

Fountain Diagnostic Limited

Thorpe Park Clinic

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

We rated this service as requires improvement because:

Although we found the service largely performed well, it did not meet legal requirements relating to governance, safe care and treatment and fit and proper persons: directors, meaning we could not give it a rating higher than requires improvement.

Staff did not always receive the appropriate training on how to safeguard patients in line with best practice.

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not always record detailed discussions of the consent process.

Managers did not always assess the effectiveness of the service, staff compliance of adhering to policies was not audited and actions were not always taken from audits to improve outcomes for patients.

Leaders did not always identify relevant risks and issues and therefore could not take action to reduce their impact.

The service did not display complaint information making it difficult for patients to share negative feedback.

The service did not have a robust process to ensure equipment was properly maintained. The design of rooms used to deliver bad news had not been considered.

However:

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

Staff assessed risks to patients and acted on them. The service controlled infection risk well. Safety incidents were managed well and learned lessons from them.

The service provided mandatory training in key skills to all staff and had processes in place to make sure everyone completed it.

Staff provided good care and treatment and gave patients pain relief when they needed it. Managers made sure staff were competent and had access to good information.

Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care.

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.

Summary of findings

The service planned care to meet the needs of local people and took account of patients' individual needs. People could access the service when they needed it and did not have to wait too long for treatment.

Staff understood the service's vision and values, and how to apply them in their work.

Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities and were focused on the needs of patients receiving care.

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Endoscopy

Requires Improvement



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The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

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Leaders did not always identify relevant risks and issues and therefore could not take action to reduce their impact.

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Summary of findings

The service provided mandatory training in key skills to all staff and had processes in place to make sure everyone completed it. Staff provided good care and treatment and gave patients pain relief when they needed it. Managers made sure staff were competent and had access to good information. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care. 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 and took account of patients' individual needs. People could access the service when they needed it and did not have to wait too long for treatment. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities and were focused on the needs of patients receiving care.

Services for children & young people

Requires Improvement



Although we found the service largely performed well, it did not meet legal requirements relating to governance, safe care and treatment and fit and proper persons: directors, meaning we could not give it a rating higher than requires improvement.

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- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- Staff did not always record detailed discussions of the consent process.
- Managers did not always assess the effectiveness of the service, staff compliance of adhering to policies was not audited and actions were not always taken from audits to improve outcomes for patients.

Summary of findings

- Leaders did not always identify relevant risks and issues and therefore could not take action to reduce their impact.
- The service had no formal agreement to access a paediatric nurse in the event they needed advice about children or young people.
- The service did not display complaint information making it difficult for patients to share negative feedback.
- The service did not have a robust process to ensure equipment was properly maintained. The design of rooms used to deliver bad news had not been considered.

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

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- Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities and were focused on the needs of patients receiving care

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Outpatients

Requires Improvement



Although we found the service largely performed well, it did not meet legal requirements relating to governance, safe care and treatment and fit and proper persons: directors, meaning we could not give it a rating higher than requires improvement.

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- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- Staff did not always record detailed discussions during the consent process.
- Managers did not always assess the effectiveness of the service, staff compliance of adhering to policies was not audited and actions were not always taken from audits to improve outcomes for patients.
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Outpatients is a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Summary of findings

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Summary of this inspection

Background to Thorpe Park Clinic

Thorpe Park Clinic is operated by Fountain Diagnostic Limited, one of three providers within The LivingCare Group. The LivingCare Group was founded in 2002 and is a set of companies across Yorkshire delivering various health services.

Thorpe Park Clinic undertakes; endoscopy services, including sigmoidoscopy (examination of the large intestine) and colonoscopy (examination of the large bowel), and outpatients services, including dermatology, ear, nose and throat, and minor surgery. Thorpe Park Clinic did not provide general anaesthetic (GA), so patients requiring a GA would be referred for treatment by a local NHS trust. However, during endoscopic procedures, patients were, depending on their individual needs, offered conscious sedation (CS) or a throat spray.

We conducted an unannounced, comprehensive inspection on 14 September 2021. This service had not previously been inspected and therefore did not have a rating.

