OneWelbeck Digestive Health

Quality Report

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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

One Welbeck Digestive Health is operated by ASI London A Limited. The service has no overnight beds. Facilities include three endoscopy rooms and eight single bedded patient rooms. The service did not treat anyone under the age of 18.

The service provides oesophago-gastro-duodenoscopies and colonoscopies. These are examinations to detect changes in the stomach and the intestines.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the clinic on 11 March 2020.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?. Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

The service had not been rated before. We rated it as **Good** overall.

We found good practice:

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Premises and equipment were suitable and were well looked after.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff cared for patients with compassion, dignity and respect and involved them in decisions about their care and treatment.
- The provider planned and provided services in a way that met the needs of the patient group and people could access the service when they needed it.
- Leaders had the right skills and abilities to run a service providing high-quality sustainable care and promoted a positive culture that supported and valued patients and staff.
- There was a systematic approach to continually improve the quality of the service and safeguarding high standards of care. And there were effective systems in place for managing risks.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good 	We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

Contents

Good

OneWelbeck Digestive Health

Services we looked at

Medical care (including older people's care)

Summary of this inspection

Background to OneWelbeck Digestive Health

One Welbeck Digestive Health opened in July 2019. It is a private endoscopy service in Central London.

The hospital had a registered manager in post since July 2019.

Our inspection team

The team that inspected the service comprised two CQC inspectors and a specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Why we carried out this inspection

This was the first inspection since registration of the service.

Information about OneWelbeck Digestive Health

The service is registered to provide the following regulated activities:

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury

During the inspection, we visited all rooms. We spoke with eight members of staff including nursing and medical staff and managers. During our inspection, we spoke with one patient and reviewed one set of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC.

Activity (July 2019 to December 2019)

• In the reporting period, there were the following episodes of care:

o Colonoscopy: 434

o Oesophago-Gastro-Duodenoscopies: 264

o Oesophago-Gastro-Duodenoscopies and colonoscopies: 255

o Sigmoidoscopy: 42

All episodes of care were privately funded.

24 gastroenterologists (doctors who investigate, diagnose and treat diseases of the stomach, intestines, liver, gallbladder and pancreas) worked at the service under practising privileges. There were six registered nurses, two health care assistants and two receptionists. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- No never events

- No serious injuries

- Clinical incidents: 26 low harm, three moderate harm, no severe harm, no deaths

There had been one formal complaint.

Services accredited by a national body:

- The centre was working towards Joint Advisory Group (JAG) accreditation for endoscopy.

Services provided at the hospital under service level agreement:

Summary of this inspection

- Clinical and non-clinical waste removal
- Interpreting services
- Grounds Maintenance
- Maintenance of medical equipment
- Pathology and histology
- Anaesthetist provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated it as **Good** because:

- The service made sure that staff completed mandatory training in key skills.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear patient records and asked for support when necessary.
- The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service kept detailed records of patients' care and treatment.
- The service followed best practice when prescribing, giving, recording and storing medicines.
- The service had systems and processes to manage patient safety incidents well.

Are services effective?

Good

We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink after their appointments to meet their needs and improve their health.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The service made sure staff were competent for their roles.
- Staff of different kinds worked together as a team to benefit patients.

Summary of this inspection

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Are services caring?

Good

We rated it as **Good** because:

- Staff cared for patients with compassion, dignity and respect.
- Staff provided emotional support to patients to minimise their distress.
- The service involved patients in decisions about their care and treatment.

Are services responsive?

Good

We rated it as **Good** because:

- The provider planned and provided services in a way that met the general needs of the patient group.
- The service took account of patients' individual needs.
- People could access the service when they needed it.
- The provider had systems in place to handle concerns and complaints seriously.

Are services well-led?

