Eastwood Community Endoscopy Centre Ltd

Eastwood Community Endoscopy Centre LTD

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

This is the first rating inspection for this service. We rated it as requires improvement because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all staff had completed mandatory training as required. The service controlled infection risk well, although not all water samples were recorded. Staff managed medicines, although not all records to show controlled drugs had been given were recorded quickly enough and one issue in the medicines audit continued for several months.
- Not all staff felt respected, supported and valued. Auditing and monitoring processes were not always completed frequently enough to provide up to date oversight of the service. Staff did not always identify timescales for improvement where actions were identified following audits.

We rated this service as requires improvement in safe and well led and good in caring and responsive. We do not rate effective for diagnostic services.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Requires Improvement 	This is the first rating inspection for this service. We rated it as requires improvement because: • The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually. However:

Summary of findings

- Not all staff had completed mandatory training as required. The service controlled infection risk well, although not all water samples were recorded. Staff managed medicines, although not all records to show controlled drugs had been given were recorded quickly enough and one issue in the medicines audit continued for several months.
- Not all staff felt respected, supported and valued. Auditing and monitoring processes were not always completed frequently enough to provide up to date oversight of the service. Staff did not always identify timescales for improvement where actions were identified following audits.

We rated this service as requires improvement in safe and well led and good in caring and responsive. We do not rate effective for diagnostic services.

Summary of findings

Contents

Summary of this inspection

Background to Eastwood Community Endoscopy Centre LTD

Eastwood Community Endoscopy Centre LTD is operated by Eastwood Community Endoscopy Centre Ltd. The endoscopy unit it located in an adapted residential property on a main road close to the centre of Leigh-on-Sea in Essex. The adapted property comprises a reception area, waiting area, admission rooms, procedure rooms, recovery room and discharge area.

The service provides endoscopy (colonoscopy, flexible sigmoidoscopy and oesophagogastroduodenoscopy (OGD)) for patients ages 18 years and over. These are procedures that look at different parts of the gastrointestinal tract.

The service is directly commissioned by the local Integrated Care Board (ICB), to provide routine endoscopy services and serves the communities of Southend-on-Sea and the surrounding area.

The service has had a registered manager in post since December 2021.

How we carried out this inspection

We carried out this inspection as the service had not had an inspection previously, using our comprehensive inspection methodology. We carried out this unannounced inspection on 20 December 2022.

During the inspection visit, the inspection team spoke with staff, including an endoscopist, the registered manager, the head of care and 5 staff. Following this inspection visit the registered manager sent us data electronically, including a range of policies, procedures, audit reports and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure that auditing and monitoring processes are completed frequently enough to provide up to date oversight of the service. That action timescales for improvement are identified and that action is taken where the same shortfall is identified in consecutive audits. Regulation 17(2)(a)(b)
- The provider must ensure staff record administration of medicines in all records as soon as practicable following administration. Regulation 12(2)(g)
- The provider must ensure staff record formally any concerns around patient capacity and best interest decisions, in line with the Mental Capacity Act 2005. Regulation 11(3)

Action the service SHOULD take to improve:

Summary of this inspection

- The provider should ensure that all water samples are recorded. Regulation 12(2)(h)
- The provider should ensure that shortfalls in medicines audits are addressed. Regulation 12(2)(g)
- The provider should consider what changes are required to ensure all staff feel respected, supported and valued. Regulation 18(2)(a)
- The provider should ensure all staff complete required training. Regulation 18(2)(a)
- The provider should ensure all staff receive appraisals annually. Regulation 18(2)(a)
- The provider should ensure storage areas for perishable products are water and pest resistant. Regulation15 (1)(c)(f)
- The provider should ensure the risk register is kept up to date and reviewed throughout the year. Regulation 17 (2)(b)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Diagnostic and screening services

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Diagnostic and screening services safe?

Requires Improvement

This service has not previously been inspected. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff although not all staff completed it.

Staff received but not all staff kept up-to-date with their mandatory training. Information provided about mandatory training showed that not all staff had completed all of the training assigned to them. Only 6 staff members had completed all of their required training and not all staff had completed immediate life support training. The registered manager also told us all staff had received immediate life support training, although the matrix had not been updated to reflect this.