The location is registered to provide the following regulated activities:

Diagnostic and screening procedures

Treatment of disease, disorder and injury

Surgical Procedures

The location has a manager registered with the CQC.

The main service provided by Thorpe Park Clinic was medicine. Where our findings on medicine – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the medicine service.

How we carried out this inspection

We inspected the location using our comprehensive methodology as the service had not previously been inspected.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. The team that inspected the service comprised of two CQC inspectors. The inspection team was overseen by Sarah Dronsfield Head of Hospital Inspection.

As this was a comprehensive inspection, we inspected all key lines of enquiry in the safe, effective, caring, responsive and well-led key questions. We rated all domains apart from effective as this is not rated for diagnostic and outpatient services.

During the inspection visit, the inspection team:

Visited all areas of the clinic including, waiting areas, recovery areas, consultation rooms, and the endoscopy unit.

Summary of this inspection

Looked at the quality of medicines and emergency equipment

Spoke with the registered manager and senior leadership team

Spoke with ten staff and five patients.

Reviewed five patient care and treatment records

Looked at a range of policies, procedures 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 trust **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 service must ensure that all non-clinical staff receive safeguarding training for adults and children to the correct level, as necessary, to evidence that systems and processes are operated effectively to prevent abuse of service users **(Regulation 12 (2)(c))**
- The service must assess, monitor and improve systems and processes to ensure the proper and safe management of medicines **(Regulation 12 (2)(g))**
- The service must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity and include the experiences of service users within this **(Regulation 17(2)(a))**.
- The service must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity **(Regulation 17 (2)(b))**.

The service must maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user. This must include decisions taken in relation to the care and treatment provided and consent including when consent changes and why the person changed consent **(Regulation 17 (2)(c))**.

Action the service **SHOULD** take to improve:

- The service should ensure that there is a system to enable staff to quickly identify if equipment is past its due date for maintenance and so unsafe to use
- The service should ensure that the environment used for delivering potential or actual 'bad news' is suitable for the purpose for which it is being used
- The service must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Endoscopy	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Services for children & young people	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Outpatients	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

Endoscopy

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

Are Endoscopy safe?

Requires Improvement 

We rated safe as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The mandatory training was comprehensive and met the needs of patients and staff.

Staff received and kept up to date with their mandatory training. Mandatory training compliance was at 96%.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service employed a learning and development coordinator to monitor training compliance.

Endoscopists employed using practice privileges were up to date with their NHS mandatory training. Endoscopist staff had received Joint Advisory Group on gastrointestinal endoscopy (JAG) accredited training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff did not always have the appropriate training on how to recognise and report abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm, how to make a safeguarding referral and who to inform if they had concerns. For example, staff escalated a possible case female genital mutilation.

The service had an up to date safeguarding policy for protecting vulnerable adults and children.

The safeguarding training was comprehensive and included PREVENT (radicalisation), female genital mutilation and child sexual exploitation.

Endoscopy

However, staff did not always receive the appropriate level of safeguarding training for their role in line with intercollegiate guidance. For example, non-clinical staff should have been trained to level two children whereas they were trained to level one.

Cleanliness, infection control and hygiene

The service 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 visibly clean and had suitable furnishings which were clean and well-maintained.

The service performed well for cleanliness. In an environment audit for July 2021, the service had scored an overall cleanliness average of 97.6%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). For example, at the main entrance, visitors were greeted by staff wearing PPE.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, we did find some labels were undated and unsigned. Staff were told and corrected this immediately

Environment and equipment

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

The environment was clutter free, wheelchair accessible, and had enough equipment for staff to carry out their role, all of which supported staff in keeping patients safe. However, seating in the waiting areas did not always allow for social distancing. For example, there were sofas available, but no signage to encourage social distancing for people from separate households.

Rooms used for pre-assessment and recovery of endoscopy patients were on the first floor with secure access away from the patient waiting area. Rooms used for outpatients were on the ground floor, there was a lift available for patient use between floors. All rooms seen included handwashing facilities, a trolley bed, desk, chairs and emergency resuscitation equipment. However, access to the minor surgery theatre was did not have secure access and could be accessible to the public.