Good

We rated it as **Good** because:

- Leaders had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action.
- The provider promoted a positive culture that supported and valued patients and staff.
- There was a systematic approach to continually improve the quality of the service and safeguarding high standards of care.
- There were effective systems in place for identifying risks, planning to eliminate or reduce them.
- The service managed and used information well to support its activities.
- The service engaged with patients and staff.
- The provider was committed to improving services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care (including older people's care)

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

Are medical care (including older people's care) safe?

Good

We rated it as **good.**

Mandatory training

The service made sure that staff completed mandatory training in key skills.

- All staff (100%) working in the clinic had completed training modules for fire safety, health, safety and welfare, advanced life support, intermediate life support (ILS), basic life support (BLS), bowel preparation patient group directive, conflict resolution training, health and social care, control of substances hazardous to health (COSHH), coping with stress, display screen equipment, drug calculations, equality and diversity, infection prevention and control, information governance, data security, lone worker, medicines management, mental capacity and deprivation of liberty safeguards, patient consent, preventing radicalisation, statutory duty of candour, understanding dementia and safeguarding adults and children.
- The service also provided in house training sessions every month, this included: BLS, ILS, medical gases, basic airway management, fire safety, endoscope decontamination and manual handling.
- Mandatory training requirements were regularly reviewed by managers.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

- An up-to-date safeguarding vulnerable adults policy, with flow charts for the escalation of concerns was available. The policy referenced relevant national guidance and included relevant contact numbers. Although the clinic did not see any children, a child safeguarding policy was also available for staff, in case there were any concerns about a child who may attend with a patient. All staff had the correct level of safeguarding training relevant to their role in line with national guidance. The registered manager was the safeguarding lead for the service and had completed safeguarding vulnerable adults level three training and safeguarding children level three training. All other staff had undertaken safeguarding vulnerable adults level two training and safeguarding children level two training. This level of training was in line with the intercollegiate guidance for this type of service. The service also had a separate female genital mutilation policy (FGM).
- In the reporting period, the clinic did not report any safeguarding concerns to the local authority and no notifications were recorded by Care Quality Commission (CQC). However, staff were clear on how they would do this and who else to inform if any concerns were raised.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

- All areas that we inspected were visibly clean and dust-free, including equipment. There was an infection

prevention and control policy, which referenced to current legislation and relevant guidelines. The policy was to be reviewed annually by the Quality Assurance Performance Improvement committee.

- Adequate supplies of personal protective equipment (PPE) were available. All staff changed into scrubs style uniform and adhered to 'bare below elbows' (BBE) dress code. We observed doctors and clinical staff adhered to this during inspection.
- The service cleaned and disinfected all endoscopes with endoscope decontamination units within the centre. There was a track and trace system to monitor and highlight each stage of the cleaning process; all endoscopes marked yellow were in use, those marked blue were in the wash and green were in the drying cabinet. A nurse was employed to ensure the cleaning process was followed appropriately. We observed an endoscope being manually cleaned as the first step in the process and found staff to be wearing PPE including gloves, apron and visor.
- Staff told us that all medical equipment was cleaned after every use and documented on cleaning checklists. We saw evidence of this. There were pedal bins available in the clinic to minimise infection risk by not touching the bins.
- Cleaners from an external cleaning company kept all non-clinical areas and patient rooms clean. They also cleaned the procedure rooms, using a checklist. We saw two months records of daily cleaning by cleaners and there were no gaps or omissions. The cleaning company were also contracted to perform deep cleans of the treatment rooms every six months.
- Dispensers with hand sanitising gel were situated in appropriate places within the clinic, such as next to hand wash basins and doors. Guidance for effective hand washing was displayed by hand washbasins. Hand washbasins were equipped with soap and disposable towels. We observed staff washing and sanitising their hands during inspection. Hand hygiene audit results showed 99% compliance rate in January 2020.
- Sharps containers within the clinic were dated and signed when assembled, not overfilled and temporarily closed when not in use. This was in line with the Department of Health's Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste to protect staff and patients from accidental injury.
- Clinical waste disposal was provided through a service level agreement (SLA) with an external provider. Clinical and non-clinical waste was correctly segregated and collected separately.
- The clinic did not screen patients routinely for Meticillin-resistant Staphylococcus aureus (MRSA) or other multiple drug resistant organisms as they had no inpatients and was not necessary for the setting and types of procedures undertaken.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- The environment and equipment were appropriate and well maintained. The service offered endoscopy procedures only. The procedure rooms were equipped with endoscopy units and there was easily accessible disposable equipment which was in date and stored appropriately. All accessory items were single use. All clean endoscopes were stored in a designated locked room.
- If an endoscope needed repair or replacement, it would be sent to the manufacturer after decontamination. The track and trace system would highlight that the scope had gone for repair. A loan endoscope would be provided in the meantime.
- The service maintained and tested electrical equipment to keep it safe and fit for purpose. Portable appliance testing (PAT) for electrical equipment and fittings had been undertaken in June 2019. All portable equipment we checked had been tested and labelled and the next review date was June 2020.
- Staff completed checklists for all procedure rooms at the beginning and at the end of the day to ensure it was ready and secured before and after procedures. The checklist included looking at expiry dates of medicines, locking the medicine cupboards and closing sharps bins.

