporting period.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

Requires improvement

Surgery

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Information about the service

North East London NHS Treatment Centre (NELTC) is an independent healthcare service provided by Care UK. It is commissioned to provide elective surgical procedures under contract to a local acute NHS trust in the North East London area. The contract encompasses orthopaedics, gastroenterology, ophthalmology, oral surgery, endoscopy and general surgery specialities.

NELTC is located on a large campus that also contains an acute NHS hospital, a NHS community and mental health trust and a large care home. Surgical activity takes place from two sites within this campus. The main NELTC site is where surgery appointments and patient beds are provided, while pre-assessment clinics and post-operative follow-up appointments are mostly provided at Barley Court, a five minute walk away. The service has six surgical theatres, 22 in-patient beds (Kingfisher Ward) and 24 day-case beds.

Between April 2015 and March 2016 NELTC had 8,283 visits to the operating theatres, which included 747 overnight inpatient attendances and 7,807 day case attendances.

The service has been working closely with the acute NHS hospital located on the same hospital grounds, and NETLC currently rents theatre space to their surgical department for two lists per week. NELTC is also working in partnership with the acute NHS hospital to clear their backlog of surgical appointments.

To be accepted in to the service, patients must not require complex surgery or prolonged inpatient rehabilitation or have a chronic disease that would require immediate post-operative care in an ITU, must not have sickle cell anaemia, complex clotting disorders or significant renal failure, must not have suffered a myocardial infarct, undergone coronary artery bypass surgery or coronary stenting in the last 6 months or have suspected cancers, must not have a Body Mass Index of more than 40 or be less than 19 years old. The service also does not accept any patients for surgery with a clinical emergency.

We inspected Kingfisher Ward, the day case ward, pre-assessment clinics at Barley Court, theatres, and waiting areas. Information provided by the trust prior to our inspection was reviewed and used to inform our inspection approach.

During the inspection visit we spoke with 15 patients, including with their family members and carers, and 25 staff members including nurses, doctors, consultants, senior managers, therapists, and other support staff. We also observed interactions between patients and staff, and looked a randomised selection of 10 patient care records.

Requires improvement

Surgery

Summary of findings

The surgery service used the Five Steps to Safer Surgery checklist, however despite this, there were three serious incidents that had occurred in theatre between April 2015 and March 2016.

There was a low compliance for resuscitation training for clinical staff.

We found an instance of controlled drugs left unattended in an unlocked cupboard. Patient's own controlled drugs were also not always recorded or accounted for.

There was not sufficient oversight or risk management in place for patients coming from the local NHS acute hospital for treatment. Staff we spoke with stated this was due to unclear communication and difference in operating procedures.

Staff we spoke to were not aware of the future plans or strategic vision for the service.

Some staff we spoke with stated they had experienced or seen instances of bullying and harassment of staff while working with the service.

However, there were good patient outcomes across surgical specialities. The service performed well on most national audits, and care was delivered in line with relevant national guidelines. The service was also meeting the NHS standard of providing treatment for all surgical pathways within 18 weeks of referral.

The feedback from patients we spoke with regarding the care they received was positive. Patients stated that staff were friendly, helpful, and professional. The service also received consistently positive feedback in the Friends and Family test.

Staffing levels in wards and theatres were generally good with low use of agency staff.

Staff knew how to report concerns and most staff felt that they received good and timely feedback about reported incidents.

There was good multidisciplinary team (MDT) working between doctors, nurses and allied health professionals.

Are surgery services safe?

Requires improvement

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as requires improvement because:

- The surgery service used the Five Steps to Safer Surgery checklist, however despite this, there were three serious incidents that had occurred in theatre between April 2015 and March 2016.
- There was a low compliance for resuscitation training for clinical staff.
- Controlled drugs for the service were stored and managed appropriately, however patient's own controlled drugs could not be accounted for in pharmacy documentation. On inspection we also observed an incident where pre-prepared medication was left unattended in an unlocked cupboard within an unattended room.
- When reviewing patient records, we found some consent forms were missing patient identification details.
- An Incident Management & Escalation Procedure policy was available, although ward and theatre managers were unaware of the policy and any escalation procedure associated with it.

However:

- Staffing levels in wards and theatres were good with low use of bank and agency staff.
- All of the clinical areas we visited were visibly clean and tidy, and there was good compliance with hygiene processes.
- Staff knew how to report concerns and most staff felt that they received good and timely feedback about reported incidents.
- There were low surgical site infection rates across surgical specialities.

Incidents

Requires improvement

Surgery

- The surgery service at the North East London NHS Treatment Centre (NELTC) reported three serious incidents (SIs) from April 2015 to March 2016. However, during inspection another incident in June 2016 was brought to our attention by surgery staff . We saw evidence of a thorough investigation into this incident. Two of the three incidents from the reporting period were never events. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented.
- Two never events requiring investigation took place in the surgery service at NELTC between April 2015 and March 2016, of which one was a wrong site dental extraction and the other retained surgical equipment post surgery resulting in an amputation. Both of these incidents had been thoroughly investigated and changes were made to improve safety.
- Reviewing incidents was a standard agenda item on the monthly clinical governance meetings and we saw evidence of this from meeting minutes. This ensured that any themes of incidents were highlighted and new incidents discussed.
- Learning from incidents was shared effectively. Learning was disseminated in staff memos and nurses told us it was discussed at handover and weekly ward and theatre meetings. The quality and governance manager and head of nursing and clinical services shared findings and learning from serious incidents with managers each week. However, less severe incidents were discussed on a more ad hoc basis.
- Hospital policy stated that incidents should be reported through the hospital electronic reporting system. All surgery staff had individual user login details to access this system. Doctors and nurses told us they felt able and comfortable to submit incidents to the system. However, agency staff were not supplied with login details to access and raise an incident on the computer system. Staff told us that agency staff had to log an incident by reporting it to permanent staff or use another staff member's login details.
- Staff were encouraged to report all near misses, so that robust investigations and root cause analysis (RCA) could take place to drive improvements in the patients' pathway and care.
- Staff described the process for reporting incidents and told us they received feedback which was disseminated by email, ward meetings and safety briefings. Consultant surgeons told us that all reported serious incidents were followed up with action plans and a completion date for their implementation.
- We observed incident logs and RCA's reported open and transparent conversations with patients when incidents had occurred.
- RCA's were completed as part of the investigation of incidents. This included investigation into the event, identification of contributory factors to the incident, lessons learnt, and detail of apologies to patients if the incident related to a patient's experience.
- RCA investigations resulted in new standard operating procedures (SOPs) and learning was shared across the provider organisation, Care UK. For example, staff told us following the never event where the wrong tooth was extracted, practice was changed. Whereby more stringent surgical checklists were introduced to highlight by varying methods at different stages which tooth was to be extracted.
- The theatre manager informed us of a quarterly peri-operative meeting where theatre managers from all Care UK hospitals met and share incidents and discussed best practice. This information was then taken back to the site and disseminated to staff within weekly meetings.
- The surgery service lead told us that they held morbidity and mortality (M&M) meetings where difficult surgical cases and all patient deaths were discussed by consultants and doctors in training. Staff were unable to tell us when these meetings were held and staff told us that they may be discussed within monthly governance meetings. We were provided with a spread sheet that detailed summaries of cases discussed within M&M meetings.
- Regulation 20: Duty of candour, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the organisation to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

- NELTC had a duty of candour policy. We found a good level of understanding of duty of candour responsibilities amongst senior staff. More junior staff did not have a good understanding of the term duty of candour, but were able to describe how they would address a concern with a patient should something go wrong which reflected openness and transparency.
- The hospital's electronic reporting system included prompts to ensure duty of candour obligations were undertaken. The hospital kept appropriate records of incidents that had triggered a duty of candour response and we saw a sample of these.

Safety Thermometer

- The Safety Thermometer is a national tool used by the NHS for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (blood clots in veins).
- Requested data from the safety thermometer showed there were no incidents of hospital acquired venous thromboembolism (VTE) or pulmonary embolism (PE) and no new pressure ulcers, catheter or urinary tract infections from April 2015 – March 2016.
- The VTE screening rate target of 95% for each quarter was consistently achieved for period April 2015 – March 2016.
- Current safety thermometer results were not clearly displayed on the wards which meant this information was not available to patients and their families. We asked managers and junior staff to show us where safety thermometer results were displayed or located; they were unable to do so. We viewed safety thermometer results on the notice board within the medical director's office. Subsequently, on our unannounced return visit we once more found that the results were not visible or displayed. Staff were unable to relay what information the safety thermometer displayed.

Cleanliness, infection control and hygiene

- All of the clinical areas and surgery wards we visited were visibly clean, tidy, well organised and clutter-free. The cleaning of theatres was done daily by theatre staff and in between theatre cases. We observed good wiping down and decontamination between patients in theatres and hand washing by doctors and nurses was witnessed. Domestic staff were in attendance to clean floors and walls at the end of the list. All floors in corridors were clean. Disposable curtains were used in the recovery area and there was no evidence of dust. Infection prevention and control was generally well managed. All bays, side rooms, toilets and shower facilities in wards were seen to be clean.
- Documentation provided by the treatment centre showed there had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA) from April 2015 to March 2016. On inspection of pre-assessment we found MRSA screening of orthopaedic and neurology patients were not consistently being carried out for all patients as per Department of Health guidance. As per this guidance MRSA screening should be universal for all patients admitted for surgical procedures.
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. In the PLACE audit 2015 The North East London treatment centre scored 98.5% which is better than the national average of 97.6%.
- There were infection prevention and control (IPC) policies and procedures in place that were readily available to staff on the hospital's intranet. Infection prevention and control was included in the mandatory training programme. On questioning staff, some junior nursing staff and health care assistants were unable to locate these for us to view on the intranet.
- We saw the services annual IPC strategy, which was reviewed quarterly and contained action points monitored through a dedicated infection control working group and clinical governance meeting. NELTC is part of a national Care UK infection prevention and control forum, meeting minutes viewed showed good evidence of sharing of case histories and incidents.
- Meeting minutes showed that the IPC report was a standard agenda item on monthly clinical governance committee meetings. Although, it was noted that there was poor attendance at the antibiotic stewardship meetings held.

- Records of regular IPC audits that took place to ensure all staffs were compliant with the centre's policies such as hand hygiene and the use of personal protective equipment (PPE).
- There was a lead IPC practitioner, who had additional training and responsibilities. For example undertaking investigations and root cause analysis relating to surgical site infections (SSIs) and conducting hand washing audits.
- There was easily accessible hand washing gel facilities located at the entrance to the wards, throughout the wards and theatres.
- Hand washing sinks were available throughout all the areas we inspected. All sinks in patient areas did have posters of 'hand washing technique' displayed. We witnessed staff used a good hand washing technique which was compliant with the HPA (health protection agency) guidelines.
- We witnessed the lead IPC practitioner conduct regular hygiene compliance walk rounds and assessment of the care environment across all surgery clinical areas. We witnessed staff challenge drug representatives on complying with hand hygiene when walking through into theatres.
- During our inspection we observed staff adhere to the 'bare below the elbows' policy, this demonstrated staff understood and complied with Infection control guidelines. There was easily accessible personal protective clothing such as disposable gloves and plastic gowns and we saw staff using this appropriately when delivering care.
- Equipment was marked with a sticker when it had been cleaned and ready for use.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment surfaces in between patients, and we saw staff using these.
- Housekeepers provided patients with hand wipes and ensured trays were disinfected before meal times.
- Decontamination and sterilisation of instruments was managed by a dedicated facility on site which was shared with the neighbouring hospital. This facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres, ward and clinics. The theatre manager and staff told us there was a good working relationship with this facility.
- The clinical waste unit was secure and all clinical waste bins we looked at were locked. We checked sluices on wards and in theatres, all were clean, tidy and well organised.
- Cleaning rotas and duties were displayed on ward information boards. We reviewed cleaning schedules which were all up to date, fully completed and signed including who was responsible for cleaning different areas and equipment (HCAs and housekeepers). All cleaning records were complete for the two months prior to our inspection. There was a daily and weekly cleaning plan for the external cleaning contractors. Cleaning equipment was colour-coded and used appropriately.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The sharp bins were clearly labelled, within date and tagged to ensure appropriate disposal. None were overfilled. Syringes and other disposable single use medical equipment was discarded appropriately into the sharps bins. Laryngoscope blades were single use and handles had single use sheathes.
- We noticed that sharp safe cannulas (a thin tube inserted into a vein) and sharp safe hypodermic needles (hollow needle) were being used. These devices reduce the risk of a member of staff receiving a sharps injury.
- Clinical and domestic waste bins were available and contained no inappropriate items. A member of staff was able to clearly describe to us the arrangements for the segregation of waste.
- Two of the theatres had laminar flow air filtration systems. These were mainly used for orthopaedic procedures and enabled containment and control of airflow, so reducing the risks of cross contamination and infection due to air borne organisms.

Environment and equipment

- All of the clinical areas such as theatres and wards we visited were well organised and quiet. Wards were well laid out with adequate space to move and no clutter or trip hazards blocking walk ways. Patients on the wards

looked comfortable. Theatre infrastructure was well maintained. We observed the day surgery unit (DSU) was clean and well equipped although we noted the bed spaces as being quite cramped and could have impacted on patient privacy.

- We observed a daily maintenance checklist which included daily off load generator testing.
- The equipment within surgery was managed by an external company with an electrical and biomedical engineering department (EBME). This company monitored anaesthetics and theatre equipment. A manual system for checking equipment was in place in theatres. Environment checks in theatres were undertaken on a weekly basis by the EBME contractor.
- Temperature checks of fridges and freezers within kitchens were completed daily by kitchen staff and a log book was kept.
- In theatres, equipment was neatly organised, clean and available in marked trollies. On inspection we were told that two theatres had recently been contracted out to a neighbouring NHS Hospital to use for surgical procedures. This was a relatively juvenile arrangement and represented ten theatre sessions a week.
- Staff described liaison meetings to clarify and develop plans with the neighbouring hospital as “challenging”. This was due to the fact that the neighbour hospital required their surgeons to use their own implants and all disposables including needles and gloves. This involved the treatment centre partitioning off space to duplicate storage of items. We observed two rooms dedicated to this, in addition to two large storage rack trollies which had the ability to be pushed from theatre to theatre. Subsequently there was a lack of storage facilities in theatres for large items; this meant there were risks to expensive equipment becoming damaged and an additional risk to staff injuring themselves on it. There were no risks relating to this documented on the risk register.
- Medical gases were securely stored and we saw evidence of quarterly air quality testing in conjunction with up to date training competencies.
- The centre had an endoscopy specific theatre which operated Monday to Friday, as well as occasional Saturday sessions when demand required. Endoscopy Services were accredited by the Joint Advisory Group on GI Endoscopy (JAG). NELTC went through the process of meeting the requirements of the Global Rating Scale (GRS).The initial accreditation visit took place in July 2011 and NELTC were awarded accreditation for five years. The GRS has continued to be maintained since that time and a formal re-accreditation visit was scheduled by JAG for late 2016.
- There were arrangements to ensure endoscopes were decontaminated and the risk of infection to patients minimised. We reviewed the cleaning records of endoscopes which were all compliant with patient traceability, so it could be traced which endoscope was used on each patient.
- We saw records of service visits of the endoscope washers and quarterly water samples taken to be tested for the presence of bacteria. We reviewed a sample of endoscopes and all had passed the cleaning process and this was clearly documented.
- Staff told us there was good support from outside contractors should advice be required in relation to endoscopes for example infection control experts and we saw evidence of this in minutes.
- We viewed a comprehensive equipment record which allowed for the monitoring of equipment in addition it provided evidence of the condition and age of equipment.
- Each theatre had forced air warming blankets and fluid warming systems to keep patients warm during and after surgery.
- Portable appliance testing (PAT) labels were attached to electrical items showing it had been inspected within the last year and was safe to use. This meant electrical safety and efficiency could be assured of these items.
- Association of Anaesthetists of Great Britain and Ireland (AAGBI) safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Anaesthetic equipment was being checked on a regular basis with appropriate log books. We checked two anaesthetic machines and these had been serviced within the last 12 months. The inspection team identified the log books and examined all were complete with signatures for the days theatres were in use.