The service had introduced a swabbing centre outside the entrance of the building to ensure people did not have COVID-19 prior to their procedure.

The design of the endoscopy environment followed national guidance and had achieved JAG accreditation. However, the service took place in an annual review of flexible endoscope decontamination facilities which, in March 2021, had identified that the ventilation system was insufficient for purpose and required review. An action plan was in place for all ventilation improvement to be completed by December 2021.

Endoscopy

Staff in the endoscopy service showed us the system used to track and trace any medical equipment or devices used on a patient. We found this was safe although, being a manual system, this was a time-consuming exercise for staff to undertake. However, management told us the process was embedded and worked well.

The service had easy access to a resuscitation trolley and weekly and monthly checks of the trolley were in date.

Fire exit signage was visible and exits were free of obstructions, and all fire extinguishers seen were in date for their next maintenance check.

Staff disposed of clinical waste safely.

However, the process used to ensure that equipment was properly maintained was not robust or recorded in line with policy. The service had external agreements to ensure the maintenance of equipment and kept an asset register for oversight of maintenance. However, this did not include all information required by the provider policy. This made it difficult to identify when equipment next required maintenance. Dates of maintenance were also not shown on equipment, making it difficult for staff to quickly identify and escalate any out of date maintenance testing.

Rooms used to deliver a potential cancer diagnosis were not always comfortable for use. The rooms used to deliver bad news also served other purposes as changing facilities pre-procedure and recovery post-procedure. This meant that the rooms had a bed, monitoring and emergency equipment inside and appeared clinical, consideration had not been given to making the room appear more comfortable for the delivery of bad news.

Assessing and responding to patient risk

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

Patients were assessed for risk before undergoing any treatment. On referral, patients were triaged by a consultant, and risk factors identified triggered a pre-assessment from a registered nurse. Patients whose risk factors fell outside of the services inclusion criteria were referred back to the NHS trust.

Staff shared key information to keep patients safe when handing over their care to others. The service held 'buzz meetings' internally for the lead of the department to attend and receive information and share with staff. The service used an electronic system that was accessible by the GP and was used to handover information or transfer a patient to another speciality. The endoscopy department sent reports immediately back to the referrer, or to the referrer's multi-disciplinary team in the event of a suspected cancer.

Patients medical history was assessed to identify if they were taking any routine medications. For those undergoing an endoscopy procedure, guidance was provided on when to stop taking medications such as digestive medications or anticoagulants to ensure patient risk was minimised. Patients on diabetes prescribed insulin were directed to speak with their diabetic nurse when fasting was required prior to a procedure.

Measures were taken to ensure patient deterioration was recognised. For example, during a procedure requiring CS, observations were taken in line with the National Early Warning Scores (NEWS) to identify a deteriorating patient. An emergency transfer policy was in place and staff were to call 999 in the event of any complications.

Endoscopy

The service used tools for the recognition of sepsis in both adults and children from the UK Sepsis Trust and had a service level agreement with a local ambulance service in the event sepsis was identified. Management ran campaigns on the service intranet to raise staff awareness of Sepsis.

Staffing

The service had enough 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, agency and locum staff a full induction.

The service had enough medical, nursing and support staff to keep patients safe however, managers recognised recruiting endoscopy nurses was a challenge. The service had created an 'trainee endoscopy programme' to upskill their existing staff team of registered nurses to be able to perform endoscopies.

Managers calculated and reviewed the number and qualifications of medical staff, nurses and healthcare assistants (HCA's) needed for each shift in accordance with national guidance such as: Academy of Medical Royal Colleges, Safe Sedation Practice for Health Procedures standards and guidance, October 2013. For example, during an endoscopy procedure requiring conscious sedation, the unit would run on a minimum of five staff including; the consultant, a nurse to monitor the patients observations and wellbeing, a nurse to ensure the comfort of the patient, and two healthcare assistants for decontamination.

The manager could adjust staffing levels daily according to the needs of patients. Endoscopy lists and outpatient clinics were scheduled and staffed based on the needs of patients being referred to the service.