- The clinic stored and maintained equipment to allow them to respond to medical emergencies. A sealed resuscitation trolley was located in the corridor of the clinic. It was
- well organised and contained adult resuscitation equipment. The contents included emergency medicines, defibrillator, suction machine and equipment to maintain airways. We saw completed checklists documenting that the resuscitation trolley had been checked daily. Emergency drugs were available and within the use by date. There were emergency guidelines available, for example sepsis pathway, anaphylaxis algorithm, adult advanced life support.
- The clinic also stored and maintained a sealed airway trolley, located in the corridor. It contained equipment for intubation and for difficult intubations. We saw completed checklists documenting that the trolley had been checked daily.
- The service kept a locked storage room for control of substances hazardous to health (COSHH) products, such as cleaning products. This was to prevent or reduce staff and patient exposure to hazardous substances.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

- The service had a patient selection criteria policy that provided guidelines for the types of patients they treated. It included a list of exclusion criteria. Patients had to be classified as American Society of Anaesthesiologists (ASA) class 1 or 2, in rare occasions ASA 3 after review by the anaesthetist. (ASA class 1 would be a normal healthy patient, ASA class 2 would be a patient with a mild systemic disease, ASA class 3 would be patient with severe systemic disease.)
- Before procedures, doctors ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw a comprehensive pre-assessment medical questionnaire that was used for all patients. This included questions about any recent surgery, medications, any treatment for any medical conditions, allergies, and if female patients could be pregnant or breast-feeding.
- The service used an adapted 'five steps to safer surgery' checklist for patients undergoing endoscopy procedures. This was in line with national recommendations (NPSA Patient Safety Alert: WHO Surgical Safety Checklist). Audit data provided showed a 91% compliance rate for January 2020. Staff received updates and reminders to improve compliance.
- Patients who had undergone surgery could contact the centre or the consultant's secretary on the telephone. The numbers would be given at the time of discharge.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. All staff had undertaken life support training. In the event of any emergency, 999 would be called, however, this had not happened.
- There was rotational cover for anaesthetists at the service. This meant that an anaesthetist was based in the service for the whole length of opening until the last patient left the service. The anaesthetist also supported nursing staff with pre-assessments.
- Patients undergoing sedation were required to have an escort for the journey home. If an escort could not be provided, the patient would be offered to have the procedure without sedation or to re-schedule.
- There was service level agreement with a neighbouring private hospital in the event of a patient requiring an overnight admission.

Nurse staffing

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

- There were seven full time members of nursing staff. One registered nurse would be assigned to each procedure room and one nurse would be allocated to greet patients and perform the pre-assessment and observations. Rotas were done in advance with short notice changes as required in accordance with staff. There were no vacancies at the time of inspection.