The mandatory training was comprehensive and met the needs of patients and staff. Training consisted of a mixture of subjects, such as safeguarding, fire safety and infection, prevention and control. Staff received training in a mixture of face to face and online sessions.

Managers monitored mandatory training and alerted staff when they needed to update their training. The registered manager told us they maintained a spreadsheet matrix that indicated when staff were next due training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and adults formed part of the mandatory training programme for staff. Staff told us they had received this training. Records provided following this visit showed all staff had completed safeguarding adults training to level 2 and all but one staff member had completed safeguarding children training to level 2.

Requires Improvement

Diagnostic and screening services

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff provided examples of issues they would report, they knew who to report to and how this process worked. Up to date safeguarding policies for adults and children were available to guide staff. These had flow charts for the escalation of concerns and clear information about each staff member's responsibility. Staff had access to a level 3 trained safeguarding lead, who worked onsite and was easily contactable.

The organisation had a recruitment pathway and procedures to help make sure relevant recruitment checks had been completed for all staff. These included a disclosure and barring service (DBS) check, health declaration, references and qualification and professional registration checks.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. All areas we visited were visibly clean and free from clutter. The building was laid out to enable a one-way flow system for patients from arrival to exit.

The service generally performed well for cleanliness. Staff cleaned equipment after each patient contact and labelled equipment to show when it was last cleaned. We observed cleaning taking place after a procedure. This included fixed equipment such as examination beds and portable equipment. Each room had a disposable privacy curtain and staff marked each curtain with the planned date of change. All privacy curtains were within their expiry date. Items were visibly clean and dust-free, and we saw a daily cleaning check list was in use and completed.

Staff used single use equipment where appropriate; disposable endoscopes were available if needed.

Endoscopes were cleaned immediately after use. Used endoscopes were passed from the procedure room to the decontamination room for initial cleaning, testing and decontamination. Staff used a system to track and trace equipment at each stage of the decontamination process.

Water quality sampling was carried out weekly to measure the level of bacteria in the final rinse water and if levels were outside of acceptable parameters, the equipment would not be used. Records showed bacteria levels had been within acceptable ranges. A water system risk assessment by an external company identified 2 'deadlegs' (water pipes that had been disconnected) in the service's water system. Staff told us they were aware of these and flushed the end pipe to prevent the build up of stagnant water. However, they were not able to provide up to date water sample results for these 2 pipes. These should be recorded to ensure action could be promptly taken if concerns were identified and to provide a clear audit trail of checks.

Staff followed infection control principles including the use of personal protective equipment (PPE) and had access to personal protective equipment (PPE) such as gloves, aprons and masks. All staff wore PPE where necessary.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Hand-washing and sanitising facilities were available for staff and visitors.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff completed an infection control audit annually, which included the safe disposal of sharps and environmental factors. The most recent audit in September 2022 showed improvements were required to ensure all areas were clean and maintained to a hygienic standard. An action plan had been implemented, although no target dates were available for completion. Records should include target dates and information to show how far the action was to being achieved.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed all clinical waste well.

Staff disposed of clinical waste safely. Staff followed the provider's clinical waste policy and disposed of waste in appropriate waste bags, which were then disposed of correctly. The provider had arrangements in place to ensure clinical waste was removed from the site.

The design of the environment followed national guidance. Although the building was an adapted residential building, staff had laid out a circular route, so patients moved through the building in a one-way flow from the waiting room to the exit. Each endoscopy suite had a designated clean to dirty circulation area in line with national guidance. The service had secured doors leading to clinical areas which meant that only staff had full access to clinical areas. Patients were escorted by staff from the waiting room into clinical areas.

Staff carried out daily safety checks of specialist equipment. The resuscitation trolley was checked daily by staff and records demonstrated this without gaps. We checked the resuscitation trolley, all equipment was correct and single use equipment was in date. Staff kept comprehensive records of decontamination and sterilisation equipment checks. The service had robust tracking and tracing systems that recorded each stage of the decontamination process for each endoscope. The service had their own endoscopes and did not use endoscopes across multiple locations.

The service had enough suitable equipment to help them to safely care for patients. The provider had an effective system to ensure that repairs for broken equipment were carried out quickly so that patients did not experience delays to treatment. Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. We checked the service dates for all equipment and found them to be within their service date.