There was limited use of bank and agency staff. The service had bank HCA's that were familiar with the service for endoscopy. If they were unable to source the appropriate amount of HCA's, an endoscopy list that does not require sedation would be run.

The service had low vacancy rates with vacancies available being due to the expansion of the business as opposed to staff turnover. The service had low staff turnover and sickness rates.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Records did not always evidence the detail of conversations held with patients regarding consent. All patient records we saw had generalised consent information. Consent information stated that risks of the procedures had been discussed with the patient, however, there was no area within records to outline the discussion, or any questions or concerns raised by the patient. We asked staff what would happen if a patient did not consent to part of the generalised statement and were told a handwritten note would have to be added to the side of consent form, however we did not see any examples of this.

However, staff could access patient care notes easily. Staff were given access to patient notes from the referring service for information such as their medical background and allergies.

Endoscopy

When patients transferred to a new team within the clinic, there were no delays in staff accessing their records. The service used the same system across departments that allowed for a smooth transition if a patient was referred to a different speciality, such as dermatology.

Records were stored securely on an electronic database. Staff were allocated a photo ID card that was required to gain access to the computer systems. Human resources documents were kept in a separate building.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Medical gas cylinders were not always stored safely. We found some medical gas cylinders were not appropriately secured to walls or placed in trollies and so posed a safety risk from falling. Staff were alerted and told us this would be addressed. Following the inspection staff told us the cylinders were removed. However, the area in which medical gases were stored was clearly sign-posted.

Medication room temperatures were not recorded. Whilst the service had air conditioning in place, this meant the service was not assured that the medicines were stored within their recommended temperature ranges and remained effective. However, processes were in place providing assurance that medicines requiring refrigeration were stored within their recommended temperature ranges. Staff told us how they would escalate concerns and alternative fridge storage if required.

The service did not carry out medication audits to ensure medications were being safely prescribed, administered and stored. We reviewed the audit schedule which did not include medication audits other than the controlled drug (CD) cabinet and register.

However, the service had a medicines management policy in place. The policy defined who was responsible for the prescribing and administration of medicines. Staff followed systems and processes when safely prescribing, administering and recording medicines.

Medicines were administered in accordance with a Patient Group Direction (PGD). A PGD is a written direction that allows the supply and administration of specified medicines, by a named authorised health professional, to a defined group of patients. During inspection we saw that medications were in date and contained in their original boxes with patient safety information. There was a system in place to ensure that stock was rotated to identify which medications use by date was approaching and ensure these were used first.

The service did not hold patient medication and advised patients not to bring medication to the clinic unless they needed to take the medication whilst they were there.

Medicines for medical emergencies were readily available when needed, sealed and fit for use. Regular checks of emergency medicines and equipment were carried out by staff, and there was a delegated resuscitation lead to ensure these checks were taking place.

Endoscopy

Controlled drugs (CD) were stored and managed effectively. Access to medicines and CD's were restricted to authorised persons. CD's were stored in an appropriate and secure metal safe, inside a locked cupboard with the keys stored separately from other storage facilities. Audits of the CD register took place monthly and identified any omissions in the register and completed actions to address these. We checked a random sample of medications in the CD register and saw that there were no gaps in entries, and these were signed by two members of staff in line with best practice.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service had an incident reporting policy. The policy was in date and updated in January 2021 and required review every two years.

Staff knew what incidents to report and how to report them with all job roles having reported incidents. Staff raised concerns and reported incidents and near misses in line with service's policy. The service had not had any never events.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. For example, staff found the incident reporting policy and procedure difficult to follow and the service reviewed the policy as a result.

Managers investigated incidents thoroughly and debriefed and thanked staff after any serious incident.

Are Endoscopy effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance.

The service held speciality meetings to review and implement the latest guidance. We reviewed governance meeting minutes and saw that changes to guidance were discussed during meetings under standard agenda items.

Staff followed up-to-date policies to plan and deliver high quality care. For example, endoscopists administered conscious sedation in line with guidelines such as Academy of Medical Royal Colleges, Safe Sedation Practice or Healthcare Procedures Standards and Guidance October 2013.