Medical staffing

Good

Medical care (including older people's care)

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

- Consultants performing endoscopies were employed under practicing privileges. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital, clinic or in independent private practice. The practicing privileges were granted, reviewed and revised in accordance with the Medical Staff Governance Document. To ensure consultants were operating within their scope of practice, both consultants and anaesthetists were provided with an approved procedure checklist.
- Anaesthetic services were provided by an external company, contracted by the clinic. The service was organised so there would always be at least one anaesthetist present in the clinic.
- Staff told us they occasionally used bank or agency staff to cover gap in the rota or in unexpectedly busy times. All bank and agency staff underwent a local induction which was overseen by the clinic director who kept documentation of it.

Records

The service kept detailed records of patients' care and treatment.

- Patient records were stored securely. Patient clinical records were electronic and paper based. The records included pre-assessment forms, consent forms, medical documentation and checklists.
- The clinic used an electronic clinical management system to store patient information and clinical records. The system was password protected. All paper-based documentation was scanned and included with the electronic patient notes.
- The patient record we saw was complete and legible. We looked at the record of one patient who had a procedure at the clinic. We found it contained a medical history, description of the problem, an assessment of the patient and post procedure advice. Medical records and documentation audit results showed 100% compliance rate in August 2019.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

- There was a medicine optimisation and management policy which referenced to relevant national guidance. The clinic held limited stocks of medicines relevant to the service they offered.
- Medicines were stored in secure locked cupboards within the clinic. Controlled drugs were kept in separate locked cabinets within the locked medicine cupboards. Controlled drugs are prescription medicines that contain drugs controlled under the Misuse of Drugs legislation. The nurse allocated to the procedure room held the keys. We saw the controlled drug registers and found them accurate and well maintained. The clinic measured and recorded ambient temperatures and all medications were stored within the manufacturers recommended range to maintain their function and safety. All stock medicines which we inspected were in date. A medicines storage and security audit showed 100% compliance in August 2019.
- Stock medicines were only given as first dose to the patient at the clinic. Any take-home medication was prescribed by the doctors for the patient to collect at their choice of pharmacy.

Incidents

The service had systems and processes to manage patient safety incidents well.

- The service did not report any never events since opening in July 2019. Never events are serious incidents that are entirely preventable as guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were 26 incidents resulting in low harm reported since opening July 2019, three resulting in moderate harm. No serious incidents were reported since July 2019.

Good

Medical care (including older people's care)

- Staff reported incidents on an electronic incident reporting platform and received notifications by email. All staff we spoke with knew how to report an incident. Incidents and learning were shared in team meetings and governance meetings.
- The nature of service provided at the clinic did not require mortality and morbidity reviews.
- The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. There had been no incidents which met this threshold. The provider was aware of their regulatory duties relating to DoC should any relevant incidents arise in the future.

Safety Thermometer (or equivalent)

The clinic did not use any clinical quality dashboards to monitor safety due to the nature and size of the service.

- The clinic, unlike NHS trusts, was not required to use the national safety thermometer to monitor areas such as venous thromboembolism (VTE). The clinic did not use any other clinical quality dashboards to monitor safety due to the nature and size of the service.

Are medical care (including older people's care) effective?

Good

We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

- Clinical policies and procedures we reviewed were all in date and referenced relevant National Institute of Health and Care Excellence (NICE) and Royal College guidelines. All clinic policies were reviewed annually at the January board meeting.
- Policies and procedures were available in a folder at the clinic. Staff we spoke with knew where to find policies.
- The service was working towards Joint Advisory Group (JAG) accreditation. 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. At the time of our inspection the service was in the process of providing the required data. They had submitted the first load of data in October 2019 and endeavoured to submit the next requirement of data in April 2020 followed by a request for an inspection by the JAG accreditation team.

Nutrition and hydration

Staff gave patients enough food and drink after their appointments to meet their needs and improve their health.