- Resuscitation equipment was available in all clinical areas with security tabs present and intact; the trolley was located in a central position. Resuscitation trolley checklists demonstrated a robust checking process. Checklists were completed daily and in full, audit and policy documents were present, signed and up to date for all trolleys. All necessary trolley equipment was present, within date and in working order. On inspection of one of the three resuscitation trollies we found that a set of forceps and laryngoscope blades were open and not in sterile wraps. The staff we spoke with confirmed they had access to the equipment they required to meet peoples care needs.
- Theatres used a smoke extraction system for all major surgical cases, in accordance with HSE evidence which prevents exposure and harmful effects of diathermy plumes (surgical smoke) to staff. (RR922) (2012) guidelines.
- Health and Safety Control of Substances Hazardous to Health (COSHH) assessments in theatres were up to date and displayed.
- There was a machine for testing blood on the ward and we saw records of daily calibration and monthly maintenance checks.
- The inspection team viewed the theatre implant register. We found four separate registers; orthopaedic implants (upstairs), orthopaedic implants (downstairs), ophthalmic implants and general surgical implants (e.g. Hernia mesh). The registers were viewed as being up to date and legible so therefore deemed perfectly adequate.
- We spoke to the maintenance manager who confirmed there was a generator with sufficient oil and fuel to maintain electricity for a significant time. Theatres were fitted with an uninterrupted power supply (UPS) which meant lifesaving equipment would continue to operate in the event of a power cut.
- Two patients we spoke with told us their previous appointments had been cancelled due to equipment failure in the eye clinic. One said “this is a return visit because when we came in before the machine was not working. That was five weeks ago. When we came in to see the optician he was not as helpful as we expected”. However, the provider told us that their records showed no such cancellations and equipment failures.
- We asked senior managers about equipment failure in both eye clinic and endoscopy, were these issues logged and how the leadership team responded to them. We were told that staff logged any equipment failures as an incident, which was then picked up by the management team. For example, the response within endoscopy was for equipment renewal. They told us they were not aware of any ophthalmology problems.

Medicines

- Evidence seen during our inspection showed medicines including controlled drugs (CDs) were stored and managed appropriately across the surgery service.CD checking was completed daily and competently. CDs were appropriately stored.
- We looked at CDs (medicines liable to be misused and requiring special management) in wards and theatres. We checked order records, and CD registers and found these to be in order. Ward staff checked stock balances of CDs daily.
- On inspection we saw the TTO (To Take Out - medicines given to patient on discharge from hospital) register. All the medicine received and records of TTO dispensed to patients were recorded here.
- CD PODs (patient’s own drugs) were recorded in a separate register but stock was not always accounted for. An entry for medication where 140 capsules could not be reconciled. Pharmacy staff told us that this was due to poor documentation, and although regular audits had been completed it was difficult to maintain training due to the high staff turnover.
- Medicine stock was checked weekly on day surgery ward where two controlled drugs were stocked. We sought the CD register where we found it had been completed correctly with two people signing as a check.
- Staff told us the CD audit took place every three months; however, records showed us that this had taken place twice in 18 months; once in June 2016 and in April 2015.
- NELTC held monthly quality, governance and assurance meetings where pharmacy had a regular slot to share updates, reminders and also grievances.
- Within September governance meeting minutes pharmacy had reminded staff to record allergy status on

all pages of drug charts and for staff to provide sample signatures. Staff were reminded to attend the mandatory antibiotic stewardship meetings as only one member of staff attended previously.

- Staff had good understanding and demonstration on reporting medicines safety incidents. However, governance and management of medicines related incidents were not adequate or consistent as the outcomes were not always shared with staff. For example, staff told us they had heard about an incident of a nerve block in the wrong leg through the "grapevine".
- Pharmacy staff told us about starting an omitted dose audit in July 2016.August figures were provided and demonstrated a decrease in number of blank omitted doses from 47 in July to 18 in August. We were told that findings were shared in the monthly Medicines Management, where attendance was remarked as being variable. Meeting minutes were not made available to us.
- Most medicines were locked and within their expiry dates on Kingfisher ward. On inspection we found that patient medications to take away on discharge (TTOs) were left on the bench unlocked. This meant that the TTOs could have been misplaced or removed. However, we found TTOs were pre-planned and done in advance leading to zero waiting times for patients on discharge.
- Staff were able to give examples of frequently prescribed take home medications and common side effects which they warned patients of.
- Utilisation of a pain relief enhanced recovery protocol was evident, which was used starting from anaesthetists. The patients' pain relief needs were assessed during ward round each morning.
- Robust management controls were in place to access the drug rooms. The keys to drug cupboards were kept in a key safe with a digital lock. The pharmacy manager kept the pharmacy CD keys in a security box with a combination code, which was only known by the pharmacy manager and changed monthly.
- Medicines were stored in dedicated medication fridges when applicable. We noted the temperature monitoring devices were integral to the fridges. Although fridge and room temperatures were monitored, we saw no evidence of recordings at weekends. Two documented readings were out of range (11°c), this was highlighted to pharmacy. We observed daily records correctly kept, staff were able to explain what the safe minimum and maximum temperature ranges were. Fridge temperature checks in theatres were done but not completed daily. However, where the checks were completed the readings were within the safe range.
- We found consistent evidence that room temperature was above 25 degrees in the four months prior to inspection. Pharmacy staff told us they had escalated this and highlighted it in the medicines management report in July 2016.
- We reviewed prescription charts and found them to be legible and completed appropriately. Patient allergies had been clearly noted on the chart and identified with orange stickers. The charts reviewed demonstrated prescribing was in line with national guidance. This included compliance with the National Institute for Health and Care Excellence (NICE) VTE guidance, with a section in the front of the chart confirming a completed VTE assessment and that prophylaxis had been prescribed and administered.
- Staff told us that patients self-administer some of their medications and we saw evidence of this on patient's charts. However the service did not carry out any formal assessments as to whether patients were capable of self administering their own medications. Staff were unaware of the formal assessment.
- In theatres we found the CD registers were completed consistently. This included the amount used, the amount disposed and had two signatures every time. On inspection we observed the anaesthetist consultant preparing Intravenous (IV) medication for patients' assisted by the anaesthetist nurse practitioner or ODP.
- There was piped medical gas on the wards and in theatres. We saw evidence that these were checked quarterly, the latest check being September 2016.
- We found evidence of a resuscitation audit tool and checklist which was used to check the resuscitation trolley every morning. Date checks were carried out monthly on all resuscitation drugs. Notes on the daily check log indicated when medicines were due to expire. Anaphylaxis boxes were prepared by the pharmacist.

- The neighbouring hospital utilised their own medicines when using theatre space, but CDs were provided by Care UK. The neighbouring hospital pharmacy were responsible for maintaining the stock and supply of anaesthetic drugs required for surgery in Care UK theatres.
- During inspection we entered one of the theatres where we saw pre-prepared medicines were kept in an unlocked medicines cupboard inside an unattended room. This could have been a potential tamper risk. This was highlighted to the theatres manager and anaesthetic nurse who agreed about the potential risk. Pre-prepared medicines seen included IV antibiotics, anti-sickness in syringe, steroids in syringe and medication used to prevent or stop excessive blood loss in a syringe.
- There was pharmacist support Monday to Friday 8.15am to 4.15pm with on-call pharmacy available for advice on weekends. Out of hours cover on site was provided by a Resident Medical Officer (RMO) and a member of staff accessing medicines in pharmacy where needed.
- Pharmacy staff consisted of a pharmacy manager (PM) and pharmacy technician. They provided both clinical and management services.
- Pharmacy also provided service to another Care UK centre. This was initially taken on as a temporary service in 2011 but is still on-going.
- We found that the current pharmacy resource was not reflective of the duties and workload. There was no contingency plan in place for covering pharmacy if the PM and technician were absent. This had been highlighted in quality governance meetings and medicines management meetings with details present on the risk register. Agency cover was used in the absence of PM where only the basic elements of the service were covered due to access.
- The pharmacy manager told us they had escalated the issue of support and staffing but had been told that the budget couldn't incorporate this. We were told the head of pharmacy for Care UK had requested relief pharmacists which were also turned down. We saw evidence of a risk assessment on staffing in august 2016 on the risk register, the risk had been raised in quality governance meetings and regional pharmacy meetings. The pharmacy manager told us that they had submitted a business case for staff but it was rejected due to lack of funds.
- We were told of a demand to extend services to 6 days a week but there were no plans to ensure there would be enough resources in pharmacy.
- Pharmacy staff told us that they had concerns patients' clinical safety was compromised due to the excessive workload and lack of resources. They stated that more time and resources would allow them more opportunity to train nursing and medical staff.

Records

- The NELTC had a medical records management and archiving policy dated March 2015 and we saw staff adhering to this policy. Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept secure preventing the risk of unauthorised access to patient information.
- On Kingfisher ward, the patient records were stored in locked record trolleys in close proximity and within sight of administrative staff and the nurses' station.
- We looked at twelve medical and nursing paper records and found a good standard of record keeping. Patients were given a paper copy of their discharge summary and a copy was manually sent to their GP. However, some sets of notes included copies of consent with no patient identifiers on them apart from a signature. This could have posed significant consequences of not being able to identify which patient the consent form belongs to if lost from case notes. This was escalated to the head of nursing and clinical services at the time of our inspection.
- The inspection team noted when reviewing case notes that they did not see any evidence of medical review of patient's longer term outcomes in clinic. However there was good evidence of physiotherapy input and follow-up in patient records.
- The surgical care pathway included a pre-operative assessment including previous medical history, social history, anaesthetic assessment, input from physiotherapy, discharge planning and allergies together with baseline observations.

- The care records included multidisciplinary input where required, for example, entries made by physiotherapy.
- Falls assessments were completed and recorded. We saw evidence of assessment for pressure areas (Waterlow score), venous thromboembolism (VTE) assessment and nutritional status (Malnutrition Universal screening Tool- MUST) as well as safeguarding status. Fluid balance charts we reviewed were recorded within patient notes and were updated.
- Information governance training was mandatory and 96.67% of theatre and ward staffs were up to date with this training.

Safeguarding

- The North East London Treatment Centre had a safeguarding adults policy and a separate safeguarding children's policy authorised in August and May 2015.
- Some staff were unable to demonstrate access to the safeguarding policy. However, staff were able to identify the potential signs of abuse and process they would follow to raise a safeguarding referral. We were given examples of concerns they had identified and referrals made. The head of nursing and clinical services was the dedicated safeguarding lead and had up to date level three safeguarding training.
- There was good completion of mandatory safeguarding training within the surgery service. Safeguarding awareness was included in corporate induction and additional safeguarding training was available for staff depending on their seniority and role.
- Staff we spoke with confirmed they had received safeguarding vulnerable adults training as part of mandatory training.
- Patients we spoke with told us they felt safe in the hospital.
- The treatment centre did not have a policy or guidance on female genital mutilation (FGM).However, all staff were aware of FGM and how to raise a referral. The head of nursing and clinical services advised us that there had been an update regarding FGM given to all staff and gave us an example where a referral was made surrounding a staff member and their family. Doctors and nurses felt comfortable in managing and escalating concerns in this area.

Mandatory training

- Mandatory training was monitored and all staff expected to attend on an annual basis.
- Nurses, health care assistants (HCA) and ODPs told us that mandatory training was booked by ward managers for surgical wards and the theatre manager in theatres.
- Staff told us mandatory training was a mixture of on-line training and face to face training, and that it was always completed in work time. We were shown mandatory training on-line known as E-learning. The system highlighted any breaches. Staff could access their own learning record using this system.
- The NELTC mandatory training programme included health and safety, infection control, information security, manual handling and workplace diversity. There was an overall compliance rate of 95%. However, data supplied to us showed that only 52% of consultants, surgeons and RMOs and 39% of Nurses, HCAs and AHPs had resuscitation training.
- Mandatory training was monitored and compliance discussed during appraisal, we reviewed three appraisals which included details of completed mandatory training.
- There was a set programme of learning and development during staff induction. This included a corporate induction, and a local induction on the wards and theatres. Local induction on wards included orientation, meeting team members, review of codes of practice and completion of the centres competency book which contained all aspects of basic nursing care. Newly qualified nurses were also assigned a mentor.
- Senior staff told us that the same agency and bank nurses were used where possible. Local induction checklists and staff handbooks were completed with the nurse in charge on their first day of work.
- Consultants and trainee anaesthetists told us that there was no formal induction process for agency anaesthetists. Locum doctors were introduced to their duties and orientated by a doctor covering another rota.

Assessing and responding to patient risk

- The theatre manager informed us that the AGPP (association of peri-operative practice) had been invited to complete a peer review of the department a month ago and was awaiting a report.
- We visited theatres to survey operations and observed specific WHO checklists for different procedures, this ensured the most important safety factors relating to the procedure were highlighted and checked. The WHO (World Health Organisation) checklist is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from the theatre.
- We found evidence of staff completing WHO checklist documentation when we reviewed patients' notes postoperatively. Staff told us compliance with the checklist was closely monitored and monthly audits took place.
- The June 2016 surgical safety checklist audit demonstrated a compliance of 100% across all five steps. Staff told us if the check list had not been completed correctly it would be discussed with the individual staff member and any themes discussed at staff meetings.
- We observed multiple examples of the WHO checklist in use. In all cases they followed a standardised, accurate approach were well led and had good staff engagement.
- We attended a pre-operative team brief which was perfunctory. We found this was not documented; this meant any concerns highlighted were not recorded and could not be evidenced if issues occurred. This was not in line with the 'WHO Guidelines for Safe Surgery' 2009 and Royal College of Surgeons, 'The High Performing Surgical Team-Best Practice for Surgeons' 2014. However, evidence provided post inspection showed that previous team briefings were recorded and kept.
- We witnessed anaesthetic practitioners lead the sign-in procedure and complete sign-in of the patient in the presence of the anaesthetist. On transfer of the patient from anaesthetic room to operating theatre, we observed time outs which were led by consultant surgeons once the patient was safely transferred to operating table and secured. The 'time out' is a momentary pause before the procedure begins to confirm essential safety checks are undertaken and this involves the whole team. Although we witnessed time outs, an observational audit by the centre on one day in December 2015 highlighted that 'time out' was not happening in all cases. WHO guidelines states that missing this stage could result in a procedure on the wrong patients or wrong site of the patient's body.
- In theatres we saw empowerment of scrub nurses, with scrub nurses asking surgeons to wait during the swab and instrument check. Scrub nurses spoke confidently and with authority. There was good communication during the swab and instrument count and usage of the swab board was seen which included patient details such as allergies, procedure details and required instrumentation. The theatre manager told us they felt staff were empowered to challenge when necessary. We were told of an example where a consultant spoke in an offensive manner to an assisting nurse. The nurse flagged this up and challenged the situation and raised a Datix.
- On transfer of patients into recovery from surgery we witnessed anaesthetists provide full handover to the recovery nurse.
- The hospital used the National Early Warning System (NEWS) track and trigger flow chart. It is based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse) already undertaken when patients present to, or are being monitored in hospital. The scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support. We reviewed five completed NEWS charts which were completed correctly and we saw evidence of intervention when indicated.
- Nursing staff told us medical support was readily available when required as the Resident Medical Officer (RMO) attended to patients quickly.
- A RMO told us that there was a robust support process in place should they require support or advice, and told us of several examples of when patients had suffered complications and how support and advice was available quickly initially via telephone and then consultant attendance.
- Local preoperative assessment policies should ensure pregnancy status was checked within the immediate preoperative period in accordance with NICE guidelines.