Medical staff kept up to date with guidance in their specialism such as dermatology. Learning was disseminated through speciality and clinical governance meetings and changes implemented. For instance, the service was reviewing new guidance in performing cyto sponge (a test to collect cells from the Oesophagus) instead of performing endoscopy as this could pose lower risk to patients.

Endoscopy

However, we were not assured the service effectively audited staff compliance with policies. For example, the consent audit required doctors to record the discussion around consent however, staff told us this was not audited. We found all patient records we saw had no documented consent discussion.

Nutrition and Hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

The service provided patients with nutritional advice dependant on their procedure. There were procedure specific leaflets that offered patients information on how to prepare appropriately for their procedure, for example whether fasting or low fibre diet was require.

Patients with diabetes received specific leaflet instructions to prepare for their procedure. This varied dependant on whether the person managed their diabetes with diet or medication, the type of procedure and appointment time. Patients were signposted to their diabetic nurse for management instructions.

Patients were offered refreshments following recovery from their procedure.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain

Pain relief was discussed during the pre-assessment discussion for endoscopy procedures. A nurse would explain pain relief options and agree what was required for the procedure, for instance, a throat spray or conscious sedation.

Patients had a nurse responsible for their comfort during endoscopy who acted as their advocate in relation to pain and who could call the procedure to a stop if required.

Staff prescribed, administered and recorded pain relief accurately. We saw patient records that accurately detailed the type and quantity of pain relief patients had received.

Staff used pictures of faces expressing different emotions to help children and young people express their pain score.

The service audited comfort scores both internally and reported these as part of their JAG accreditation.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They did not always use the findings to make improvements and achieve good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Endoscopy

The service monitored the effectiveness of care and treatment. For example, as part of its accreditation by JAG, they submitted an annual audit, looking at various aspects of endoscopy outcomes, for example, comfort scores, or successful biopsies.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Endoscopist performance was measured against national standards with a minimum expectation. We reviewed dashboards for endoscopists and saw that most outcomes met the minimum standard required by JAG.

Managers held regular meetings to share information from the audits with staff.

However, managers did not always use information from the audits to improve patient care and treatment. As part of the annual JAG audit report, comfort scores of patients undergoing endoscopic procedures were reviewed. Although moderate and severe comfort scores remained under the 10% minimum standard expected by JAG, we did not see evidence that the service had used the findings to make improvements for patients.

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. For example, consultant and nurse endoscopists were trained in administering conscious sedation as they had undertaken JAG accredited training.

Managers gave all new staff a full induction tailored to their role before they started work. Staff received a corporate induction, completed mandatory training and shadowed experienced members of staff before starting their role. Staff spoke highly of the induction.

The service had appointed a learning development coordinator to support the learning and development needs of staff. A workforce development programme had been implemented that focussed on mandatory training and staff development.

Managers identified any training needs of both the service and their staff and gave them the time and opportunity to develop their skills and knowledge. For example, following the COVID-19 pandemic, management offered staff secondments in the COVID swabbing centre and trained them appropriately.

Managers supported staff to develop through yearly appraisals of their work and regular supervision. Managers kept a log to ensure that staff remained up to date with their appraisals.

Staff attended team meetings relevant to their speciality and had access to full meeting minutes when they could not attend.

Managers made sure staff received any specialist training for their role. Staff were recruited based on their skills for the speciality they worked within. Managers had recognised a shortage of nurse endoscopists and had created a trainee endoscopy programme to upskill the existing staff team.

Endoscopy

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us that the service had given them opportunities to develop their skills in new areas, such as biopsy, and received appropriate training from experienced staff and online learning.

Multidisciplinary working

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

The service held regular meetings with clinical commissioning groups to discuss the needs of the local area and capacity of the service. There was also regular ongoing communication with the service that had referred patients to share information and diagnostic results.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. They offered advice on weight loss and smoking cessation.