- Patients were informed to arrive to appointments fasted at the time of their bookings and were reminded during pre-assessments on the telephone. Bowel preparation was prescribed and could be collected at the clinic or sent by a pharmacy. Staff told us that these processes generally worked well and there had not been a patient yet coming to their appointment unprepared.
- After procedures, patients were offered hot and cold beverages of their choice, fruit and other small cold meals. Anti-sickness medicine could be prescribed and was available in case of nausea.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

- The service managed patients' pain well. An anaesthetist was available for all patients during and after procedures, should they experience any discomfort.

Patient outcomes

Good

Medical care (including older people's care)

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

- All 24 consultants performing endoscopies within the service peer reviewed each other's work monthly. Two consultants looked at a colleague's performance and completed two peer to peer case reviews. This helped improve the quality of the service and maintain a high level of quality of care.

Competent staff

The service made sure staff were competent for their roles.

- Doctors had appraisals and revalidation undertaken by an independent body or within their NHS post. We saw evidence of these.
- Nursing staff had yearly appraisals planned, however, since the centre opened in July 2019, those had not taken place yet.
- We were provided with evidence to show that the clinic held staff records. The files included relevant documents such as: references, training records, CV, and copies of identification.
- The provider carried out staff checks at the time of recruitment or hiring. Disclosure and Barring Service (DBS) checks were undertaken on all staff members. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

- Doctors showed a willingness to work with patients' GPs. A copy of the endoscopy report was sent to the referring doctor and patients' GP.
- We found a good culture in multidisciplinary working within the centre and a good team ethos.

Seven-day services

The service was open five days a week, including evenings to meet the patients' needs.

- The service was open Monday to Friday from 9am to 8pm. Patients were seen by appointment only.

Health promotion

- Consultants had individual conversations about diet and health promotion after procedures.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

- The service sought patients' consent to care and treatment in line with legislation and guidance. We looked at one set of patient records and found clear documentation of consent, including a signed consent form. There was a consent policy available. The provider had developed protocols and procedures to ensure that consent for procedures and treatment was obtained and documented. Consent forms contained benefits and risks associated with the procedure. Written consent was taken twice; firstly by the anaesthetist to consent for the use of anaesthesia, and secondly by the consultant to consent for the procedure.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. There was a mental capacity policy, which made reference to carrying out mental capacity assessments where necessary. The clinic only accepted low risk, medically fit patients for procedures, and patients lacking capacity to provide consent for their own treatment were not treated at the clinic.
- The service had a mental capacity plan. The purpose of the plan was to ensure that all patients were appropriately involved in healthcare decisions and were capable of understanding information while allowing them to participate effectively and make informed decisions. The plan provided guidance on the instances that staff should be aware of if they were concerned that a patient lacked capacity.

Are medical care (including older people's care) caring?

Good

Medical care (including older people's care)

Good

We rated it as **good.**

Compassionate care

Staff cared for patients with compassion, dignity and respect.

- The clinic environment ensured privacy as all patients booked for a procedure were accommodated in one of the single bedded ensuite rooms. Staff confidently told us how they would ensure privacy and dignity of all patients. Patients were given a room to change and to store their belongings and all conversations took place in this room.
- The service shared patient satisfaction survey results. There was a 64% participation rate between July and December 2019. Of these responses, 94% would recommend the service to friends and family and 95% felt they were treated with respect and dignity.
- During inspection, we spoke with one patient who complimented the service. Written patient testimonials shared by the provider were mostly very positive about the service. One of the comments was, “All staff are wonderful, thank you so much”. Another patient commented: “Excellent care”.
- The service had a chaperone policy in place. The policy maintained that all patients should be offered a chaperone. The purpose of the policy was to ensure that the service was providing a safe, comfortable environment where patients and staff could be confident that best practice was always being followed. Staff knew about the role and responsibilities of a chaperone and received chaperone training.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- The team demonstrated a good understanding of providing compassionate care to patients. They told us of examples of how they would reassure nervous patients and try to answer any questions.
- The team understood anxiety or distress associated with the procedure and supported patients as much as possible. Patients were encouraged to bring a friend or relative.