However, storage areas for perishable products were outside of the main building and could not be guaranteed water or pest resistant, putting items stored at risk of being unusable.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff responded promptly to any sudden deterioration in a patient's health. Staff used the National Early Warning Score (NEWS) for a deteriorating patient condition. This involved measuring a patient's vital signs such as temperature, blood pressure, heart rate and consciousness which provided a numerical score. Patient's vital signs were monitored during their procedure. The score determined the actions staff should take in relation to a deteriorating patient and staff knew how to access this protocol. Both the procedure room and recovery area had an emergency alarm in the event of emergency or patient collapse. If a patient required urgent treatment staff told us they would call 999 for an emergency transfer to the local hospital.

Requires Improvement

Diagnostic and screening services

The clinic had a major haemorrhage protocol, which made sure patients would have access to immediate help in the event of a major haemorrhage, whilst awaiting paramedics.

There was enough emergency oxygen stored securely and in line with current guidance on site to provide urgent care to a patient if they deteriorated. Patients undergoing sedation were required to have an escort for the journey home.

Anaphylaxis awareness training was a part of the mandatory training and clinical staff completed it.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The service had a patient selection criteria that provided guidelines for the types of patients they treated. Staff used an adapted 'five steps to safer surgery' checklist based on guidelines from the WHO Surgical Safety Checklist.

Endoscopists ensured they had adequate knowledge of the patient's medical history, medication and any relevant test results. They used a medical assessment questionnaire for all patients.

Staff knew about and dealt with any specific risk issues. Staff said any unexpected or significant findings from endoscopic tests were escalated to the treating consultant. Staff would contact the referrer by telephone and follow this up with an urgent report.

Staff assessed each patient's suitability for receiving conscious sedation. Patients received information before their procedure regarding conscious sedation. The service completed a fire risk assessment and had a protocol for evacuating a sedated patient. The registered manager told us all staff had up to date training in immediate life support (ILS), although this was not recorded on the service's training matrix.

Staff shared key information to keep patients safe when handing over their care to others. Staff shared appropriate information verbally when transferring patients from one area to another and to other staff members. Other key information was also written in the patient's notes, which were also transferred with the patient.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. The clinic had a combination of full and part-time staff. There was a lead nurse, 2 sisters, 14 registered nurses and 5 health care assistants (HCA)/decontamination assistants. There was always a nurse and HCA or two nurses within the procedure room and a nurse assigned to the recovery area.

The lead nurse and sisters could adjust staffing levels daily according to the needs of patients. The registered manager and lead nurse planned staffing levels and skill mix needed for each day. Rotas were done in advance with short notice changes as required in accordance with staff.

The service had low vacancy rates. The service had only one registered nurse vacancy at the time of our inspection. The registered manager told us they were able to fill any shortfall in staffing levels with existing bank staff.

Requires Improvement

Diagnostic and screening services

The service had low turnover rates. The registered manager had recruited 7 new staff in 2022, without any existing staff leaving the service.

The service had low and/or reducing sickness rates. The service had an average of 5% sickness rate amongst registered nurses and HCAs. The registered manager was able to adjust staffing levels and obtain short term cover through existing bank staff.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. The clinic had 14 endoscopists performing endoscopies under contract to the service. The registered manager told us these endoscopists did not have practising privileges but worked at the service under contract.

We saw evidence that the clinic checked all medical staff had valid professional registrations, medical indemnity insurance, and completed appraisals. The clinical lead was responsible for obtaining this information, keeping it up to date and liaising with NHS trusts to support GMC revalidation.

The medical staff matched the planned number. There were enough medical staff to complete the procedure lists and each endoscopist knew when they were required to work.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Staff used secure electronic patient records to document the patient's needs and treatment. Records were stored securely with password only access, after patients had been seen. All patient's data, medical records and results were documented via the clinic's secure patient electronic record system. We reviewed 8 patient records and found them to be complete and legible.

The clinic received patient referrals through a secure email from the referring GP.

Each patient was provided with a written report of their care and treatment before they left the clinic on the day of their procedure. The clinic provided referrers with electronic reports, so they could follow up with the patient and take any further action if needed.

Medicines

The service used systems and processes to safely prescribe, administer and store medicines, although records were not always up to date.