Staff assessed patient's health at appointments and provided support for any individual needs to live a healthier lifestyle and receive the correct treatment. For example, patients received information about how to prepare their bowels or stop taking medications dependant on the procedure they were receiving.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff could not evidence that they supported patients to make fully informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff did not clearly document consent information in the patients' records in line with the services policy. Patients were asked to sign a consent form to agree that they had received information about potential risks of their procedure. However, in the five patient records we saw, staff had not recorded the discussion. This contravened the service's own consent policy. The service did not accept referrals of patients that were unable to consent to treatment themselves. Staff told us this was due to being unable to acquire a signature from the referrer for a best interest's decision. Two signatures are required from healthcare professionals when making a best interest's decision in line with the Mental Capacity Act.

However, staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients who did not have capacity to consent to treatment themselves would not be treated at the service.

Staff we spoke with demonstrated understanding of the principles of the Mental Capacity Act 2005.

The service had an in-date Consent and Mental Capacity Act policy which was due for review in October 2021.

Are Endoscopy caring?

Endoscopy

Good 

Compassionate care

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

Staff treated patients with compassion and kindness. Several patients we spoke with described staff being friendly or welcoming.

Staff demonstrated a good understanding of how to ensure people's privacy and dignity were maintained during intimate care and examinations, confirming that the patient was always comfortable and covered.

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. For example, during an endoscopy procedure, there was a nurse solely responsible for patient safety, comfort, continuous communication and diverting attention from the procedure.

Staff demonstrated a sensitive and supportive attitude to people attending the service. For example, staff told us about a patient that preferred to be seen by a specific nurse. When the nurse had not been available the patient was introduced given options to see another nurse or to reschedule their appointment to minimise their distress.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. However, rooms used for the delivery of a potential cancer diagnosis (bad news) were clinical and so not wholly suitable for that purpose.

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.

Friends, relatives or carers could accompany patients to the service. Patients were asked to invite a friend, relative or carer to accompany them to the clinic when undergoing a procedure involving sedation for their safety. At the time of inspection, people that accompanied patients to the service were asked to wait in the car park to enable social distancing due to the COVID-19 pandemic.

Staff demonstrated an understanding of the challenges of delivering difficult news. The service encouraged that a friend, relative or carer join patients when receiving bad news, to ensure everyone understood their results. Staff told us, "We help patients understand what we are doing and help patients know that it is a good thing we have identified it (an abnormal result)."

Endoscopy

Patients were offered the choice to view their procedure in real time on screen. The nurse responsible for the comfort of the patient would then describe both the procedure and what was visible on screen supporting the patients understanding.

Are Endoscopy responsive?

Good 

Service planning and delivery to meet the needs of the 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. Management met with local clinical commissioning groups (CCG) monthly to identify the needs of the NHS acute trusts in the area. The service would accommodate these needs where possible. For example, they had recently accepted patients to the ear nose and throat department on a two-week cancer pathway. This supported patients in receiving a diagnosis and treatment in a timely manner.

Managers monitored patients who did not attend appointments and ensured they were contacted. The services electronic system had a flag for patients that did not attend the service and this was monitored twice a month. Patients would receive a second appointment before being passed back to the referrer.

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.

The endoscopy service offered flexible appointment times to meet the needs of patients offering morning, afternoon and evening appointments and some weekends.

Information was available in different formats such as easy-read and braille and the service had good relationships with interpreter services. Signage was in waiting areas to encourage people to ask if they required information in an alternative format.

Patients were given detailed information about how to prepare for their procedure prior to the day of treatment. For example, the service had created information leaflets about the use of an enema (used to empty bowels) for patients undergoing a colonoscopy. The service had plans to audit procedures that were unable to go ahead, due to the poor preparation, with the introduction of a new electronic recording system

Access and flow

Endoscopy

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed. Patients could receive same day appointments if necessary.

Audits of two week waits and urgent referrals were conducted monthly to identify the reasons patients had not been seen in expected time frames. Action was taken from audits such as feeding back to the staff team and working with the CCG to reduce non-attendances.

Managers and staff worked to make sure patients did not stay longer than they needed to. Procedures were carried out in one day. Patients were verbally informed of all relevant information upon their discharge and there were systems in place to hand over information to the referring service.