The check should be recorded on preoperative documentation used by staff performing final clinical and identity checks before surgical intervention. We observed evidence of this guideline being used in practice.

- All patients had a VTE assessment completed and all patients wore anti-embolic stockings. Neurovascular assessments were complete and all patient records we reviewed had a pressure area assessment completed.
- There were three daily nursing handovers. In addition there was a morning 'huddle'. This was an informal meeting held at the start of each working day where the heads of department came together to discuss potential issues for the day. During our inspection we attended a morning 'huddle'. We observed a brief overview from the night staff and brief discussion of the plans and any potential issues for the day including staffing or changes to the operating lists.
- All patients had their call bell within reach, and patients told us if they pressed it they were responded to almost immediately.
- There were up to date clinical standard operating procedures in the management of emergency situations for example massive blood loss and the management of the deteriorating patient. These ensure a standardised evidence based approach to managing emergency situations, the majority of staff we spoke to confirmed that they had access to these and were aware of the content.
- During our inspection staff told us about a patient that had deteriorated and had to be transferred to another hospital, we saw well-documented evidence of prompt intervention and rapid arrival of a consultant to provide support and assistance. NEWS had been completed correctly and triggers prompted interventions.
- We undertook a review of unplanned transfers and given the nature and volume of operations undertaken, both were appropriate and there were no common themes or concerns. Between April 2015 and March 2016 there were only two unplanned transfers of patients.
- There were six unplanned returns to the operating theatre for the period April 2015 – March 2016. We undertook a review of unplanned returns to theatres and there were no common themes and all patients had been treated appropriately.
- We did not witness debriefings at the end of a list and theatre staff told us that debriefings were not fully embedded as standard practice.
- The American Society of Anaesthesiologists (ASA) used a grading system of 1-6 which determines the fitness of patients. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma. Only patients that have been assessed at pre- assessment that are ASA grade one or two have operations undertaken at the NELTC. This was because there were no facilities or staff to support patients who are more unwell. The decision was made by the nurse who undertook the pre assessment of the patient if they had any queries regarding patient's suitability it was discussed with an anaesthetist.

Nursing and support staffing

- There was occasional use of agency staff (less than 30%) from April 2015 - March 2016 for operating department practitioners (ODPs). Agency use and 'man hours' were monitored through monthly head of department meetings.
- Data supplied on staff vacancies showed the centre was at full capacity with no vacancies. However this was not reflected in the use of agency and bank staff. Conversely there was a notable reduction in agency usage of 23.9% in October 2015 to 15.2% in March 2016 for nursing staff in theatres.
- Theatres used the Association of Perioperative Practice (AFPP) staffing guidelines to ensure there were adequate numbers of appropriately trained staff available for each theatre. Staffing guidelines were not displayed but inspection staff saw evidence from staffing rotas and allocations that the guidelines were adhered to.
- Day surgery unit staffing arrangements were three qualified nurses and one HCA to 20 patients on the early shift, the same for the afternoon shift. We were told that staff were planned against projected activity.

Requires improvement

Surgery

- On inspecting Kingfisher ward we were told that staffing target was three trained nurses and two HCAs, but that it was not always achieved. The lead nurse told us that even if staffing of qualified nurses is low it still remained safe because of the acuity of patients.
- Ward managers told us internal bank staff were used as a preference to cover shifts, but agency staff were employed when necessary. Staff told us the service tried to use known agency workers and there were a number of regular, long term agency nurses which provided some stability.
- The ward manager told us that the use of bank and agency staff had reduced and was able to tell us the competencies of the regular staff. The ward manager told us that they do use an acuity tool for staffing but it wasn't always useful as the patients were not generally sick.
- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse (RN) for eight patients; surgical services were compliant with this. We saw two staff rotas that demonstrated planned staffing met actual staff ratios for each.
- Sickness and absence rates for each clinical area were reported to ward and theatre departmental leads on a weekly basis. Ward managers reported good support from Care UKs human resources department in reducing long term and short term sickness level.
- On speaking to varying members of staff we were told that staff morale was generally low. Reasons given were due to staff turnover, contract issues and some staff suspensions during periods of investigation regarding never events. Some staff reported seeing some improvements within morale.
- A few members of the nursing staff stated that a culture of favouritism was demonstrated within NELTC, where they perceived that certain senior staff had gained their position due to nepotism and not because of leadership skills. Some theatre staff held a similar view where they felt certain surgeons were favoured above others.

Surgical staffing

- Surgical treatment at NELTC was consultant led. There was a stable cohort of consultant surgeons and anaesthetists working in the surgery service and many doctors we spoke with had worked at the trust for many years.
- There were 20 consultants who were employed on either a permanent or bank contract, all of whom had been undertaking work at the hospital for over 12 months.
- The Resident Medical Officer (RMO) provided continuous medical cover and conducted regular ward rounds to ensure that all patients were appropriately treated and safe. Any changes in a patient's condition were reported to the consultant and their advice was followed in respect of further treatment.
- The treatment centre had four RMOs. Each RMO worked twelve hours on and twelve hours off shift. We spoke to RMOs during our inspection and found some had just resigned. On questioning we identified an atmosphere of unrest due to proposed rota changes. The centre wanted RMOs to move to a 24 hours a day 7 days a week shift pattern. This change would be monitored by an external company. RMOs felt this change would be too onerous.
- RMOs told us they had had extra burdens imposed on them via management in an incremental way. We were given an example of RMOs having to carry a phone to field all calls from post-op patients if they had problems. The RMOs said that the calls often extended to social and administration problems which took their time away from wards. RMOs were seen to conduct 60-80 discharges a day and RMOs told us they often sat at night going through patients' hospital notes.
- We were told that a few weeks prior to our visit a change was introduced by management to stop nursing staff administering IV injections because it was found that nursing competencies were out of date and skills required in administering IV medications needed to be individually reassessed. RMOs now had to administer all IV injections, however not all staff were clear what the current protocol for administration was.
- We were told by the RMOs that they felt unsupported by management.

Requires improvement

Surgery

- RMOs identified significant risks concerning the patients from another hospital operated in the rented theatre spaces. The NHS acute hospital insisted on a different set of discharge protocols (Medway system) compared to NELTC for their patients.This was said to cause extra work and confusion for the RMOs. The NHS hospital patients' post op issues fell onto the centres RMOs responsibility, the RMOs felt it was a risk as the centres consultants had not operated on these patients so details were not to hand.
- During the inspection we were told that RMOs were allocated £1000 per year for training, but we were told it was difficult to secure time off. There was no rest room or accommodation at NELTC for the RMOs. RMOs told us they did not get enough time to eat during their 12 hours shift although technically they were allocated an hour break.
- Staff told us that procedures new to their expertise had been introduced into theatres (example given of lumbar discectomy). RMOs told us that they had received no verbal communication or training on new procedures which they were expected to take on. We were informed that they had only a list of 'what to look out for' in patients post surgery. This was evidence of unsatisfactory clinical communication and could give rise to risk for patients.
- Staff told us that a formal hand over process was undertaken between RMOs however we did not see this as there was no change over during our visit.
- We spoke to a RMO who confirmed support from consultants was always available and gave examples of when advice had been given via the telephone prior to attending the hospital.
- A rota of the on call consultant surgeon was available. Staff were able to demonstrate how they would identify who the consultant and anaesthetist were. Consultants informed the hospital management team when on annual leave.
- Staff confirmed the surgeon and anaesthetist were available for 30 minutes immediately after a procedure or operation before leaving the hospital in case any complications occurred. After leaving the hospital they were available by telephone 24 hours a day as they maintained responsibility of the patient for the duration of the patients stay. Staff reported that they did not encounter difficulties in contacting the relevant anaesthetist during this post-operative period.

Major incident awareness

- NELTC had an Incident Management & Escalation Procedure policy (January 2016)
- Ward and theatre managers were unaware of the policy and any escalation procedure associated with it.
- Nurses were unaware of the major incident plan and where to access emergency information.
- We saw no evidence of any emergency scenario training undertaken and staff were unable to tell us if any took place.
- We asked what measures were in place in theatres in case of a complete power failure, the theatre manager told us "I rely on our engineer" and agreed that it is something that should be looked into. Maintenance engineers confirmed that NELTC had a back up generator that was utilised if there was a power failure. On our return unannounced inspection we found that the theatre manager was proficient in the major incident policy and procedure.

Are surgery services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because:

- There were good patient outcomes across surgical specialities.
- Care was delivered in line with relevant national guidelines.
- The service performed well in national clinical audits.
- There were short length of stay and low readmission rates.

- All of the patients we spoke to said they had effective and timely pain relief.
- There was good multidisciplinary team (MDT) working between doctors, nurses and allied health professionals.

Evidence-based care and treatment

- We were told by management that staff had access to national and local guidelines through the intranet, and information folders and were readily available to all staff. However, on questioning some nursing staff were unable to locate them on the intranet for us to view.
- There was a range of clinical pathways and protocols for the management and care of various surgical procedures which had been developed in conjunction with healthcare professionals from a range of specialties, for example the knee and hip replacement pathway. We reviewed two pathways which were fully completed and easy to understand.
- Care was provided in line with guidance from the National Institute for Health and Care Excellence (NICE).Policies and guidelines were developed based on both NICE and Royal College guidance and were available to all staff. This included the use of early warning systems (EWS) charts to identify and take appropriate action when a patient's condition was deteriorating. (NICE guidance CG50).
- We observed patient care carried out in accordance with national guidelines and best practice recommendations for example early recovery after surgery (ERAS) in knee and hip replacement surgery. The enhanced recovery programme aims to improve patient outcomes and speed a patient's recovery after surgery.
- There was an audit programme set by Care UK which reviewed clinical practice by clinician and by procedure. This allowed benchmarking both internally and externally.
- Mortality and morbidity meetings were held, designed to discuss clinically interesting cases. In addition, feedback from other sites within the company was discussed.
- Within the theatre, we observed that staff adhered to the NICE guidelines CG74 related to surgical site infection prevention and staff followed recommended practice. This guideline offered best practice advice on the care of adults and children to prevent and treat surgical site infection. For example we observed the patient's skin at the surgical site was prepared immediately before incision using an antiseptic (aqueous or alcohol-based) preparation: povidone-iodine or chlorhexidine.
- The surgical unit has Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. JAG is a quality improvement and service accreditation programme for gastrointestinal endoscopy. They support and assess endoscopy units to meet and maintain the JAG standards. The endoscopy services at NELTC have JAG accreditation, which is due for renewal in late 2016.
- Senior staff understood specific NICE guidelines that related to operations undertaken and additional NICE guidelines for example in relation to VTE management.

Pain relief

- All the patients we spoke with who had recently undergone surgery told us there were no problems in obtaining adequate pain relief.
- Patients told us nurses responded quickly when extra pain relief was required and the effect checked by nurses.
- Patients' pain was assessed as part of the NEWS process and a nationally recognised scoring system was used.
- We saw evidence of a pain relief enhanced recovery protocol where consultant anaesthetists with an interest in pain relief gave advice on pain management.
- Patient records showed that pre-operative assessment for all patients included details of post-operative pain relief. This ensured that patients were prepared for their surgery and were aware of the types of pain relief available to them.

Nutrition and hydration

- There was a process in place to ensure patients were appropriately starved prior to undergoing a general anaesthetic, each patient was asked to confirm when they last ate and drank during the checking process on arrival to theatre. The amount of time patients were kept nil by mouth prior to their operation was kept to a

minimum, patients were allowed to drink clear fluids up to two hours prior to their operation and patients having operations in the afternoon had an early breakfast, this was in line with best practice.

- The Malnutrition Universal Screening Tool (MUST) was used to assess patients' risk of being under nourished. The records we reviewed had a nutrition and hydration assessment undertaken.
- We reviewed patient menus. These included options for people with specialist dietary needs such as religious beliefs or vegetarians. Patients with specialist dietary requirements were highlighted at pre-assessment and the catering staff informed.
- Patients we spoke to said they were offered enough to eat and drink and were happy with the variety and standard of food offered.
- All the patients we observed had water jugs on their bedside table so could access drinks.

Patient outcomes

- National clinical audits were completed, such as patient reported outcome measures (PROMs) in relation to hip replacements. The hospital took part in PROMs, Hernia, National Joint Register (NJR) and Hip/Knee surveillance audits.
- The PROMs audit is used for the routine collection and use of patient reported outcome data. Data is collected for patients both before and after surgery to assess a variety of patient factors pre and post-surgery. All PROMs scores for groin hernia, hip and knee replacement primary were within the expected range of England average, with all patients reporting an improvement in their condition after surgery.
- The NELTC had good outcomes and processes in relation to hip and knee replacement procedures. Outcomes were measured nationally for example via the National Joint Registry.
- The number of referrals and admissions to the hospital were reported on monthly at the clinical governance meeting. The majority of patients received care as a day case. From April 2015 to March 2016 a total of 7,807 patients were treated as day cases and a total of 747 patients were treated as inpatients.

Competent staff

- The hospital had in place appropriate job descriptions used for staff recruitment. Recruitment checks were made to ensure new staff were appropriately experienced, qualified and suitable for the post.
- Staff members' registration status was monitored by a local electronic database and managers. Managers told us it was staff's responsibility to make sure their registration was up to date as it was a professional requirement.
- New employees undertook both corporate and local induction with additional support and training when a need was identified. We saw evidence of a new starter's induction programme which was comprehensive; the staff member was happy with the induction process. We also saw an example of a competency document that new staff had to complete before they were permitted to work independently. This ensured staff had been assessed as competent to undertake their role.
- All consultants who worked at the NELTC had to have the correct pre-employment checks completed.
- Surgeons were required to provide evidence to Care UK's HR that they had completed relevant training and had received appropriate supervision and appraisals from their primary employer. There was a system followed for the treatment centre to provide information for these surgeons' appraisal processes. There was a system where any concerns with any surgeon substantively employed by either an NHS acute trust who worked within Care UK were shared with Care UK and, where appropriate, management and resolution plans agreed.
- Each department developed their own induction programme for new staff. Staff confirmed they had completed the organisation's induction day and their local area induction programme.
- The hospital tried to use the same agency staff that were familiar with the environment. We asked the HR department to view orientation and induction packs but these were not made available to us.
- During the period April 2015 – March 2016 between 84.6% and 100% of surgical staff and theatre staff had an appraisal undertaken.

- Learning and development needs were identified during appraisal. Staff were supported in their learning and development by their manager and the training lead.
- The theatre manager told us of the arrangements of first assistants (their role is to assist the surgeon during surgery) in theatres. There were five full accredited first assistants. All were nurses by background. They all had AFPP certification and their own personal insurance (self-paid). They were routinely allocated to lists involving bigger procedures.
- HR did not have oversight of key areas of the services requirement of staff. For example when we asked for information on agency staff competencies and training we were told it was held by the finance department, we were also told that mandatory training was monitored by a secretary to the medical director.