Staff did not always complete medicines records accurately or keep them up-to-date. Not all medicines were recorded as administered at the time of giving or even immediately following the patient's procedure. We saw that sometimes medicines were only signed for by the endoscopist giving the medicine at end of the list of procedures, which was not safe practice and did not follow best practice guidance.

Requires Improvement

Diagnostic and screening services

Staff did not all learn from safety alerts and incidents to improve practice. The clinic completed monthly medicines management audits, which consistently showed that entries in the main controlled drug register were not always completed accurately. Actions must be developed for shortfalls in audits to reduce risk of consistent reoccurrence.

Nurses used patient group directions (PGDs) to administer medicines in line with the provider's established policy.

Staff followed systems and processes to prescribe and administer medicines safely. The clinic held limited stocks of medicines relevant to the service they offered. Controlled medicines were administered in line with published guidance. Medicines were within date and stored in a secure locked cupboard.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff used an electronic incident reporting system and told us they were familiar with how to report incidents.

Staff raised concerns and reported incidents and near misses in line with the service's policy. The registered manager told us staff were encouraged to raise all types of incidents, including near misses. We saw from staff meeting minutes that staff were aware of concerns and that the minutes included actions from recently reported incidents.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Meeting minutes identified when duty of candour was needed and when this has been completed. Staff were able to describe their responsibilities under duty of candour and the process for discussing issues with patients.

Staff met to discuss the feedback and look at improvements to patient care. Staff met during clinical meetings and discussed any incidents as part of the standing agenda items. Actions were also discussed as were any formal changes to procedures. Information could also be passed on to staff during safety huddles at the beginning of each day.

Are Diagnostic and screening services effective?

Inspected but not rated

We do not currently rate effective for independent endoscopy services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Requires Improvement

Diagnostic and screening services

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Clinical policies and procedures we reviewed were all in date and referenced relevant guidelines such as NHS England, the WHO Surgical Safety Checklist, and the Department of Health. Staff could access policies and procedures electronically.

Managers checked to make sure staff followed guidance. There was a system of rolling audits to benchmark standards of care internally and with national guidance, such as the Infection Prevention Society and The Royal College of Physicians Joint Advisory Group on GI Endoscopy (JAG). Audits showed where there were shortfalls, the need for actions was identified, although these were not recorded in detail but included which staff member was responsible for the action. Many audits were in relation to patient experience and while staff completed some audits clinical audits, such as infection control and decontamination process, there was a lack of auditing of care and treatment records.

Nutrition and hydration

Staff gave patients food and drink when needed.

Patients were informed to arrive to appointments fasting at the time of their bookings and were reminded during pre-assessments on the telephone. Diabetic patients were given early appointments to reduce the amount of time they needed to be fasted.

After their procedure, patients were offered a snack and a cold beverage of their choice.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The service managed patients' pain well. Staff asked patients about pain during pre-assessments, during and after treatment. They documented pain using an established scoring system and documented this in the patient's records. An anaesthetic spray was used to numb the nose and throat before Oesophagogastroduodenoscopy (OGD) procedures which reduced the gag reflex making the procedure more comfortable for the patient.

Sedation was available, and staff worked with patients to identify the most appropriate level of sedation for their individual needs and planned procedure.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They did not use all the findings to make improvements and achieved good outcomes for patients. The service has not yet been accredited under the Joint Advisory Group.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The clinic provided endoscopy results immediately after the procedure, which meant patients could review their treatment options with their GP or referring doctor at their next appointment. Where results, such as pathology results, required further scrutiny, staff told patients when to expect these.

Staff audited report turnaround times, patients' perspectives of aftercare and transportation of specimens. Information showed the service performed consistently to a high standard. The clinical lead reviewed the Global Rating Scale (GRS) scores for individual endoscopists periodically to assess standards of care and contributed this data to the national endoscopy database as a strategy to benchmark patient outcomes.

Managers and staff used the results to improve patients' outcomes.

Managers and staff carried out a programme of audits to check improvement over time. Audits completed by staff did not cover all areas of the service, nor were they all repeated as frequently as recommended. Patient care and treatment records were not audited. Clinical processes, such as the decontamination process, waste disposal and infection control were only audited once a year. This was not comprehensive enough to ensure all areas of the service were checked or rechecked so that action to improve could be taken in a timely way.