Patients were given choice of two appointments following their referral. Patient information gave details of how long patients could expect their procedure to take and how long they may be in the department.

The service had a backup washer disinfecter for the decontamination of endoscopes. This reduced the likelihood of endoscopy lists needing to be cancelled if there was an issue with the machine.

Learning from complaints and concerns

It was not always 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.

Staff knew how to acknowledge and respond to complaints in line with the service's complaint policy. Patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. We saw three complaints that had been investigated and received a full response in line with the providers policy. An annual review was completed into complaints to identify any trends and opportunities for learning.

However, the service did not always clearly display information about how to raise a concern in the patient areas. We did not see any evidence of complaint procedures in patient waiting areas or on notice boards around the building. We raised this with the registered manager. Following the inspection, we saw photograph evidence of complaint information leaflets and posters being displayed within the patient waiting areas. areas.

Are Endoscopy well-led?

Leadership

Endoscopy

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.

We found that leaders had many years of experience of working in a health care setting. We were given examples of how leaders added to their skills, as leaders, by taking part in further education.

Leaders used various meetings to understand and manage the priorities and issues faced by the service. For example, leads for each specialty held meetings from which information was fed up to fortnightly best practice, monthly board and executive meetings.

The senior leadership team was approachable and visible. It consisted of a managing director, the registered manager, and various specialty leads and was a small team that met regularly with each other and staff.

Staff told us that there was a development programme for any staff member to join which meant staff were supported to develop their skills and take on senior roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, but this had not been 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. Whilst leaders and staff understood and knew how to apply them it was challenging to monitor progress.

The service had a vision they wished to achieve however this was not always developed with all relevant stakeholders. Clinical commissioning groups and staff had been consulted with in creating the vision and strategy, but patients had not been involved. However, managers told us patient feedback was considered where available.

The process to monitor the implementation of the business plan was not robust. Members of the senior leadership team were appointed actions within the strategy with progress monitored through individual appraisals and objective setting that followed this. As the implementation of the strategy depended on individual capacity and feedback, we considered this would likely make oversight of the strategy's development challenging to monitor.

The service also had a 'People plan' for 2021-2022 outlining the expectation of leaders and colleagues. The plan outlined actions required but did not appoint ownership of actions or propose timeframes. However, after the inspection the service provided staff council minutes which evidenced discussion of the plan, the responsible person for each action and proposed timeframes for completion.

However, the provider had a finance arm that ensured any plans were fully costed and sustainable. Staff gave us examples of where plans considered the local plans within the wider health economy. For example, working with a local NHS trust to create a gastro-intestinal hub to support clearing of backlogs.

Culture

Endoscopy

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear, although the complaints process was not always made easily available for everyone using the service.

Staff we spoke with reported feeling respected, supported and valued. For example, staff mentioned taking part in a staff council which helped them feel included in the future direction of the business. Other initiatives included 'shine' awards where staff could nominate each other if they felt that a staff member had gone above and beyond. Staff spoke to us about the access they had to freedom to speak up guardians.

The service promoted equality and diversity. Staff used a culture agenda to celebrate religious and non-religious festivals throughout the year. For instance, one consultation room was temporarily changed into a prayer room to support the needs of staff.

Staff spoke about the leadership programme the service promoted so that all staff had opportunities for career development.

Patients we spoke with described the service as friendly and welcoming. Staff we spoke with described a no bullying culture.

However, information and guidance were not made easily available and accessible to tell patients how they could complain about the service. For example, we saw no notices describing how to make a complaint in patient waiting areas.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. 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.

Governance processes were not always effective and did not identify the issues found on inspection. For example, the records audit used did not review patient consent information and had not recognised that consent information did not record discussions about treatment risks in line with provider policy. Environment audits did not include the medication room and therefore had not identified that room temperature checks were not in place.

We reviewed the service's compliance with the fit and proper person regulations. On the day of inspection staff were unable to provide records to support that all required checks were carried out in directors' files. However, following the inspection evidence was provided to support that annual checks were completed to ensure fit and proper persons were appointed as directors.