Multidisciplinary working

- Care planning took place at pre-assessment with input from the multidisciplinary team, there was involvement from members of the team including doctors, nurses and allied healthcare professionals.
- Overall, staff reported good multidisciplinary working with other services within the hospital and with external organisations, such as local authorities and general practitioners.
- We observed a good culture in multidisciplinary working and a good team ethos. In particular we witnessed good interaction between patients and physiotherapists who used a variety of equipment and techniques to enable patients to mobilise after surgery.
- The treatment centre had service level agreements for imaging and pathology. Care UK, the local NHS Trust had an agreed pathway and process for the rapid transfer of patients to the local acute NHS Trust if required.
- There was a robust process in place to ensure district nursing support in the community after the patient had been discharged. This was detailed in an information folder which was easy for staff to access.
- Daily 'Huddle' meetings meant that leads from all disciplines met to discuss and resolve any issues ensuring effective multidisciplinary working throughout the centre.

Seven-day services

- Surgery occurred five days of the week, Monday to Friday. Occasionally, when demand for services indicated the need, surgery was carried out on Saturdays. All other services were available seven days a week. This included the imaging service that was provided by another organisation.
- Pharmacy services were available on site five days a week from 8.15 am to 4.15pm. Outside of these hours the RMO & matron could access pharmacy to dispense medicines. An on-call pharmacist was available for advice out of hours. Staff reported they could access pharmacy advice at all times.
- Physiotherapy services were provided seven days a week.

Access to information

- Patient records were accessible on the wards and departments. Staff reported that a majority of notes were prepared in advance but some had documentation missing. Staff stated that access to patient notes on the morning of surgery may be problematic as nurses want to check the list and consultants and anaesthetists want to speak to or examine the patient at the same time.
- Staff reported late receiving of notes (sometimes the night before) especially from patients attending NELTC from neighbouring acute NHS hospital using rented theatre space.
- Discharge summaries were provided to GP's within 48 hours. We observed discharge letters being populated and sent at the time of a patient's discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on Mental Capacity Act 2005 (MCA) guidance, and checklists.
- Some staff were aware of their responsibilities under the mental capacity act (MCA) 2005 and deprivation of liberty safeguards (DoLS). Staff that were aware were unable to describe the arrangements that were in place should the legislation need to be applied.

- Consent for surgery was only obtained by consultants. Initial discussions regarding consent were commenced by a consultant at the outpatient clinic stage. Once admitted, consent was reaffirmed with the patient by the operating consultant. Consent forms appropriately detailed the risks and benefits to the procedures.
- Staff said they had completed training about the Mental Capacity Act 2005. Data provided by the treatment centre about compliance with training showed a 92% compliance rate for nursing staff and 100 % compliance for consultants with training about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.
- During inspection we were able to shadow a patient's pathway. This patient had a consultation for dental extraction. During consultation the patients ID was not ascertained or confirmed prior to completing the consent form. The consultation was directed at the patient's carer and no attempt was made to engage with the hard of hearing patient. On completion of the consent form the patient's carer enquired about the do not attempt resuscitation order (DNACPR) that the patient had. The consultant said that the DNACPR would not be upheld during surgery as it was not valid for elective surgery. There was no copy of the DNACPR order placed within the patient's notes. Although the circumstance around the management of the patients Advance Directive (AD - An advance decision is a decision by which a person, with capacity, makes provision for their healthcare in the future and in the event that he/she becomes unable to make those decisions) ahead of the elective surgery would support a temporary suspension of DNACPR, we saw no evidence of a thorough and fully documented discussion take place that clearly explained to the patient why the AD was being temporarily suspended.
- Following the consultation, the inspection team observed the next stage with the patient which was pre-assessment. The pre-assessment was undertaken by a health care assistant (HCA). The accuracy of the patients identification details were checked with the hospital stickers on the notes and consent form. The date of birth was incorrect. New hospital stickers were produced after amendment and checked. We witnessed the HCA remove the incorrect sticker from the consent form and replace it with the new amended sticker. We questioned the legality of this process and the HCA seemed unconcerned.
- During pre-assessment the carer informed the HCA that the patient's last recorded blood pressure reading had been low. However, during the pre-assessment the blood pressure was not checked or escalated to a surgeon or qualified nurse.
- Our concerns were immediately escalated to the attention of the medical director who responded directly to mitigate further occurrence.

Are surgery services caring?

Good

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good because:

- The feedback from patients we spoke with regarding the care they received was very positive. Patients stated that staff were friendly, helpful, and professional.
- The service received consistent positive feedback in the Friends and Family test.
- Interactions we observed between staff and patients were friendly and empathetic. Staff gave patients the opportunity to ask questions regarding their care and be involved in decision making regarding treatment.
- Results of the Friends and Family test and other patient surveys were visible in the communal areas of the wards and in the main reception area.

Compassionate care

- Friends and Family test scores were consistently very positive for surgery at the North East London Treatment Centre in the last twelve months. For the period September 2016 – October 2015 surgery services had a recommendation rate of 99% for inpatient cases and 97% for day cases. This was consistently above the recommended standard for NHS services (94%) and in

line with standards for other Care UK treatment centres (99%). Response rates for inpatient surgery (74%) and day case surgery (82%) also consistently outperformed the Care UK standard of 50%.

- Patients we spoke with were very positive regarding the quality of care they had received. Staff felt they were well treated from pre-assessment visits to post-operative care, and that staff were friendly and informative. Patient stated that staff gave them plenty of opportunities to ask questions about their recovery, and provided information documents to support verbal discussions. Direct quotes from the patients include: "every member of staff, from porter to surgeon, has a smile on their face", "the staff have described anything I can expect", "the food is very good, with many different choices", and "I have felt involved in my treatment".
- Inspectors viewed interactions between patients and staff, and found staff to be compassionate and attentive. Staff were quick to respond to patients requests and were friendly and supportive to patients and their family members. Staff treated patients with dignity and respect, and were calm and polite on all of the wards we visited.
- Surgery services at North East London NHS Treatment Centre had a 4.5 star rating on NHS Choices, with many responses relating to the caring attitude and support available from staff. The service responded to individual feedback from the NHS choices website to thank patients for feedback, and also to address informal complaints that were raised and attempt to resolve the issues.
- Results of the friends and family test and other patient surveys were visible in the communal areas of the wards and in the main reception area. There was also 'you said, we did' boards on wards which communicated what the service has done with feedback they had received from patients.

Understanding and involvement of patients and those close to them

- Patients stated they felt involved in their treatment and the decision making in their care from pre-assessment to discharge from the service. Patients told us that staff provided plenty of opportunities to ask questions about the treatment they would receive, and that any information they needed was explained well. Patients also stated there was access to a phone number to ask any questions following discharge after surgery, and that patients could come back into the service if they needed post-operative support.
- Patients on the surgery ward and in day case surgery told us they had pre-surgery visits from the consultant surgeons and consultant anaesthetist, who fully explained the risks and benefits of the procedure, and provided information about post-operative care. Patients told us that meeting with staff prior to the operation helped to reduce their anxiety.
- Information boards for patients, family members and carers were located at points throughout the inpatient and day case ward. This included ward contact details, feedback from patient surveys, and information on Care UK. Each ward also had a photo-board of ward staff, including the ward manager and other senior staff.
- Staff told us that patients with a learning disability, or with dementia, would be provided with additional care and support to meet their needs. Staff stated that patients with complex needs would be seen at the beginning of the list to minimise the time they had to wait; would be given a link nurse who could offer more individual support, and family members or carers of these patients would have more access to pre-assessment and recovery areas to help reduce any anxiety.

Emotional support

- Patient support needs, including emotional support, and any complex patients or cases were identified in multidisciplinary team (MDT) meetings. The MDT would decide as a group any additional support needs of patients, and make appropriate adjustments to the provision of care to meet individual needs.
- Staff were not sure what formal emotional support or bereavement support was available to families in the event of a patient death. The service did not have any written information available on bereavement support in the areas we visited. This was a conscious decision following advice from the patient forum that advised it was potentially unpleasant for patients undertaking 'routine' procedures to see bereavement leaflets in reception areas.

Requires improvement

Surgery

Are surgery services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good because:

- The service was meeting the NHS standard of providing treatment for all surgical pathways within 18 weeks of referral.
- The admission guidance, exclusion criteria, and discharge processes were clear and well documented.
- Complaints and actions arising from complaints were discussed in governance meetings. Staff also had a good understanding of how they would handle a complaints they received.

However:

- The service did not have a specific learning disabilities policy or available input from staff with training in supporting the needs of patients with a learning disability.
- The service had not responded to more than half of all complaints within a 20 day target set out by Care UK in the last 12 months.

Service planning and delivery to meet the needs of local people

- The service did not have much information or signage available in languages other than English in communal areas. Some staff were also not sure how they would provide access to written information in other languages. We were informed by NELTC that they have access to 39 languages and can print off information in a language or alternative format which meets the patient's individual needs.
- The service was able to provide interpreters to facilitate communication with patients who did not speak English well.
- Patients and staff we spoke with stated that there was availability of meals to cater to different religious needs. Patients stated they were asked about any preferences or restrictions they had when they were admitted.
- The service had a good working relationship with the Clinical Commissioning Group (CCG), and was working with a local NHS hospital provider to help reduce their backlog of surgical operations which the hospital was seeking to clear. North East London Treatment Centre was renting theatres to the hospital trust for two days a week for their lists of patients. The service also included MDT input from inpatient and community physiotherapist who were employed by the local NHS community trust.

Access and flow

- Many staff we spoke with stated that cancellations of surgery on the day of the appointment had been a problem, however the service was quick to offer an alternative appointment to most of these patients. In the 12 month period prior to inspection, 196 surgical procedures were cancelled by the service for a non-clinical reason, which would equate to approximately 2% of all procedures in that year. Although this is a significant number of patients missing appointments, 166 (85%) of these patients were offered another date for the surgery within 28 days. Staff and management discussed cancellations for each surgical pathway as part of Quality, Governance and Assurance meetings.
- Patients booked assessment appointments through self-referral or referral from their GP. The outpatient manager triaged all referrals that come in, with more urgent case given priority or inappropriate referrals redirected. Assessment appointments are then arranged for the next available clinic by a patient pathway coordinator, and patients are asked to complete a questionnaire on their medical history to bring to the assessment. Assessment appointments can be between 30 minutes and three hours depending on the complexity of the surgery.
- The service collected data on length of time a patient is waiting from referral to receiving treatment (RTT). Over the six month period between April and September of 2016, the service was meeting the NHS standard of providing RTT for all surgical pathways within 18 weeks. The service had also significantly improved the length of time patients had to wait to receive diagnostic results,

particularly for X-rays. Staff stated this improvement may be due to improved service from the NHS acute hospital located on the same site as North East London Treatment Centre.

- The service provided data on the number of unplanned returns to theatre and unplanned transfers of patients to another hospital (due to deterioration). In the 12 month period between April 2015 and March 2016, the service had six unplanned returns to theatre and two patient transfers.
- The service had an admissions, discharge and transfer policy detailing the admission process, and a referral criteria policy, which outlined the exclusion criteria for patients not eligible for treatment. This included patients under the age of 18, patients with poorly controlled co-morbidities, pregnancy, or patients with adverse reactions to anaesthesia. As part of the exclusion criteria, the service also did not accept surgery for clinical emergencies.
- The service discharge arrangements were planned using a multidisciplinary approach. The consultant surgeon and anaesthetist reviewed and agreed any discharge, with input and planning from nursing and physiotherapy. Pharmacy was informed to provide necessary medication ahead of the patient leaving, and the relevant GP was contacted within 24-72 hours. The staff provided patients with a summary of the discharge, and the booking team arranges appointments for post-operative follow-up. Patient are also provided with a phone number, available 24 hours a day, to speak to the Resident Medical Officer (RMO) if there are any complications following discharge.

Meeting people's individual needs

- The service did not have a specific learning disabilities policy or available input from staff with training in supporting the needs of patients with a learning disability. The staff we spoke with stated they can provide ad-hoc support to patients with learning disabilities, however there was no specific pathway to meet the additional support needs. Despite there being no specific learning disabilities policy staff told us that patients with learning disabilities and other complex needs were well supported when using the service.
- The service developed a dementia strategy in June 2016 to improve the quality of care for patients with dementia. The strategy contained improvement goals until the end of 2018 such as improving frailty risk assessments, improving liaison with community partners for dementia patients, and introducing hospital passports for patients and carers.
- The inpatient ward had a side-room available for patients who required additional post-operative care following discharge. Patients could be readmitted to this room if they had complex care needs, or needed support in their rehabilitation. Discharged patient were provided with a phone number which was active 24 hours a day and held by the RMO. The RMO established the needs of the any patient contacting this number and could offer re-admission if necessary.
- The service had made equality and diversity training mandatory, with 98% of all staff having completed the course.
- Physiotherapy support was available for patients in post-operative care, provided by a local community NHS trust. Physiotherapists worked with patients to develop rehabilitation plans and demonstrate use of rehabilitative equipment. The physiotherapy team also provided a six week follow-up with patients to check on patients rehabilitation progress and provide additional support if necessary.

Learning from complaints and concerns

- The service had not responded to more than half of all complaints within a 20 day target set out by Care UK in the last 12 months. The quality accounts for Care UK, released in May 2016, detailed the response times from the service to complaints. During the 12 month period, North East London Treatment Centre received 46 complaints, and had not responded to 54% of these within 20 working days. However of these records, 100% of complaints were acknowledged within three working days.
- Complaints and actions resulting from complaints were discussed by staff in monthly governance meetings and disseminated further in team meetings. Minutes from surgical specialty meetings show staff in specific surgical pathways discussed complaints regularly.
- Staff had a good understanding of how they would address a complaint from a patient or member of the public. Most staff stated they would pass the complaint

on to the governance lead or Director of Nursing. The service also had a local complaints policy detailing responsibility for acknowledging, recording, and addressing complaints or comments received.

Are surgery services well-led?

Requires improvement

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

We rated well-led as requires improvement because:

- There was not sufficient oversight or risk management in place for patients coming from the local NHS acute hospital for treatment. Many staff we spoke with stated this was due to unclear communication and difference in operating procedures.
- Staff we spoke to were also not aware of the future plans or strategic vision for the service.
- The service had a patient forum; however this group did not have much input from patients other than the representatives.
- The risks we identified on inspection were not reflected on the risk register, particularly relating to the governance arrangements with another healthcare provider using NELTC theatres.
- A significant portion of staff we spoke with stated they had experienced or seen instances of bullying and harassment of staff while working with the service, particularly towards Black and Minority Ethnic (BME) staff.

However:

- The senior leadership team had recently completed a restructure of governance at the service, and there were a number of meetings in place for staff to attend and discuss risks and learning from incidents.
- Staff we spoke with stated that the senior leadership team were visible around the service and had an open door policy for any staff members needing to access them.
- Minutes from the staff forum recorded a number of initiatives to recognise the contribution of staff and report back on issues that staff have raised.