Managers used information from the audits to improve care and treatment. Information from audits showed there were few areas identified as needing improvement. However, one area was identified consistently each month between January and June 2022 as not meeting expectation. Although records showed most audits were discussed at staff meetings, this issue was not discussed and continued without resolution.

The service was working towards accreditation by the Joint Advisory Group (JAG). JAG accreditation is a patient-centred and workforce-focused scheme based on principles of independent assessment against recognised standards and is a formal recognition that a gastrointestinal endoscopy service has demonstrated competence to deliver against criteria set out in the JAG standards. The service was working towards this accreditation.

Key performance indictors and individual endoscopist's outcomes were audited on a quarterly basis using the GRS as identified by JAG. Results were reviewed by the clinical lead who provided clinical support to endoscopists if results fell below national benchmarks.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All health care and nursing staff were registered with their appropriate professional bodies. The provider ensured it received evidence annually from doctors about appraisals and professional registrations as part of their practising privileges.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff received an induction, were allocated a mentor and attended training in skills required to care for patients undergoing endoscopy procedures. Training records showed they had received an induction tailored to their role.

Managers made sure staff received any specialist training for their role. Clinical staff completed competency-based training modules based on their role and responsibilities.

Managers supported staff to develop through yearly, constructive appraisals of their work. The registered manager told us annual appraisals had almost all been completed, although information sent to us showed almost half of nursing and other non-medical staff had either not received an appraisal in the last 12 months or had not received one at all.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Minutes of staff meetings showed a good range of staff, if not all staff attended meetings, which were also recorded and made available to staff to view.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patient outcomes and improve their care. There were daily meetings between endoscopists and their clinical teams to discuss the patient's needs.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked closely with the NHS trusts they supported and the referring GP to ensure patient information was shared in a timely manner if onward referral was needed. Endoscopists had a fast track link to NHS hospitals if they suspected a cancer diagnosis.

Histology samples were sent to the provider's chosen pathology laboratory and when test results were returned to the service, they were reviewed by the endoscopist and sent to the patients GP to inform them of the findings.

Seven-day services

Key services were available to support timely patient care.

The unit opened six days a week, Monday to Saturday, from 8.15am to 6.15pm.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Endoscopists and nursing staff had individual conversations about diet and health promotion after procedures. Staff provided information on lifestyle choices which might relieve patients' symptoms. We saw examples of patient information leaflets.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff explained they would report to the endoscopist if they had concerns about a patient's capacity to consent to a procedure. The endoscopist would then make the decision about whether to proceed or not. Assessment forms prompted staff to complete a mental capacity assessment if they had concerns about a person's ability to consent. However, the registered manager confirmed staff did not complete a capacity assessment and the endoscopist's decision could go either way.

Most nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Records held by the registered manager showed that most of staff had completed this training.

Requires Improvement

Diagnostic and screening services

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff gained informed written consent from patients after a discussion about the risks and benefits of the procedure. An audit of the consent process completed in July 2022 showed that all of 20 patients returning the questionnaire agreed the process had been completed correctly.

Staff clearly recorded consent in the patients' records. We reviewed 8 sets of patient records which demonstrated that written consent had been completed correctly.

Are Diagnostic and screening services caring?

Good

This is the first rating inspection for this service. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff took time to interact with patients at the patient's pace and by explaining each step of the procedure before it occurred and while the procedure was taking place. The clinic environment ensured patient's privacy and dignity was maintained. Patients had privacy for discussions pre procedure, during the procedure and in a separate cubicle in the recovery phase. In the provider's August 2022 privacy and dignity audit all of patients who responded said their privacy and dignity was respected.

Patients said staff treated them well and with kindness. Staff were very helpful and reassuring. The provider's privacy and dignity audit showed patient commented, "Staff are very friendly and welcoming," "Can't beat the care. Excellent!" and "Cannot thank the doctor and nurses enough, they explained everything, were gentle and made what I thought was going to be an uncomfortable experience so comforting."

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff we spoke with stressed the importance of treating patients as individuals with different needs. We observed staff caring for patients with sensitivity and staff monitored patients with care and compassion.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We saw that staff showed how they reassured patients and answered any questions they had. One patient in the provider's privacy and dignity audit said, "All staff were very kind and looked after me wonderfully and reassured me continually. After all my prior worries and trepidation, it was a good experience.".