Understanding and involvement of patients and those close to them

The service involved patients in decisions about their care and treatment.

- Patients were advised of the cost and expectations of their treatment at the time of booking the appointment. Information about fees were available on the service’s website.
- Patients were advised about different options of sedation they could decide on before the procedure.
- All patients were given a discharge information sheet before leaving the clinic. This contained information and advice in relation to the procedure they had undergone.

Are medical care (including older people's care) responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

The provider planned and provided services in a way that met the general needs of the patient group.

- The clinic provided elective endoscopy procedures to patients aged over 18 years. No procedures conducted involved an overnight stay at the clinic.
- The clinic was open five days a week and provided elective endoscopy procedures by appointment only, at a time to meet the needs of the patient group. Appointments were generally arranged on the telephone or by email.
- There was a reception desk with reception staff and a spacious waiting area. It was bright, well-lit and kept tidy. The waiting area had comfortable seating in a quiet surrounding.

Good

Medical care (including older people's care)

- There were service level agreements with healthcare waste, cleaning services, interpreting, medical gases, laboratory diagnostic services and anaesthetist provision.

Meeting people's individual needs

The service took account of patients' individual needs.

- The clinic produced a detailed post-procedure information leaflet on different endoscopic procedures for patients to take home.
- There was a dementia strategy as part of the mental capacity plan. Staff told us in general, they would not see patients lacking mental capacity or living with dementia.
- The service audited call bell response times and data provided showed 100% compliance rate in January 2020.
- There was a service level agreement (SLA) with an interpreter service, which provided telephone or face-to-face interpretation. Staff knew how to contact the service and would arrange an interpreter to be present, if required.
- The clinic was accessible for wheelchair users and the service kept an extra wheelchair if needed.

Access and flow

People could access the service when they needed it.

- The service provided elective and pre-planned endoscopic procedures to referred or self-referring patients. Patients could telephone and book an appointment for a date and time that suited them. The team told us there was no waiting period for appointments. The service was not running at full capacity yet and was gradually expanding to accommodate growing patient numbers.
- All patients underwent a nurse-led pre-assessment process. Patients filled in a pre-assessment health questionnaire on an application developed by the service, which was reviewed by nursing staff. Nurses completed pre-assessment proformas also on the telephone or face-to-face in the clinic. Should any questions arise during this process, nursing staff asked for support from the anaesthetist on duty.
- Data provided showed that between October 2019 and January 2020, no patients had been cancelled on the day of procedure.
- The service outsourced biopsies to a laboratory based in the local area. The biopsies took 48 hours to perform and results would be sent back to the service and individual consultants' secretaries.

Learning from complaints and concerns

The provider had systems in place to handle concerns and complaints seriously.

- The service had a formalised process of handling complaints which was outlined in a written policy. The policy stated that all complainants would receive a written response within seven working days of the complaint and the complaint should be resolved within 21 days, or otherwise agreed timeframe. The service received one formal complaint in the reporting period which was followed up In line with the complaints policy.
- The team told us they would always try to handle and resolve complaints informally first, with the patient referred to the complaints procedure if required. If no resolution could be reached, the clinic would refer the complaint for independent review. The service subscribed to the Independent Health Complaints Advocacy Service and patients could escalate their complaint if they were not satisfied with the clinic's response, although this had not happened.
- Information for patients how to make a complaint was available in the clinic.

Are medical care (including older people's care) well-led?

Good

We rated it as **good.**

Leadership

Leaders had the right skills and abilities to run a service.