Leadership and culture of the service

- The leadership for the service was under the responsibility of the Hospital Director. The Head of Nursing and Clinical Services had oversight of the inpatient wards and outpatients department, as well as managing clinical governance arrangements and complaints response. The Medical Director for the service managed the different surgical pathways offered, and retained overall managerial responsibility for medical staff within these pathways.
- A significant portion of staff we spoke with stated they had experienced or seen instances of bullying and harassment of staff while working with the service, particularly towards Black and Minority Ethnic (BME) staff. This issue had also been reflected in correspondence we received prior to inspection. Some staff stated that there had been bullying behaviour from some managers, that some staff had been publicly shouted at, and that staff did not feel this was an appropriate way to manage. Minutes from the staff forum in August 2016 stated that the staff survey showed improvement in staff feeling they can report bullying; however recognised that it remains a part of the culture at NELTC.
- Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS provider organisations, and also applies to independent provider organisations that provide NHS services. Care UK provided documentation that outlined their commitment to equality and diversity. However, at the time of our inspection this was not specific to the implementation of WRES.
- We spoke with some Resident Medical Officers (RMOs) while visiting the wards, and they stated they were concerned about upcoming changes to their working arrangements. RMOs stated they their contracts would be moved to an external company and working shift patterns would change to one week on shift, followed by one week off shift. RMOs we spoke with felt this

change did not offer enough time off between shifts, and that their concerns were not being addressed. Other medicals staff we spoke with stated the changes to the RMO working patterns were a concern.

- Some staff we spoke with stated that they were concerns that promotions were not always awarded to the most appropriate candidate, and that the recruitment process for managerial roles was not always followed. Some staff stated this meant that staff members who had repeatedly applied for promotions were not given fair consideration.
- The service had recently begun renting their theatres to the surgery teams of the neighbouring acute NHS provider, and some staff we spoke with stated there were cultural differences between the two services that needed to be resolved. Staff at NELTC felt their approach towards risk management, clinical governance, and MDT working were not aligned with that of their NHS colleagues, and this resulted in some tension in how best to manage the working environment and patient safety. Senior staff we spoke with stated that they had weekly meetings with surgery leads at the acute NHS provider, and felt the relationship was improving as they worked together more closely.
- Staff from all disciplines stated there had been low morale at the service due to some of the uncertainty around the future of the service and job security for staff. This had resulted in issues in recruiting and retaining staff; however staff did say they felt morale had improved following the recent Monitor decision for elective care services at the service to continue under the control of Care UK.
- Staff we spoke with stated that the senior leadership team were visible around the service and had an open door policy for any staff members needing to access them. Managers we spoke with stated that the Managing Director, Medical Director, and Director of Nursing were supportive to new managers and accessible when needed.
- Care UK made ad-hoc counselling services available through an independent healthcare insurance provider for staff. Staff who needed counselling could self-refer, which had a cost per sessions. Staff we spoke with stated they had not needed to access this service, however there was a leaflet which provided information on the availability of counselling.

Vision and strategy

- Staff we spoke with were not aware of the long term vision for the service and did not feel there was a strategy in place for future development. Staff stated there had been a lot of uncertainty regarding the future of the service following a decision to award the provision of elective surgery in North East London to the local NHS provider; however this decision had been overturned on appeal, and re-awarded to Care UK.
- The service used a marketing development planning tool to help service managers identify opportunities for business development and service growth. Proposals for service development were researched and developed by service managers, who worked with support from the Hospital Director and Managing Director to finalise the plan.
- As of August 2016, the service was performing to the standards required to meet CQUIN targets.

Governance, risk management and quality measurement

- Minutes from quarterly clinical governance for the all Care UK orthopaedic pathways state that attendance at the governance meeting, and reporting on quality of performance within orthopaedics, must improve from North East London Treatment Centre. Some staff we spoke with stated that this meant the orthopaedic pathways were not providing the information needed for oversight of their pathway.
- Staff we spoke with stated that the governance arrangements in place to monitor the use of NELTC theatres for surgery by the local NHS provider had not been aligned, creating gaps in clinical oversight. Many staff we spoke with stated that the differences in standard operating procedures, safety checks, and follow-up care which presented risks to patient safety, and provided examples where the risk had not been monitored. The medical director for NELTC had set up a weekly meeting with the NHS provider to discuss patient lists, and had organised a specific meeting to discuss clinical governance, however this had not yet resulted in alignment of clinical governance systems to minimise risk to patients.
- The risk register is updated and reviewed on a monthly basis and any outstanding actions reviewed. However in

monthly data provided by the service, risk registers for July and October 2016 were overdue for review of risks. The risk register provided stated all items were due for review in September 2016, however the risks did not reflect some significant risks identified as part of our inspection, particularly relating to the governance arrangements with another healthcare provider using NELTC theatres.

- Each surgical pathway had a half-day central governance meeting to monitor performance within their speciality. This included opportunities to review complex cases with colleagues, address similar issues emerging in different services, and share learning. Staff within these specialities also used these days to conduct training sessions and improve competency within their teams.
- The central Care UK governance team provided a monthly report for governances managers to update staff on new policies, risk registers, learning from incidents, and serious incidents. Governance managers also attended a monthly meeting with governance leads from other Care UK Treatment Centres to discuss the report and actions. Reports were then disseminated by the governance manager to the rest of the staff through emails and team meetings.
- The service had a centrally agreed governance policy covering local governance reporting structures, meetings for staff to attend for updates on governance, and how local risks are reported centrally to Care UK. Local data from NELTC were included in the Care UK quality accounts each year for comparison with other treatment centres in the UK, and these accounts were published publically.
- The senior leadership team had recently completed a restructure of governance at the service, and there were a number of meetings in place for staff to attend and discuss risks and learning from incidents. The service provided minutes of the monthly Health, Safety and Environment meetings which were open to all staff to attend. The Director of Nursing also held a monthly heads of department meeting to review all risks and put action plans in place. Heads of department are then required to feed back to their teams.

Public and staff engagement

- The service had a patient forum; however this did not have much input from patients other than the representatives. The patients' forum met twice a year to advise on developments to the service and also visit the wards, looking at the quality of catering, the environment, and accessibility for patients. The patient representatives on the forum were invited to join the forum by staff members, however the representatives told us they did not speak to patients using the service, and did not gather patient feedback as part of their roles. This meant the feedback from patient forums was limited to the views of representatives.
- Staff stated in discussions with inspectors that while they would be informed of changes to the service by their managers, they did not feel they were always consulted before actions were taken. Many staff stated that discussions about changes to the service or working arrangements would take place after the change had occurred, and did not feel that their suggestions had any impact, or that they were actively consulted.
- Many staff we spoke with were not aware there was a staff forum that they could attend. The service ran a monthly staff forum to update staff on on-going developments and offer staff an opportunity to discuss concerns or other issues. However, the minutes from the meeting show that it was not well attended, and many staff told us they did not know it was happening.
- Minutes from the staff forum recorded a number of initiatives to recognise the contribute of staff and report back on issues that staff have raised. The service used the staff forum to introduce a "healthcare heroes" award to reward staff who were nominated by their colleagues, discuss social opportunities and patient feedback, and update on on-going improvement and service development work.
- Staff completed a staff satisfaction annually and results were reported in the August staff forum. 92% of staff stated they were proud of the work they did, however some staff stated they were treated unfairly due to their race, religion or sexuality. The minutes also stated that staff did feel more able to report bullying and harassment.

Innovation, improvement and sustainability

Requires improvement

Surgery

- The quality accounts for Care UK released in May 2016 detailed a patient case at North East London Treatment Centre that utilised new techniques in anaesthetics to improve patient recovery time following orthopaedic surgery.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

North East London NHS Treatment Centre (NELTC) is an independent health service provided by Care UK. It provides elective procedures under contract to a local acute NHS trust. The contract encompasses orthopaedic, gastroenterology, ophthalmology, oral, endoscopy and general surgery specialities.

Outpatient activity includes first appointments and follow up appointments in relation to these procedures. Between April 2015 and March 2016 NELTC had 10232 first attendances and 10981 follow up appointments within outpatients.

NELTC is located on a large campus that also contains an acute NHS hospital, a NHS community and mental health trust and a large care home. Outpatient activity takes place from two sites within this campus. One was based at the main NELTC site which also provides surgery and the other, a five minute walk away at Barley Court. Orthopaedic outpatient clinics also took place on a one session a week basis at GP health centres located at Harold Wood and Dagenham.

Endoscopy at NELTC took place in a dedicated theatre space with an adjoining decontamination suite that had been adapted for use. Although not a purpose built unit, it was fit for purpose. It was spacious, clean and there were no privacy or dignity issues.

Radiology services did not take place at NELTC and are not included in this report. These services were provided under contract with a local NHS trust and patients requiring these services went to the local hospital located next door to the main NELTC site.

To be accepted in to the service, patients must not require complex surgery or prolonged inpatient rehabilitation or have a chronic disease that would require immediate post-operative care in an ITU, must not have sickle cell anaemia, complex clotting disorders or significant renal failure, must not have suffered a myocardial infarct, undergone coronary artery bypass surgery or coronary stenting in the last 6 months or have suspected cancers, must not have a Body Mass Index of more than 40 or be less than 19 years old.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients as Good.

There were systems in place to report and learn from incidents, standards of hygiene were maintained and clinic rooms were well equipped. Risks were appropriately identified during assessment and communicated back to the patient's GP. A large amount of risk was automatically excluded by the referral criteria, picked up in the triage process.

The department was running at a high nursing vacancy rate which was being managed, and caused minimum service disruption. Staff underwent a formal orientation programme and induction when they joined the service and completed job related skills as part of induction. Patients and staff spoke highly of doctors and other clinical staff.

Effective evidence based care and treatment was demonstrated. Accreditation for endoscopy provision had been achieved for the past three years. Patient consent was collected routinely.

Patients were treated with dignity and felt involved in decisions about their own treatment. Patients also spoke highly of medical and nursing staff.

The hospital was meeting its referral to treatment time targets. A 'one stop' clinic enabled patients to see the consultant, have diagnostic tests and receive a date for surgery all on the same day. However, this meant that waiting times during clinic appointments could be long and the hospital had no audit for monitoring waiting times but provided information regarding the one stop clinic waiting times in the helpful information pack sent to patients. There was adequate space and seating areas for patients.

Staff identified patient's individual needs and put in place support where necessary. We found a number of examples where people with additional needs had been taken in to account and their support needs met.

There was a clear leadership structure within outpatients. There had been a period of instability due to staffing and job security issues that were now resolved following the renewal of the main contract. Staff we spoke with felt very much part of a team with the head of nursing described as visible and supportive. Staff were given time away from clinic and patient duties to attend the hospital wide governance meetings. Staff also attended monthly team meetings. Heads of departments met monthly and took issues from their departmental meetings.

We identified a number of actions the provider should take to improve the service:

There was no scope guide available for colonoscopy and a paediatric scope was not available for use with narrow structures such as with diverticular disease.

There was currently no security presence in the outpatients department during the day and a review of this situation had not been undertaken.

The monitoring of the quality of contracted provision through service level agreements had recently received a renewed focus by the leadership team which should continue. Uptake of patients completing the Friends and Family survey had been low and the focus on improving this should also continue.

The only audits that currently took place in outpatients were in infection control and venous thromboembolism. It was acknowledged that the service would benefit from further quality monitoring. Waiting times during 'one stop' clinics, wound clinics, privacy from conversations being overheard and security provision were examples of this we encountered.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as good.

- Staff understood their responsibilities for reporting incidents and were confident in using the system. Findings and learning was shared appropriately. Standards of cleanliness were maintained and the outpatients department was visibly clean and tidy throughout the waiting areas and clinical rooms.
- Staff were challenged by the size of the consultation rooms as they were small, however clinic rooms were observed as uncluttered. Equipment checks took place and rooms were stocked and ready for use. There was adequate space and seating areas for patients.
- The reporting mechanism in use in endoscopy relied on an old system. Due to the ageing equipment and instances of equipment failure, a business case for funding a new machine was put in to Care UK head office for this coming financial year. There was currently no scope guide available for colonoscopy and no paediatric scope ready for use with narrow structures such as with diverticular disease.
- The referral criteria meant a large amount of risk was automatically excluded. Triage took place where this criteria was used and other risks were identified. A detailed risk assessment was undertaken at the time of first appointment and included a range of health related risks. Any risks identified would be passed on to the patient's GP.
- The outpatients department were currently running at a vacancy rate of around 30%. To ensure adequate cover throughout the day, agency staff were used and nursing shifts were often staggered. The manager regularly helped with frontline duties and staff were moved from different departments to assist with cover. There were some historical disciplinary issues with outpatients staffing. The head of nursing was now addressing these issues with the use of human resource processes. Security staff were not provided during daytime hours and staff reported they were on occasions called upon to fill this gap.
- Each surgical consultant was responsible for their patients through the patient journey and the same consultant and Resident Medical Officer (RMO) saw the same patients for assessment and review. Staff spoke highly of doctors and other clinical staff. Patients told us they were treated with dignity and felt involved in their treatment.

Incidents

- Staff reported incidents through an online electronic reporting system (Datix) which alerted the outpatients manager that an incident had occurred. Staff we spoke with understood their responsibilities for reporting incidents and were confident in using the system. There had been no never events or serious incidents within the outpatients department.
- The outpatient manager investigated the incidents that occurred within the department. The staff involved in the incident would also help with the investigation. Any findings and learning was shared at monthly staff team meetings. Heads of departments discussed incidents during their meetings and cascaded information down to staff. Staff were able to give examples of learning and how patient safety had been improved as a result. Lessons learnt were shared with the reporting individual. Staff were also made aware of the outcome of incidents through the monthly governance meeting and staff team meetings.
- Within endoscopy, staff had received training in reporting incidents. Staff we spoke with told us that clinical incidents were very rare but were aware of the reporting structure. They were aware of clinical incident reporting and the feedback mechanisms but did not know of any recent incidents that had occurred, been reported or learnt from. All staff completed Datix and reported all incidents to their manager.
- All outpatients nursing staff had completed Duty of Candour (DoC) training apart from one new starter. However, staff we spoke with had varying knowledge on

the subject. They stated that it rarely had to be used in outpatients because of the relatively low incident rate, and the organisation's responsibilities with the DoC were carried out by a senior member of staff.

- Within endoscopy, staff were unaware of formal feedback within the DoC but when prompted were able to tell us that it was a recent staff meeting topic.

Safeguarding

- Safeguarding policies and procedures were in place to keep vulnerable children and adults safe from harm and abuse. If staff had concerns about a patient these were communicated within the department to relevant staff. Staff we spoke with were aware of the procedures to follow should a safeguarding incident occur. Staff told us they reported safeguarding issues to the outpatients manager and the head nurse. We were given a recent example where concerns were raised over a patient's vulnerability that was escalated to the safeguarding adults lead. Other than this incident, staff informed us that no other recent safeguarding concerns had been raised.
- Training was in both safeguarding children and adults. Level 2 training took place as part of mandatory training, which was undertaken online. Staff also received supplementary face to face training with the safeguarding lead.

Cleanliness, Infection Control and Hygiene

- Standards of cleanliness were maintained. The outpatients department was visibly clean and tidy throughout the waiting areas and clinical rooms.
- We saw evidence of up to date cleaning schedules in public areas and clinical rooms. Staff explained that clinic areas were cleaned at the end of each day by the member of staff who had been using it.
- Hand sanitizers were widely available throughout the outpatients department and staff were seen to clean their hands regularly. Hand hygiene audits were undertaken every other month. The majority of staff also adhered to the policy of 'bare below the elbows' in clinical areas. However, some of the consultants challenged the policy and refused to be 'bare below the elbows'.
- The outpatients manager was also the infection control link nurse. They attended meetings with the infection control lead every other week where any issues of concern were raised. They also carried out monthly audits as part of their duties. We saw an audit undertaken in July 2016 of the environment and sanitary areas. Any issues found were flagged up as actions to be undertaken. We saw evidence of instances where staff had highlighted actions and shown when they were completed.
- Postoperative follow up appointments were carried out in the wound clinic to check for signs of infection. If the swab came back positive then consultants would be notified and appropriate antibiotic prescribed to the patient.