Requires Improvement

Diagnostic and screening services

Staff understood the impact of breaking bad news and demonstrated empathy when having difficult conversations. A staff member explained how this sensitive conversation would be given in private with a doctor present, who would be able to answer any questions. The doctor would also be able to reassure the patient they could make immediate referrals to nearby NHS hospitals and specialist staff.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients said staff explained the procedure, checked what endoscopy procedure they were having and checked their identity. One patient commented in their friends and family response in July 2022, "They are such a lovely bunch of people, made me feel at ease all the way through until I left. They actually take their time to make sure you understand everything from start to finish."

Patients were advised about different options of sedation they could decide on before the procedure. All patients were given a discharge information sheet with advice on the procedure they had undergone. The clinic provided follow up phone calls to colonoscopy patients to ensure there were no complications.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff encouraged each patient to complete a feedback form online following their appointment. Comments and survey results were discussed at team and management meetings with the aim of improving the patients experience.

In the 2022 patient satisfaction survey most (15 out of 17) patients said risks and complications were explained to them and 16 patients said they had enough time to ask questions before signing a consent form.

Patients gave positive feedback about the service. Patient comments in the friends and family comments received by the service were overwhelmingly positive. Similarly, most comments in the service's patient satisfaction survey were also positive.

Are Diagnostic and screening services responsive?

Good

This is the first rating inspection for this service. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. There was an established inclusion and exclusion criteria which was agreed with local GPs. The clinic was open six days a week and provided elective endoscopy procedures by appointment only, to meet the need of the patient. Appointments were generally arranged on the telephone and staff would assess whether patients met the referral criteria.

Requires Improvement

Diagnostic and screening services

Staff said patients were contacted to book an appointment within 48 hours of referral and were seen at the clinic within a four-week period. Patients we spoke with confirmed being able to access the clinic in a timely manner. The environment was appropriate, and patient centred.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The registered manager and staff made sure lists at the same time of day were single sex only, so that patients of the opposite sex did not undergo procedures at the same time. This also eliminated the risk of mixed sex patients being in recovery at the same time.

Managers monitored and took action to minimise missed appointments. Missed appointments were recorded electronically. Those patients who had been referred due to a possible cancer diagnosis were contacted to rebook appointments. Other patients were referred back to their GP for reassessment of whether they still needed a procedure.

In the previous 12 months missed appointments averaged 2.9%, which was below the service's threshold of 5%. Patient cancellations for non-clinical reasons averaged 5.7%, which exceeded the service's threshold of less than 1%. To reduce the number of non-clinical cancellations staff made discretionary decisions about whether to rebook or refer back to the patient's GP. Staff also checked if patients understood all the instructions, they needed to follow to prepare for their procedure, which ensured they were aware of the preparation necessary for their procedure.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

There was a comfortable seating area and toilet facilities for patients and visitors. The building was wheelchair accessible and had separate disabled toilet facilities, however there was a steep drive prior to accessing the service.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to virtual translation services and could call for support. If a patient needed British sign language interpretation, staff arranged to use video calls with the interpretation service to accommodate these patients.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. The contact information for signers and interpreters was readily available. The service had information leaflets available in languages spoken by the patients and local community. Information was available in other languages to support patients in the local community whose first language was not English.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice. These were discussed at leadership meetings which allowed managers to review wait times, attendance rates and demand on the service. However, the most recent meeting minutes provided were dated June 2022 and senior leadership meetings were scheduled in 2023 every 3 to 6 months. This did not provide adequate oversight of these targets.

Requires Improvement

Diagnostic and screening services

The provider monitored key performance indicators (KPIs). Procedures should be undertaken within six weeks of referral and the clinic monitored the reason for any delay, the appointment outcome and whether discharge summaries were sent within five working days. Patients were offered an earlier appointment based on clinical urgency.

Endoscopic reports were issued directly following the procedure and pathology reports were reported within five days of receipt from the laboratory. An audit of report turnaround time, along with the KPI data, showed the service consistently met the five-day report writing target.