- The service was overseen day-to-day by the registered manager. Both the clinical and business team reported

to the centre director who sat at the same level as the medical director, Quality Assessment Performance Improvement (QAPI) director and the commercial director. All these bodies reported into the operating board.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

- The service had a clear vision, striving to be 'Beyond Better'. We saw a clearly formulated strategy to deliver this vision. Its purpose was to challenge established conventions to create and deliver new models of extraordinary healthcare that do not stop at just better.
- Managers told us about expansion plans to accommodate increasing patient numbers.

Culture

The provider promoted a positive culture that supported and valued patients and staff.

- The provider had purposefully developed a service with a focus on patient experience, personal, one-to-one service, and access to doctors throughout the patient journey. The provider had created a culture and environment to attract highly skilled, motivated staff, who shared their passion and enthusiasm.
- All staff we spoke with felt proud of their role and their work.
- There was a duty of candour (DoC) policy. Staff had relevant training and were aware of the requirements of the duty of candour.
- There was a named Freedom to Speak Up Guardian for the service and staff knew how to contact them. Managers told us there had not been any concerns reported through the speak-up process.

Governance

There was a systematic approach to continually improve the quality of the service and safeguarding high standards of care.

- The service had established a governance framework and produced records to demonstrate that processes were completed. Relevant governance policies and clinical guidelines were available. The governing board held overall responsibility, supported by the Quality Assessment Performance Improvement (QAPI) committee, the medical executive committee and the finance committee. Governance meetings took place regularly. We saw meeting minutes with a fixed agenda, reviewing and discussing incidents, audits, risks and other governance topics.
- The Quality Assessment Performance Improvement (QAPI) committee met every three months and had specific functions. This committee oversaw and reviewed the quality improvement plan, reviewed the quality of service delivery, developed and revised indicators as necessary to evaluate care. They also reviewed data summaries for all identified indicators and health outcomes, identified opportunities for improvement and developed educational programmes. The QAPI committee was accountable to the governing board.
- The medical executive committee was chaired by the medical director and advised on matters such as scope of practice, patient outcomes, clinical standards and implementing new and emerging professional guidance. Meetings were organised every three months.

Managing risks, issues and performance

There were effective systems in place for identifying risks, planning to eliminate or reduce them.

- The QAPI committee oversaw all patient safety and risk management activities.
- The service kept a risk register. The risk register recorded the location of risks, a brief analysis, a description, the severity and likelihood rating, any mitigation measures, a
- responsible person and a target date to review. The risk register contained risks identified and discussed during inspection.
- The service maintained a disaster preparedness plan. The plan provided guidance for personnel to outline their responsibilities in the event of an external or internal disaster. In the event of a power outage, the centre was connected to an auxiliary generator that automatically activated in the event of power loss.

Good

Medical care (including older people's care)

- There was an audit programme in place with audits in relation to the service to improve performance and support safety. Audits were reviewed regularly at governance meetings, for example hand hygiene audit.
- We saw evidence of current medical indemnity cover.

Managing information

The service managed and used information well to support its activities.

- The clinic was registered with the Information Commissioner's Office as a data protection officer under the Data Protection Action 1998. Staff received training in information governance and data security.
- Clinical patient records were stored electronically and were available for staff if needed. All documentation on paper was scanned and stored electronically.

Engagement

The service engaged with patients and staff.

- The service actively sought feedback from patients. Patient feedback was received through the clinic application and as paper feedback form.
- The provider sought feedback from staff in regular meetings. The service also carried out formal staff surveys. Results from November 2019 showed that 60% of participants were very satisfied or satisfied with their employment and 40% were somewhat satisfied. At the same time, 80% of participants would absolutely or probably recommend the organisation to friends and family as place of employment and 20% possibly. One of the written comments was "Amazing team", another wrote: "Leadership [is] supportive and approachable".

Learning, continuous improvement and innovation

The provider was committed to improving services.

- Managers encouraged staff to improve working processes. Staff told us how they changed their daily organisation of documenting patient flow at the nurses' desk to enable different members of staff to retrieve information quickly.