Environment and Equipment

- Outpatients' appointments took place from two sites within the hospital. One was based at the main unit and the other was a five minute walk away at Barley Court. Staff were challenged by physical space of the consultation rooms as they were small. We observed the working environment for physiotherapy consultation to be spacious and uncluttered. Waiting areas had adequate space and seating areas for patients. On the day of our unannounced visit that followed our main inspection visit, there were 28 people in the waiting area at Barley Court. There were four consultants' clinics, an endoscopy nurse clinic and a nurse consultation clinic taking place. This was a pre-assessment day with patients waiting for multiple clinics that could also include radiology. The waiting area was busy but there was seating for all attendees.
- Equipment checks took place and rooms were stocked and ready for use. The members of staff using the clinical room were responsible for preparing it for use on the following day. The outpatient's manager checked that the rooms were ready for clinics in the morning. Clinic rooms were observed as clean and uncluttered.
- All equipment was ordered through the stores' manager. Broken equipment was also reported through the same system. Staff told us that they never had difficulties accessing the equipment they required for clinics.
- A contractor provided NELTC with all works that related to the fabric and maintenance of the building. There was an engineer based on site and a contract lead from

the company reported on works undertaken. We were provided with a progress report from the contractors, dated August 2016, that detailed activity undertaken and provided. This included reported repairs, educational talks and tracking of statutory health and safety checks. Quality of service was measured in a RAG (Red, Amber, Green) rated KPI (Key Performance Indicator) structure. This showed sections under contract delivery, staffing, contract management and health and safety which were all rated green.

- Staff we spoke with told us that the contracted company were responsive and were satisfied with their promptness. Staff told us they were very quick to respond and resolve any maintenance issues raised.
- Endoscopy took place in a dedicated theatre space with an adjoining decontamination suite that had been adapted for use. Although not a purpose built unit, it was fit for purpose. It was spacious, clean and there were no privacy or dignity issues.
- The reporting mechanism in use in endoscopy relied on an old system, and because of poor image capture they were still using hard copy photographs. Due to the ageing equipment and instances of equipment failure, a business case was put in to Care UK head office for this coming financial year (which runs from October to September in Care UK) for a new endoscopy machine. The hospital director was confident in this being successful as they felt the company were receptive and NELTC had just had all their anaesthetic machines replaced this year. There was currently no scope guide available for colonoscopy and no paediatric scope for use with narrow structures such as with diverticular disease.

Medicines management

- There was minimal pharmacy or pharmacist input in outpatients. The pharmacist did not take any drug histories as part of the assessment process. We were told this was due to the quick turnaround times of patients.
- In clinic rooms we found that medicines were appropriately stored. However, only a few items were actually stocked such as cortisone injections. Prescriptions slips were used by staff to replenish stock items from the pharmacy in the main building.
- The register used to log all medication prescribed for patients to take away, was checked weekly. We were informed that registered nurses provided counselling to patients regarding any advice on medications as in outpatients as there was no pharmacy input.
- Clinic dictations from consultants that included advising GPs of changes to medication, were typed up by an outsourced company. The target was to upload the notes within 48 hours (not including weekends). The target for dictated letters to be signed and sent out was five days. Consultants were emailed directly if there were outstanding dictations on the system to action. Thereafter, consultants were given one more chance after which, the matter would be raised to senior team to prevent backlog.

Mandatory Training

- The governance department sent out monthly reports to the outpatients' manager which showed completion rates of mandatory training in that department. If staff were overdue training it was the responsibility of the manager to remind staff.
- The monthly training report for September 2016 showed that all staff were up to date with their training, except for a new starter who had yet to complete their induction. Training was done through e-learning and face to face. Staff told us that they did not have difficulties finding time to complete the training.
- Staff completed mandatory training modules as part of their induction and were expected to update these in line with policy. The mandatory training modules included equality and diversity, moving and handling, infection control, safeguarding (children and adults) and fire safety.
- Within endoscopy there were two regularly employed agency nurses with endoscopy training who also worked on the unit when shifts could not be filled. They completed mandatory training through their agency, however they had to pay for this themselves.

Records

- The outpatients department held both electronic and paper records. NELTC used a software package to store patient details electronically. This would hold referral, patient details, clinics and appointments. It was not

compatible with the local acute trust to who they were contracted to provide services and who made referrals electronically. When receiving referrals a duplicate record was made on the electronic system.

- Patient details were put together in a paper based file three days before their clinic appointment. A file would be created from the referral form, and the outpatients' records department would ensure that all pre-assessment documentation were included. If the referral form was not in place this would be chased by the booking team. We spoke with the records department who told us that patients were not seen without the referral information being available. Staff said that they could not recall an incident in the last three months where this had happened.
- Files were archived six months after the patient was discharged from the service.
- We reviewed eight patient paper files chosen at random. All case notes were legible with dates and times recorded in the progress notes. Files also contained discharge summaries and clinic letters.
- The risk register shown to us in outpatients demonstrated that the transportation of patient files to and from the Barley Court site had been identified as an issue. Staff told us that records were carried by hand and not in a locked facility. NELTC would need to ensure that the transportation of files was regularly assessed and monitored to avoid any breaches in confidentiality occurring.

Assessing and Responding to Patient Risk

- Referral criteria meant a large amount of risk was automatically excluded. Patients did not meet the referral criteria if: they had a body mass index of 40 or less, they were under 19, required complex surgery or prolonged inpatient rehabilitation or had a chronic disease that would require immediate post-operative care in an ITU such as sleep apnoea or uncontrolled cardiorespiratory disease, had sickle cell anaemia, complex clotting disorders or significant renal failure, suffered a myocardial infarct, had undergone coronary artery bypass surgery or coronary stenting in the last six months (12 months for drug eluting stents) or if they had suspected cancers.
- Triage took place following a referral in to the service, where risks were identified by the outpatients manager. Patients completed a questionnaire where risks may be highlighted. A detailed risk assessment was undertaken at the time of pre-assessment appointment and included a range of health related risks including blood clots and risk of falls. Any risks were highlighted on the patient's file. Staff indicated that any risks identified would also communicated to the patient's GP.
- Within endoscopy, on the day of procedure, patients were admitted to the ward, seen by the consultant endoscopist where consent was also taken. Patients were brought in to endoscopy theatre by an endoscopy nurse. We observed thorough endoscopy safety checks carried out with four patients in total. Prior to the procedure the endoscopist summarised the case and requested equipment likely to be required such as for biopsies. Controlled drugs (CDs) were checked by two nurses as a standard process. Histology was checked by two nurses for name, date and site and entered in to the histology book.
- Specific pathways for pathology were categorised as yellow/green where routine samples were sent to a path lab that Care UK had a contract with (an independent acute hospital), with urgent (red/amber) specimens sent to the acute hospital based next door. Results were returned to the endoscopist who signed them off. Endoscopists also referred patients with a likely cancer diagnosis to the multidisciplinary team via email but would personally take notes and photos to the meeting themselves.
- A review of eight patient files chosen at random showed risk assessments had been completed. Medical history questionnaires had been completed and current medication documented, referral from GP, VTE risk assessment by nurse, and signatures of nurse / HCA who completed the assessment. Falls assessments, oxford knee score, WOMAC knee score, MUST and CQUIN documentation were also completed where appropriate.

Staffing

- There were 16 staff posts within the outpatients department who were currently running at a vacancy rate of five. This was for a team leader, two nurses and two healthcare assistants. The outpatients manager was

due to leave soon after our inspection. It was reported that shifts were covered through a variety of measures; nursing shifts were often staggered to ensure adequate cover throughout the day and the manager regularly helped with frontline duties. Staff were moved from different departments and units to assist with cover. Bank nurses were not used. However, agency staff were used when required which was cleared through the head of nursing. There was a rolling recruitment process aimed at procuring more staff.

- A new manager had been placed on secondment for six months to account for the current manager leaving. They told us they had two staff nurses (job share) who had now taken on the vacant team leader position. Interviews were set up to fill vacant staff nursing and HCA posts.
- There were some historical issues over staffing. We learned of staff who would request high levels of leave at the last minute, and staff who had gone absent without authorisation, which had not been challenged by the previous manager. The head of nursing was addressing these issues and HR processes were now being used. One member of staff was reported as being absent without authorisation at time of our visit.
- Within endoscopy there were a minimum of two qualified nurses for each clinic list. There were two regularly employed agency nurses with endoscopy training who also worked on the unit when shifts could not be filled.
- Administrative staff were allocated to specific tasks. There were separate staffing rotas for each in: bookings, scheduling, medical records, reception, medical secretarial, endoscopy admin and clinical coding. The admin manager told us that three new appointments in admin staff had recently been made. Rotas appeared well staffed.

Medical Staffing

- Appointments in outpatients were with a consultant. As an inpatient, each surgical consultant was responsible for their patients and they would see the same consultant for assessment and/or re-admission and reviewed by the same RMO and a consultant as required.
- Sessional endoscopists were booked for set days. The lead endoscopist was employed by Care UK but was due to leave. The medical director told us they were in discussion with two fully accredited nurse endoscopists regarding employment and an advert for two full time gastroenterologists to replace the endoscopy lead had gone out. In the meantime there were four consultant gastroenterologists and two consultant general surgeons within NHS trusts who were available for sessional endoscopy as well as a local consortium that could provide activity for the service. The provider's endoscopy national clinical lead would support the work of a new consultant lead.

Major Incident Awareness and Training

- Every department had a fire warden and procedures were in place for a safe evacuation in the event of a fire.
- Staff at Barley Court were concerned about current procedures during an emergency. The current procedure, should a patient become unwell, was to dial 999 as there was no resuscitation team on site. We were told the last time this happened was a year ago when a patient collapsed and it took half an hour for an emergency response.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We inspected but did not rate effective as we do not currently collate sufficient evidence to rate this.

- The hospital demonstrated effective evidence based care and treatment and published or researched guidance that related to good practice. Staff were involved in updating hospital procedures.
- NELTC had achieved Joint Advisory Group (JAG) accreditation for endoscopy provision over the past three years. Key performance indicators were well above the minimum level required. Assessments followed best practice guidance, including falls assessments, knee

assessment scores, malnutrition universal screening tool (MUST) and CQUIN documentation. Patient outcome information was collected before and after surgery.

- Orientation and induction programmes were in place. All nurses and health care assistants completed job related competency frameworks as part of their induction and staff were supported to keep their qualifications and skills up to date. Regular appraisals identified individual training needs.
- Both electronic and paper records were created for patients attending the outpatients department which sometimes led to a duplication of information in endoscopy.
- There was an adequate process in place to gain consent prior to a procedure or treatment.

Evidence-based care and treatment

- The central policy team at Care UK were responsible for advising the hospital of any new published or researched guidance that related to good practice, including National Institute for Health and Care Excellence (NICE) guidelines.
- The hospital's governance manager advised staff of any changes. Staff discussed good practice guidance and policy changes at the quality governance and assurance meetings (known as the QGM) and were updated with any new guidance. All hospital policies were ratified and agreed centrally and disseminated to the governance manager at NELTC.
- Staff discussed best practice and updates on NICE guidelines during team meetings. Nurses in the outpatients department told us they followed national and local guidelines to ensure safe and effective patient care. However, the hospital was not undertaking audits to measure performance against the guidelines.
- Staff were involved in reviewing and updating hospital policies and procedures. Outpatient staff had helped to revise the pre-assessment pathway by checking it against current NICE guidelines and making necessary amendments. In turn staff reported any changes and updating required to the quality governance manager.
- The Joint Advisory Group on Gastrointestinal Endoscopy (JAG), established under the auspices of the Academy of Medical Royal Colleges, sets standards for individual endoscopist's training, quality assurance of endoscopy units and quality assurance of endoscopy training. NELTC had achieved JAG accreditation for endoscopy provision over the last three years.
- Key performance indicators (KPI's) were well above minimum required. This was evident in colonoscopy completion rates, successful intubation in gastroscopy and bowel preparation in flexible sigmoidoscopy. Statistics were presented for March 2016 and KPIs were broken down by individual endoscopist. KPI's all related to the ability of the endoscopist. There were also KPI's on pain levels, adenoidal detection rates and complications. JAG accreditation also covered decontamination. The unit was due a further visit for accreditation.in January/December which they were preparing for.
- The hospital was taking part in the Commissioning for Quality and Innovation (CQUIN) project by collecting data regarding smoking cessation. The aim of the CQUIN framework is to support improvements in the quality of services and the creation of new, improved patterns of care. The outpatients department collected data for patients undergoing joint replacement surgery indicating smoking status and quantity, if staff offered advice around cessation and whether a referral to a cessation programme were made.
- There were a number of assessments that followed published best practice. They included falls assessments, knee assessment scores, malnutrition universal screening tool (MUST) and CQUIN documentation, all completed where appropriate.

Nutrition and hydration

- We reviewed eight patient files chosen at random. They showed that patient's nutrition and hydration needs were assessed and met. Staff had completed the Malnutrition Universal Screening Tool (MUST) as part of the assessment process.
- If a patient's waiting time exceeded three hours, staff provided complementary drinks and snacks. This included biscuits suitable for diabetics. Due to the process of carrying out all pre assessments and diagnostics at one visit, a three hour visit was a possibility and patients were advised of this in the introductory information.

Good

Outpatients and diagnostic imaging

Pain relief

- Managers told us there was no set format or pain score measured in post-operative appointments, but that this was covered where appropriate, in follow up assessments.
- On the day of our visit, we found that a post-operative review of one patient found them describing continued pain. A clinical assessment and examination took place along with an X-ray. The patient was given an X-ray form to take to the radiology department in the acute hospital next door. The patient was seen immediately and returned the same day. Images were available on PACS and the patient was referred back to the consultant.
- One patient we spoke to told us the hospital had supported them with pain relief whilst they were waiting for their operation. They were satisfied with the service they had received.

Patient outcomes

- Orthopaedics, general surgery and dental services collected clinical outcomes at the initial consultation and pre-assessment stages. Staff were required to input information regarding who the patient had been seen by, visit outcomes (for instance follow up appointment, add to day case or in patient waiting list), tests undertaken including X-ray, pathology and MRI, and details of surgery planned. Staff were also required to detail reasons if surgery was not suitable or why the patient journey was suspended.
- Patient outcomes were also collected following surgery, for instance from the physiotherapy department. The agreement with the CCG, allowed for one follow up visit to the consultant at six weeks and a follow up with the physiotherapist at 12 weeks with a view to discharge or second follow up at their discretion. Physiotherapists told us that they could refer patients back to the consultant if clinically appropriate to do so. For instance, during one post-operative review we observed that the patient was referred back to the consultant, as they were unhappy with the outcome due to their continuing knee problems. Physiotherapists told us that part of their role was to manage patient perceptions and expectations. Physiotherapists gave exercises to patients both pre- and post-operative, but outcomes were worse if they were non-compliant.
- The administrative team processed information about people's care and treatment electronically. Where patient outcomes were not completed, the software programme prompted the team to follow this up with the relevant clinic. The data analyst generated patient outcome reports for the purpose of invoicing, which were sent to the finance team when required.
- NELTC were actively collecting Oxford Knee Score (OKS) data. The OKS was developed and validated to assess patient function and pain following a total knee replacement. Patients were required to complete 12 questions on activities of daily living. This enabled staff to assess patient outcomes following knee interventions.