Managers worked to keep the number of cancelled appointments to a minimum. Staff monitored the number of appointments that had to be rearranged. The registered manager identified that not all endoscopists arrived on time to start their procedure list and ensured this was raised so that all staff knew the importance of starting procedures on time in order to reduce any cancellations.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible within national targets and guidance. When clinicians had to cancel lists at short notice the service worked to get them covered by another clinician as soon as possible, to minimise patients waiting times.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Information on how to make a complaint was available at the clinic. The complaint policy stated complaints would be acknowledged within 3 days and fully investigated and responded to within 25 days, or up to 45 days for complex cases. The policy described the process for independent external adjudication to settle any unresolved issues.

Staff understood the policy on complaints and knew how to handle them. We spoke with staff who were able to identify how to support a complaint, be it informal or formal, and how it was escalated and managed by senior managers.

Managers shared feedback from complaints with staff and learning was used to improve the service. The registered manager told us there had been no complaints made about the service since their registration with CQC. However, an action in their leadership meeting in June 2022 identified a complaint about the service's anticoagulation policy. We saw the policy had been reviewed and appropriate action had been taken to make changes to the document and discuss this with staff.

Are Diagnostic and screening services well-led?

Requires Improvement

This is the first rating inspection for this service. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Requires Improvement

Diagnostic and screening services

The provider had a senior leadership team which included a medical director, the registered manager and a clinical lead. The service was overseen day-to-day by the registered manager, who provided overall leadership, and the lead nurse who provided clinical support. The registered manager and lead nurse had previously worked in endoscopy units for many years. This provided them with most of the skills and experience to run an independent service.

There was a management structure with clear lines of responsibility and accountability. The office manager and registered nurses reported to the registered manager and the clinical lead was responsible for the overall management of the medical staff. While the office manager had responsibilities for the management of the office staff and administrative tasks.

Staff we spoke with told us that the managers were all approachable and visible. Staff told us they had received good support from leaders when needed and during the COVID-19 pandemic.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The provider's quality statement was, "We take time to care." Their strategy focused on providing non-judgemental, confidential, high quality and compassionate patient centred care. The strategy and plans were discussed at the staff team and leadership meetings.

The registered manager told us the provider's vision was to participate in community diagnostic hubs, and to continue to provide good care and treatment. They were working on Joint Advisory Group (JAG) accreditation, which would provide them with independent recognition that they provide a high-quality service. We were not provided with a date when JAG accreditation would be sought by the provider.

Staff told us they were aware of the overall vision and strategy and felt part of the vision for the service. We saw that all staff were encouraged to contribute and take part in improvement of the service and to attend meetings to discuss this.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients and their families could raise concerns without fear.

The provider's culture encouraged openness and honesty. The registered manager told us they had an open-door policy and staff could speak with them or the lead nurse at any time. Staff told us they could raise concerns and liked working in the service. One staff member told us they felt very supported by the registered manager and lead nurse, and that they felt part of the team.

Managers supported staff to develop through appraisals of their work, although not all staff had received these. These should be completed annually so that both staff and their manager can reflect on working practice, review development needs for the coming year and identify any actions needed to improve. We saw positive working relationships between staff and managers, and they reported that they supported each other.

However, the provider's most recent staff survey showed not all staff were happy working at the service. Between 14% (3) and 23% (5) of staff felt they were not respected or appreciated, there was not a nice working environment and there

was poor staff morale. Comments from staff included concerns about better communication and poor working relationships between clinical and administration staff. The registered manager told us they were aware of issues and had introduced some initiatives, such as employee of the quarter which came with a financial reward, to improve working relationships.

Results from the patient satisfaction. and friends and family surveys showed patients were able to contact the service and raise concerns if they needed to.

Governance

Leaders operated governance processes, although these did not cover the whole service or processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The provider had governance structures in place, for example for the assessment of user satisfaction, infection control systems and reports from external assessment bodies. These arrangements should ensure action was taken in response to external and internal audits and preventative action was taken in response to the management of risks.

However, we noted there was a lack of auditing or assessment of care and treatment records or processes. The provider gained some assurance through their shared learning and governance meetings; however, these meetings were only scheduled every 6 months. Other audits, such as the decontamination process and infection control, were only completed annually. Medicines audits were completed for the first 6 months in 2022 and showed continued issues with completion of the controlled drug register. There were no medicine audits for the second 6 months of the year. Audits were not often enough to ensure actions were reported on or new issues could be discussed in a timely way to assess, evaluate and improve patient care in a systematic way.