Competent staff

- Staff underwent a formal orientation programme and induction when they joined the service. All nurses and health care assistants completed job related skills as part of their induction. We saw documentation relating to the pre-assessment and outpatient competencies for registered nurses, and the assessment of general competencies for health care assistants. Staff were expected to complete the competencies and have them signed off by their assessor within 12 weeks. We were told staff were always supervised until the competencies had been achieved.
- Staff were encouraged to keep their qualifications and skills up to date by their managers. An electronic package was used to alert staff when revalidation was due for renewal. Validation documents were uploaded on to the system and signed off by an allocated mentor. Departmental managers were sent an email informing them of the revalidation needs of their staff each month, and highlighted any cases where validation had lapsed so that prompt action could be taken.
- Staff took part in appraisals, known as 'performance conversation records', on an annual basis. We found that two appraisals were due for completion within outpatients, but were not overdue. Individual staff objectives and personal development goals were set during the appraisal meetings. Staff would have ongoing conversations about these targets throughout

the year. Individual one to one meetings would be held prior to appraisal if there were concerns about an individual's performance or if a staff member had issues to raise with their manager.

- Managers encouraged staff to increase their knowledge and skills, and individual training needs were identified during appraisals. Staff also said they felt they were able to discuss any training requirements they had with management. Senior management said that training for staff was actively encouraged and staff we spoke with had not had any difficulties accessing training when required. There was a training and development co-ordinator to oversee all training needs.
- There was a plan of rotation for HCA staff throughout outpatient clinics. This enabled them to become familiar with how each clinic operated and increase their skill base.
- Within endoscopy there were a minimum of two RGNs for each list. There were two regularly employed agency nurses with endoscopy training who also worked on the unit when shifts could not be filled, who had both completed induction when first employed by Care UK. Within endoscopy, teaching did not take place on the unit. They were JAG accredited with the next inspection due in January 2017. Nurses told us there were other training opportunities at other Care UK bases such as Portsmouth.

Multidisciplinary working

- One-stop clinics involving different disciplines of staff were available. The multidisciplinary team approach during pre-assessment could involve seeing a nurse, HCA, consultant, anaesthetist and radiology at the acute hospital next door. Where applicable, patients often received their date for surgery during the same visit. This improved convenience for the patient and meant less visits to the hospital.
- Staff worked closely across teams to ensure a smooth patient journey. The patient pathway co-ordinators ensured that patient appointments were managed effectively within the department by liaising with the medical records team and nursing staff. There was also close working across departments. For instance, if a patient being seen in outpatients was assessed as needing social services input following surgery, or if an issue with their blood sample was found, an email would be sent to the ward clerk in the inpatients department to alert them.
- A number of staff told us there was good and supportive teamwork within the hospital. One nurse felt the team working in the outpatients department was outstanding and praised her manager for encouraging this. Staff told us that consultants were supportive and this had increased staff confidence.
- A core member of the endoscopy team attended colorectal, upper GI and anal multidisciplinary meetings when this was possible and did not clash with theatre lists. Endoscopists also referred patients with a likely cancer diagnosis to the multidisciplinary team via email, but would personally take notes and photos to the meeting themselves.
- There was a service level agreement between NELTC and the imaging department at the acute hospital located next door. Patients were able to get their X-rays done on the same day as part of the one-stop clinic. Consultants had instant access to the images electronically at the clinic.

Seven-day services

- The majority of outpatient's appointments ran from Monday to Friday, with clinics running between 8am and 6pm. Orthopaedics ran a Monday evening clinic every fortnight. Ophthalmology had previously run a Saturday clinic but were not currently doing so at the time of our inspection. We were told the waiting list did not demand it. Patients that we spoke with reported good access to appointments at times which suited their needs.
- Pharmacy opening hours were from Monday to Friday 8.15am to 4.15pm. There was no cover on weekends. Out of hours cover was provided by the Resident Medical Officer(RMO).

Access to information

- Administrative staff created an electronic patient record at the point of referral. The medical records team produced paper records three days prior to the patient attending clinic. This enabled staff to access referral information, risk assessments and test results. Within

endoscopy, this sometimes meant a double entry was required on both the electronic and paper record which led to a duplication of information which could be time consuming.

- Outpatient staff took samples for blood, urine and MRSA swabs and porters were responsible for transporting samples to the pathology laboratory, located at the acute hospital next door. Pathology results for bloods were available within 24 hours and within five days for urine and swabs. A trained HCA checked the system daily for incoming results that were sent electronically, and took a hard copy to place on the paper file.
- Within endoscopy specific pathways for pathology were categorised as yellow/green where staff sent routine samples to a pathology laboratory that Care UK had a contract with (an independent acute hospital), with urgent (red/amber) specimens sent to the acute hospital based next door. Results were returned to the endoscopist who signed them off.
- Patients who required an X-ray went to the acute hospital next door. The hospital sent images back to NELTC via the picture archiving and communication system (PACS) that allowed for instant access. The consultant viewed the image before seeing the patient. The acute hospital were unable to do X-rays after 4pm so patients requiring an X-ray after this time had to return.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that the process for seeking patient consent had recently changed. Patients now gave consent on the day of their surgery. Consultants would have previously sought consent from patients at the time of pre-assessment. Nurses gave patients leaflets that explained their upcoming procedure, and any benefits and risks in detail. This gave patients more time to consider the information and implications of their surgical procedure prior to giving consent.
- Consent forms for investigation and treatment had been pre populated in pre assessment, ready for the patient to consent on the day of their procedure. We reviewed eight patient files chosen at random which showed that consent had been gained appropriately in all cases.
- NELTC provided adequate support to patients to make decisions around consent. For instance, we were given a recent example where a patient, who attended with an interpreter, was concerned about their surgery. The consultant spent additional time with the patient allowing them to ask questions until they were satisfied that they had all the information they needed.
- Staff said that one of their biggest challenges was when GPs had not highlighted the need for any additional support at the referral stage. This meant patients attending for their first appointment were not always in a position to give consent, for example if an interpreter was required. Changes in the process of gaining consent meant that it was sought on the day of surgery, thus ensuring that the appropriate support was in place for that day.
- Within endoscopy, on the day of procedure patients were admitted to the ward, seen by the consultant endoscopist and consent gained from the patient. As this was done in between appointments it caused a gap in the flow of the unit and down time between cases.
- The Mental Capacity Act was part of the mandatory training programme. However, nursing staff told us the need to apply it in practice was infrequent.
- The patient's capacity to consent to treatment was assessed at the initial appointment and throughout the patient journey. Where it was suspected that a patient lacked capacity, a mental capacity and best interests' assessment were undertaken. The consultant would then complete the form for adults unable to consent to investigations or treatment which would provide details about the patient's lack of capacity and decisions regarding procedures to be undertaken.

Are outpatients and diagnostic imaging services caring?

Good

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good because:

- We observed staff taking time to interact with patients in a respectful and considerate manner. Staff took time to interact with patients. Patients were involved in their own treatment and care. Patients were provided with information and kept updated with regard to their progress.
- Privacy and dignity was respected however, in Barley Court staff could be overheard discussing patients (though not by name) behind a shutter that separated the waiting area and the staff kitchen.

Compassionate Care

- Staff took time to interact with patients in a respectful and considerate manner. In physiotherapy we observed staff communicating empathetically with patients during treatment planning. All staff in endoscopy were seen to provide kind and compassionate care to patients whilst in consultation and carrying out procedures. When a serious diagnosis was found, the consultant spoke to the patient personally.
- Staff showed an encouraging, sensitive and supportive attitude towards patients. One patient we spoke with said they had been referred for an endoscopy. They told us that they were happy with the decisions made by NELTC, and that all staff had been polite and understanding. One patient's daughter told us they came in in person to make an appointment due to phone difficulties. They told us that staff were very helpful when they turned up at the hospital.
- Staff spoken to were full of praise for clinical staff. Patients told us they were treated with dignity.
- Staff respected patient's privacy and dignity. Staff provided clinical activity within individual consulting rooms where doors were always closed. Staff respected patient privacy by knocking on clinic room doors before entering. In the Barley Court waiting area seats were sufficiently away from the reception area to allow patients to have private conversations with reception staff. However, in the main building waiting area we observed that patient conversation with reception staff could be overheard but not in detail.
- We observed one patient being passed paper records belonging to another patient. Once the patient noticed they had been given the wrong notes the receptionist corrected the mistake, handing the patient their own records. In Barley Court there was a shutter which separated the waiting area and the staff kitchen. Through the shutter we heard staff discussing patients (though not by name) which was a potential compromise to patient confidentiality.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so that they understood their care, treatment and condition. One patient who had been referred to NELTC for a knee operation told us "I have seen the surgeon and he has explained everything in a very understandable way…The consultant also gave me time…The care here is very good. They have a good understanding of how to treat patients".
- One patient told us "I had a cataract removed in July. All went well, I was very pleased. I have felt totally involved in my treatment". Another told us "They tell you what you need to have done and I felt part of the decision making process. The staff were great. I was told what was going to happen".
- Senior managers told us that patients received a copy of all letters sent by the hospital to their GPs. Patients we spoke with confirmed they received copies of progress letters sent by the hospital to their GP, thus involving patients in their own care.

Emotional support

- Staff supported patients to manage their care and treatment. One patient who had a knee operation at NELTC had been transferred to an acute hospital due to an infection. However, they had come back to NELTC to have their dressings applied. The patient was very happy with the care, saying that staff had visited them at home to provide care following discharge.
- Notices were displayed in waiting areas offering chaperone services. Patients were able to indicate when a chaperone was required and this would be provided by a member of staff.
- If a consultant needed to examine a patient they would ask at reception for a member of staff to act as a chaperone. This was usually requested for female patients when seeing a male doctor. If a HCA was

already present in the consultation they would act as chaperone. If staff were aware prior to an appointment, that a patient required additional support at they ensured a chaperone was available during that time.

- The triage process helped staff awareness of any emotional support a patient may require. During the triage process patient information was assessed and the outpatients manager made staff aware of any individual needs that had been identified.

Are outpatients and diagnostic imaging services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good.

- The hospital was meeting their referral to treatment time targets. Patients were happy about the speed at which they received a date for surgery. One-stop clinics enabled patients to see the consultant, have assessments, diagnostic tests and receive a date for surgery all on the same day. However, this meant that waiting times could be long, and were one of the main issues raised in patient feedback. The hospital had no audit for monitoring waiting times, and there was no action plan to reduce 'did not attend' rates.
- Evening clinics were offered in orthopaedics, and ophthalmology and endoscopy clinics took place on Saturdays when waiting lists developed. Patients were able to choose dates and times which suited their needs. Patients' individual needs were supported where necessary, for instance where interpreting services or transport was required. We found a number of examples where people with additional needs had been taken in to account and their support needs met. Staff told us there was support available for patients with mobility difficulties needing to travel to the nearby acute hospital, however this was not the experience for all patients.
- The facilities and premises were suitable for the services offered. Adequate seating, refreshments and patient information were available. Information on the service, including directions and expected attendance time were sent to patients prior to initial appointment. However, parking was one of the main problems raised in patient feedback due to cost and lack of available spaces.
- Leaflets were available in the waiting areas offering patient advice and information about the hospital.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population were used to inform how services were planned and delivered. Information was sought from commissioners and patients to plan the way the service was delivered at NELTC. Hospital managers normally met with the Clinical Commissioning Group (CCG) every two months which enabled them to share information about local needs. However, that had not occurred for the past six months due to meeting cancellations, but the hospital director had maintained regular contact with the CCG. The hospital also gathered local information from the patient forum which met twice a year and from feedback through the hospital microsite and NHS Choices website.
- Outpatient clinics ran from 8am to 6pm Monday to Friday. Orthopaedics ran a Monday evening clinic every fortnight. Ophthalmology and endoscopy also ran Saturday clinics when there was a waiting list.
- Patients told us they found the appointment system flexible as they could choose the appointment time convenient for them.
- The facilities and premises were suitable for the services planned and delivered. Barley Court waiting area had adequate space and seating areas for patients. There was a television in the main waiting area at a volume that was not intrusive to the waiting area as a whole. It also contained a smaller seating area away from the main area which contained a small abacus play frame for children. A leaflet rack contained information on making a complaint, 'top tips for winter wellness', smoking cessation and an introduction to PROMS (patient related outcome measures).
- Vending machines offered drinks and snacks and were available within the waiting areas. Filtered water was available free of charge in the Barley Court waiting area, but not in the main building's waiting area. On the day

of our visit the vending machine in the main outpatients building had broken, and we observed staff offering patients drinks. Drinks were also available in the coffee shop in the hospital next door.

- There was a car park behind the main building and a car park in front of Barley Court outpatients building. Both were paid for car parks and were accessible to anyone coming on to the hospital campus. Parking was one of the main problems raised in patient feedback due to the cost and lack of available spaces.
- Public transport was easily accessible. There was a regular bus service close to the outpatients department that linked to the local area and underground station.
- Both the Barley Court site and main hospital site had clear signage outside that made it clear for patients. Signs inside clearly identified where different areas were. For instance, reception, main waiting areas and clinic rooms were all well sign posted.
- Letter bundles sent to patients at the initial stage included a number of items to assist orientation and gather pre-assessment information. These were: a letter confirming appointment and saying where to come to and to expect a process that could be up to three hours in duration due to the multidisciplinary team approach in pre assessment, a leaflet detailing a map and directions to the hospital. On the back were photographs of the two buildings. Questionnaires included, and to be completed, were contact details including next of kin, ethnicity and smoking status with the offer of cessation.
- Patients had indicated that waiting times during one-stop clinics were an issue. Managers were putting plans in place to address lengthy appointment duration times. The hospital informed patients of expected waiting times in their appointment letter. The receptionist told patients when there was a delay in clinic, and offered the opportunity of rescheduling their appointment if they considered the wait would be too long. However, some patients told us there was a lack of information about how long they would have to wait. Staff offered complementary snacks and drinks to patients waiting for long periods exceeding three hours. Managers planned to install a TV in the waiting area to inform patients of waiting times.

Access and flow

- The hospital had been making improvements in meeting their referral to treatment (RTT) standards. RTT data between April and September 2016 showed that the service met its 18 week standard 100% within general surgery, orthopaedics, ophthalmology and oral surgery. A report was compiled each week to highlight any upcoming breaches which were discussed at a weekly scheduling meeting, attended by the head of nursing and department managers. Minutes of a scheduling meeting dated 8 September 2016 showed discussion about what actions could be taken to avoid potential breaches. Actions included ensuring each patient pathway was tracked and each clinic reached full capacity. Administrative staff worked with consultants to ensure efficiencies within clinics. Clinics were booked six weeks in advance of their date depending upon demand. An electronic appointments system enabled the booking team to see at a glance when clinics were full.
- The 'did not attend' rates for the outpatients department showed that there were 113 non-attendees in July 2016, 116 in August 2016 and 109 in September 2016. NELTC did not currently have an action plan to reduce non-attendance.
- The hospital monitored cancelled clinics. Data captured by the centre showed the number and reasons for clinics cancelled between 7 July 2016 and 24 August 2016. The department had cancelled eleven clinics during this period for various reasons including staff sickness and no patients being booked. General surgery had cancelled 7 clinics during the period, the main reason being that there was no anaesthetist available. The hospital did not indicate within their data whether outpatient clinic cancellations were avoidable or not.
- Referrals were logged by the bookings team and went to senior nurses for triage, which involved assessing and checking against the referral criteria. The admin team then ensured that the patient was on the correct pathway. For example, with an orthopaedic patient, the referral was accepted on to the electronic information system and the correct pre assessment appointment was booked with an appropriate consultant. With every paper based file there was an electronic patient record that set out the patient pathway, it clearly documented first appointment, first consultant appointment, nurse led consultation, operative procedure and six week

post-operative consultant follow up. As the patient progressed through this pathway records were added to the corresponding stage of the process. This included what actions staff had taken such as assessment, duplex scan and consent.

- The advertised waiting times for clinic appointments at the time of our inspection were two weeks for ophthalmology, four weeks for oral surgery, orthopaedics and general surgery, and six weeks for gastroenterology. Patients could access these waiting times live, through the NELTC website.
- GPs referred the majority of patients to the service. Patients booked their appointment online via the 'choose and book' process. Patients told us the system was user friendly and enabled them to choose an appointment time suitable to their needs. When the choose and book system was not used the bookings team phoned the patient for initial contact and confirmed a suitable time for their first appointment. If staff could not make contact after two attempts, they would write to patients with a suggested date and time with the option to change this.
- Patient feedback indicated that waiting times during one-stop clinic appointments were one of the biggest problems encountered. This was particularly the case when patients had been for an X-ray at the hospital next door and were waiting for results.
- Patient times were monitored throughout their appointment slot at the clinic. This was so that individual waiting times during clinic could be established, to highlight any delays and to the reasons for them. A patient visit schedule was placed on the front of each file, and staff entered the times the patient was seen. Management monitored the patient schedules, however the hospital had not completed audits to demonstrate the impact of this.
- Patients told us they were happy with the speed at which they received a date for surgery. There was a one-stop clinic so that patients could see the consultant, have diagnostic tests and be given a surgery date the same day.

Meeting people's individual needs

- Individual needs were identified during the triage process. We found a number of examples where people with additional needs had been taken in to account. Where patients were identified as diabetic for instance, they were placed first on the clinic lists to allow for their dietary needs. When someone with a learning disability was recently referred to the service their support needs were assessed and a carer was supported to accompany them to their appointment. A longer clinic time was allocated to meet their specific needs and staff were made aware of potential higher support needs.
- The booking team identified patients who required an interpreting service at the referral stage. The team booked interpreters through a contracted interpreting service. Staff told us they monitored interpreters on arrival, ensuring that they were prompt, had the relevant documents and name badge. There were instances where GPs did not indicate that an interpreter was required at the referral stage, and this could result in a patient's appointment having to be rescheduled. This had occurred three times in the week prior to our unannounced visit. However, staff said they could often book interpreters at short notice and found the service were able to meet their requests. Members of staff would translate as a last resort. It was not hospital policy to allow patient's family members to interpret for them to ensure that the patient's own voice was heard.
- Staff contacted patients at the referral stage to assess whether transport was required. The hospital director told us that NELTC 'piggy backed' on to the transport contract provided by the local acute trust to which they provided services. The hospital did not measure performance and response times, though staff told us they had not received any complaints regarding patient transport. NELTC had started to measure the use of the transport service as there had been concerns around under use of the provision.
- The hospital provided good level access to disabled patients. Staff told us that a porter would support non-ambulant patients by provision of a wheelchair if they were required to travel to the hospital next door. However, one patient said they had difficulty walking and were not offered support when required to go to the nearby hospital for an X-ray.
- A leaflet rack within the outpatients waiting area contained information on making a complaint, 'top tips for winter wellness', smoking cessation and an introduction to PROMS (patient related outcome

measures). Information booklets on the service were also available and included details on the service values, privacy, Wi-Fi access, infection control, cancellation of appointments, patient questionnaires, waiting times, patient information, pre-operative phone call, fire alarm, patient satisfaction, patient forum, feedback and contact details. We were informed by NELTC that they have access to 39 languages and can print off information in a language or alternative format which meets the patient's individual needs.

Learning from complaints and concerns

- The centre made complaint guides available in the waiting areas. Staff were aware of procedures on how to deal with complaints. Clinical complaints were passed to the outpatients manager whilst non-clinical complaints were handled by the administrative manager. Staff would investigate the complaint and send a formal response within 21 days. Staff told us they had not received any formal complaints for six months.
- Staff preferred to deal with concerns face to face where possible, thus resolving the issue before the formal complaint stage. We were told about one incident where a patient had not been happy with the way she had been spoken to by a nurse. The manager discussed this with the patient, ensured the nurse was made aware of the issue and resolved it to the patient's satisfaction.

Are outpatients and diagnostic imaging services well-led?

Good

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well led as good.

- Outpatient staff were given time away from clinic and patient duties to attend the hospital wide Quality Governance and Assurance meeting (QGM). Staff also attended a monthly staff team meeting. Heads of departments met monthly and took issues from their departmental meetings.
- The only audits that currently took place in outpatients were in infection control and venous thromboembolism. It was acknowledged that more audits were required with the wound dressing clinic identified as one such area.
- Radiology services, pathology services, estates, patient transport and translation services were outsourced and provided by service level agreement. Contract monitoring in some areas had been allowed to lapse in recent years but were now being given an increased focus by the leadership team. For instance, the radiology contract was nine years old and had recently been redrafted with performance and quality checks added.
- There was a clear leadership structure within outpatients, with a manager, two team leaders reporting to the hospital's head of nursing. There had been a period of instability due to staffing and job security issues. The manager was due to leave two weeks after our visit and one of the two team leader posts were also vacant. A new manager had been placed on secondment for 6 months and the vacant team leader position had been recruited to.
- Staff we spoke with felt very much part of a team with the head of nursing described as visible and supportive. Staff spoke positively about doctors and other clinical staff. Staff supported each other in their work and felt able to talk to managers about any concerns they had.
- With regards to patient involvement there was an active patient forum that met every quarter. Results were positive, but there had historically been a low response to the Friends and Family Test. Steps had been taken to improve this.
- We also found that the need for a continuous daytime security presence in outpatient areas had not been adequately risk assessed.

Leadership and culture

- Within outpatients there was one manager and two team leader posts. The manager reported to the head of nursing.
- There had been a period of instability within outpatients due to the delay in renewal of the hospital's main contract which had affected job security and staffing.

The manager was due to leave two weeks after our visit and one of the two team leader posts was also vacant. The head of nursing recognised there had also been difficulties in managing some staff related issues. The current manager and use of appropriate HR systems had helped to improve the situation, but there were still challenges within the service.

- A new manager had been placed on secondment for six months. They told us they had two staff nurses (job share) who had now taken on the vacant team leader position and would be given additional training. Interviewing had taken place to fill vacant staff nursing posts.
- Senior management reflected that recent times had also been unsettling for staff as the bidding process for the renewal of the contract with the NHS acute trust had been uncertain and drawn out. This had meant that job security had not been guaranteed. Now the contract had been renewed this was settling down.
- One staff member told us they had noticed changes and that the management were slightly better, saying "things had been difficult in the organisation but we're better now".
- Managers indicated to us that they maintained an open door policy and staff were aware who to contact if managers were in meetings. Staff told us they felt that the outpatients manager and head of nursing could be approached, but that senior managers were not visible.
- Staff talked about supporting each other and said that they felt able to talk to managers about any concerns they had. Managers told us that staff were encouraged to be open and transparent.
- There were no bullying and harassment issues raised by staff. We were told that there had been an incident in the past six months where two members of staff had a disagreement and management became involved. Mediation had been planned to help alleviate the situation, however, the staff members were able to resolve the problem themselves. Management told us they had good support from HR in managing the situation.
- Some members of staff felt that they did not feel valued for the work that they had done. This was particularly felt when staff had gone out of their way to improve the service.
- Endoscopy staff told us people and staff were lovely and felt there was good training and support. They said they had good support within the department and a reasonable workload with good time organisation.
- Staff we spoke with felt very much part of a team with the head nurse being described as very visible and supportive. Staff were full of praise for doctors and other clinical staff but some were unhappy to a degree with senior management although reticent to elaborate on this.

Service vision and strategy

- Senior staff told us the service vision was to provide safe and effective high quality care in a timely fashion. Staff we spoke with were committed to providing good care to their patients and were aware of the values of the service and how this could be embedded in to their practice.
- The hospital had reached out in to the local community and were now offering orthopaedic outpatient appointments at two local GP led health centres, one session a week.

Governance, Risk Management and Quality Measurement

- The Quality Governance and Assurance meeting (QGM) took place one afternoon a month. All staff were encouraged to be involved and were expected to attend. They were given time away from clinic and patient duties. Minutes from the monthly QGM showed service performance was discussed at the meetings. The risk register was a standing agenda item with actions to address risks recorded.
- Within outpatients, staff attended a monthly staff team meeting. Heads of departments also met monthly and took issues from their departmental meetings to discuss.
- Senior managers had a meeting with medical directors and hospital directors across Care UK on a quarterly basis which lasted for half a day. The other half of that

day was a meeting of medical directors and clinical leads for each pathway across Care UK. This was to address clinical issues across Care UK, SIs and any learning that had been identified.

- The only audits that took place in outpatients were infection control and venous thromboembolism (VTE) audits. It was acknowledged that more audits were required with the wound dressing clinic identified as one area where auditing could take place.
- The hospital director told us they had been in post for ten months. Contract monitoring was an activity they had been having an increased focus on as there were areas where this had lapsed in the past. For instance, the radiology contract was nine years old and had recently been redrafted. Minutes from the radiology meeting within NELTC for March 2016 showed this was being discussed between NELTC and the contracted provider for radiology services. There were currently no set standards to which the service was being provided, however audit, monitoring and performance were being incorporated in to the new contract that was currently in draft form.
- The hospital director told us that NELTC 'piggy backed' on to the transport contract provided by the local acute trust to which they provided services. They were not aware of how the transport contract was performing in relation to NELTC patients. Staff we spoke with also told us that the hospital did not measure performance and response times, and had not received any complaints regarding patient transport. However, staff did inform us they had started to measure the use of the transport service as there had been concerns around under use of the service.
- Security was currently provided overnight only, from 7pm to 7am and staff were concerned by the lack of a security presence during the day. We discussed the security issue with senior managers who informed us that any immediate external security concerns will be reported to the police via 999 and that internal security was provided by in house porters. We were also told there was an arrangement in place with the nearby acute trust's security company although there was no contract and no security presence at any time during our inspection. This did not adequately account for the potential risk faced by staff. Porters were not trained or paid to act as security guards. The proximity of the trust's hospital security team to Barley Court meant the response would take at least ten minutes. We were told by staff that the arrangements in place with the nearby trust's security team was not responsive enough to act when a potentially risky situation arose.
- At the main NELTC site there was unrestricted access through an automatic door which was located right next to the main A&E entrance of the local acute NHS trust. At Barley Court, where most outpatient appointments, including pre assessment appointments occurred, entry was via a restricted entry system operated by staff. Staff gave us examples where they had been called upon to step up in to a security role, without any appropriate equipment or training, when they had to deal with confrontational situations with patients and relatives. Staff reported that a daytime security presence had been requested from the senior management team but not responded to.
- Information regarding activity with the contracted interpreting service was provided. This was broken down by the hours of each language translated and showed a total of 74 and 81 hours were used in July and August 2016. The service monitored interpreters through the use of a checklist on arrival, that included checking that they were prompt, had the relevant documents and name badge.

Public and Staff Engagement

- There had been an inconsistent response to the Friends and Family Test. July and August 2016 response rates were low, but June had been above the threshold level of 50%; Staff meeting minutes indicated that response rates had been good for a period but had 'gone down hill again' and meeting minutes that raised this as a concern. Steps had been taken to improve this. Patients were encouraged to leave feedback which was now collected from a computer tablet located at reception. There was also a book at reception for patients to write their feedback in. The response rate was 42% in July 2016 and 40% in August 2016. Results were positive with 93% and 97% respectively.
- There was an active patient forum where views were taken on board. The forum met every quarter and was attended by six to eight patients.
- Staff understood the main patient concerns to be waiting times and car parking. Managers said they were

taking steps to ensure staff kept patients informed about waiting times. No plans were in place to deal with difficulties around the car parking as it was seen outside the hospital's control.

- Interpreting services were used to ensure engagement with people who did not speak English. Data collected by NELTC showed there was a good uptake of this service.
- In terms of staff engagement, staff attended a monthly team meeting and QGM where suggestions for future practise were made.
- The staff survey had recently been completed but the results were not available.

Innovation, improvement and sustainability

- The satellite clinics were seen as the main innovation within the outpatients' service. There were three satellite clinics that took place in GP surgeries and health centres, on a one session a week basis. This was managed by the outpatients manager, which provided more choice and had made services more local.
- Both the hospital director and medical director had been in post for less than a year. Along with the head of nursing they had looked at improving the service in a number of ways such as redrafting and monitoring service level agreements, improving staffing and brightening up the environment at Barley Court by re-covering the chairs and redecoration. A TV had also been installed which would provide patient information.
- Other plans were to look at clinic locations, in particular proposing the move of the dental clinic from the main hospital site to Barley Court. They also hoped to be able to allocate a nurse to every consultant clinic. There were also plans to bring an X-ray service in house.
- Staff were encouraged to deliver high quality care and we were told that staff achievement awards were given each month.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that:

- Identified risks are reported and reviewed within the agreed timescales; and there is clinical oversight, governance structures, and risk management of patients coming from other healthcare providers that utilise the theatre services. (Regulation 17) (2) (b)

Action the provider SHOULD take to improve

The provider should also ensure that:

- All clinical staff are competent in basic life support and have the required level of resuscitation training for their role
- Proposed changes to Resident Medical Officer working patterns comply with the European working time regulations.
- Structures which support staff learning from incidents are reviewed.
- The Workforce Race Equality Standard (WRES) is effectively implemented, and there is continued work towards improving culture within the service.
- Temperature checks on medicine fridges are routinely carried out on the weekend to help maintain safe levels.
- All staff are aware of the major incident management and escalation procedure, and business continuity plans.
- Current security systems in place to protect staff and patients are reviewed, and make improvements where gaps have been identified.
- Adequately risk assess the need for a continuous daytime security presence in outpatient areas.
- Provision and additional support available for patients with learning disabilities are reviewed, and develop a policy to formalise any arrangements.
- There is a scope guide available for colonoscopy and that a paediatric scope is available for use with narrow structures such as with diverticular disease.
- That equipment failure in ophthalmology is logged and responded to.
- That staff in Barley Court cannot be overheard through a shutter that separates the waiting area and the staff kitchen.
- Audits and quality monitoring is appropriate for the service and actioned accordingly.
- Continued progress is made on increasing the number of Friends and Family responses it receives.
- Ways of reducing waiting times during the one stop clinics are explored, and that patients are kept fully informed of waiting times when they attend.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Nursing care Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • We found gaps in alignment of clinical governance oversight for patients having surgical procedures at North East London Treatment Centre. There was evidence from governance reports that showed that the service had not been reviewing risks on the risk register within their review timescales. The risk register did not reflect some significant risks identified as part of our inspection, particularly relating the governance arrangements with another healthcare provider using North East London Treatment Centre theatres.