Other meetings, such as the clinical team meeting and the administration/booking meetings were scheduled monthly, which were attended by staff at all levels. We saw these meetings were well attended and the process used was a two-way interaction where staff could raise concerns.

The provider had processes and systems in place for the management of service level agreements (SLA) with other providers. A SLA defines the level of service expected, lays out how the agreement is monitored and which party is responsible for which action. The registered manager told us they had a SLA with an electrician but there were no such agreements in place for other providers of care the service worked with. However, following our visit they sent us a contract for their working arrangements with NHS commissioning authorities. This meant they had a formal agreement with commissioners they worked with to ensure consistency and responsibility. These processes ensure all aspects of the service are monitored.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The provider had a structured approach to the running and safety of the service. There were clear lines of accountability and staff knew who to report to.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, although this was not always effective. They identified relevant risks and issues, however actions were not proactively acted upon. They had plans to cope with unexpected events.

The service monitored the performance of surgeons using national endoscopy database information. The national endoscopy database collects information about every endoscopic procedure that is carried out and breaks it down to individual surgeon level, so performance can be managed. If a concern was noted the clinical lead would have a conversation with the surgeon, to understand if there was a reason for this. It was the clinical lead's responsibility to raise any issues further with the NHS trust that permanently employed the surgeon or provider, to ensure any learning points were consistent, and to improve practice.

The service had its own local and strategic risk register to reflect any concerns staff or managers had about the service. The registered manager told us the risk register needed to be reviewed as it had last been reviewed for the service's CQC registration process in December 2021. This was not reviewed at the governance meetings and we could not be assured how new risks were escalated and discussed with the provider.

There was a flowchart to manage unexpected events and a business continuity plan that provided supporting guidance to staff in the event of the loss of infrastructure services (gas, telephone, electricity) or staff, for example.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

All staff had access to the organisation's intranet to gain information relating to policies, procedures, national guidance and e-learning. Managers submitted data and notifications to external organisations, such as the National Endoscopy Database, as required. The provider had systems in place to ensure the information used to monitor, manage and report on quality and performance were accurate, valid and reliable. However, midyear governance and shared learning meetings did not show this information was discussed with the provider or external stakeholders.

The provider had a system in place to ensure the security of confidential patient data and electronic record systems were password protected. The service had arrangements and policies to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were in line with data security standards. The service provided information governance training to all staff.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The provider engaged with staff through various means, such as emails, staff meetings and a staff survey. Managers made sure staff attended team meetings or had access to minutes when they could not attend. The team meetings were planned in advance, which enabled staff to be able to attend these meetings. Staff said they could give feedback about the service or share their ideas at the meeting.

Staff completed an annual staff satisfaction survey in July 2022 and encouraged patients to complete friends and family surveys each month. The results of the patient satisfaction survey and friends and family survey showed all but one

patient rated their experience of the service as very good or good. They collated all of the information patients gave them and used the results to inform service development. The registered manager was aware that not all patients found instructions for bowel preparation easy to follow and they had planned to look at whether this could be adapted to make it easier to follow.

The provider and registered manager had quarterly meetings with the Integrated Care Board (ICB) and shared information on significant events, incidents, complaints and compliments. The registered manager told us they were working on developing a meeting with local GPs to provide an overview of the service and what GPs needed to consider when making referrals.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They understood quality improvement methods and had the skills to use them.

Staff worked with the local GPs to improve referrals made by them to the service. This improved working relationships and the quality of information provided to the service. The service had introduced a new scope guide for procedures, which improved comfort levels for patients undergoing gastroscopy.

Following one incident involving specimens, documentation completion changed to include one additional staff member, separate from the procedure room, to complete specimen checks before sending to pathology.

Staff made a commitment to green sustainability by establishing initiatives to reduce its waste.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider must ensure staff record formally any concerns around patient capacity and best interest decisions, in line with the Mental Capacity Act 2005. Regulation 11(3)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure that auditing and monitoring processes are completed frequently enough to provide up to date oversight of the service. That action timescales for improvement are identified and that action is taken where the same shortfall is identified in consecutive audits. Regulation 17(2)(a)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure staff record administration of medicines in all records as soon as practicable following administration. (Regulation 12(2)(g)