However, we found that there was an effective governance process within the service and with local clinical commissioning groups (CCG's). For example, staff told us there were regular meetings with CCG's to discuss new opportunities and existing work streams. The management team met regularly and received reports from specialty leads.

Endoscopy

Staff were clear about their roles and responsibilities. Staff described having a job description and were clear about the expectations of their roles. Specialty services had a site lead who oversaw specialty leads, information was reported to the registered manager who relayed this to board.

Staff and senior leaders had regular meetings and access to dashboards with information about the performance of the service.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The risk register did not always reflect the risks we found on inspection. For example, we found medical gases were not secured in the storage area. The risk register included the insecure storage of gas as a fire risk which was due to be reviewed in 2018. There were actions to reduce the risk including wall braces and portable devices for gas cylinders although these were not actioned on the day of inspection.

However, staff had access to an electronic system and quality dashboard to manage performance. We saw this in meeting minutes and from staff discussions.

We saw that the service had a business continuity policy to support it in coping with unexpected events. Staff also explained that because the administration function was housed in a separate building with its own server, if the server went down on the clinical site, staff could use the server in the administration building.

The finance director ensured that financial pressures did not compromise the quality of care. For example, the service had recently invested in new equipment for the endoscopy service which meant if one washer went down, there was access to another washer, so no endoscopy list would need to be cancelled.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in to understand performance, make decisions and improvements however this was not always easy to access. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Management had access to quality dashboards to support them in collecting reliable data and analysing it. However, to find out whether the strategy was on track required the service to look into the individual goals set for staff. Information about whether the strategy was on track was not therefore in an easily accessible format.

The staff used a patient database that could share data with patients' GP's and were integrated and secure. If staff needed to share information with an NHS trust this could be done using secure NHS email. Staff were also able to view some testing results for patients.

We had not received any notifications from the service but noted there were systems in place to ensure we were notified as necessary.

Endoscopy

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.

Staff described regular meetings with local NHS trusts and CCG's to help the service plan and manage its services.

The service conducted staff surveys and used the friends and family survey to obtain patient feedback. Feedback was overall positive with patient sharing comments such as, "Excellent service. No improvements necessary."

A key aspect of the service was its ability to collaborate with NHS trusts and CCG's to help reduce patient waiting times by offering procedures to help reduce waiting lists.

Learning, continuous improvement and innovation






All staff were committed to continually learning and improving services. They did not have opportunity to demonstrate a good understanding of quality improvement methods and skills to use them, or participate in research and encourage innovation, given the nature of the service.

Staff aimed to learn and improve services. For instance, staff told us about learning days they had organised for staff, both clinical and non-clinical, to gain understanding about the procedures being offered to patients.

The service did not demonstrate understanding of quality improvement methods. However, the service was largely a diagnostic service, whereby the rest of the patient pathway was taken over by the referrer, so there was limited scope for this to be of relevance to the service offered.

There were limited or no opportunities for the service to participate in research as the service supported the further patient pathway, as described above, and therefore it would be difficult to encourage innovation in what were established procedures.

Services for children & young people

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

Are Services for children & young people safe?

Requires Improvement 

Mandatory training

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Safeguarding

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Cleanliness, infection control and hygiene

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Environment and equipment

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff did not always identify and quickly act upon patients at risk of deterioration.

Staff could not always access paediatric nurse advice in a timely way. Although paediatric patients were seen by a consultant, there were no paediatric nurses employed by the service or standard operating procedure (SOP) to access advice externally. We fed this back to the registered manager. After the inspection we saw evidence of a service level agreement and SOP with the local NHS trust, giving the service access to their on-call specialist paediatric nurse.

Nurse staffing

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Services for children & young people

Medical staffing

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Records

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Medicines

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Incidents

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Are Services for children & young people effective?

Requires Improvement 

Evidence-based care and treatment

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Nutrition and hydration

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Pain relief

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Patient outcomes

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Competent staff

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Multidisciplinary working

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Services for children & young people

Seven-day services

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Health promotion

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff could not evidence that they supported patients to make fully informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

The service did not evidence the use of Gillick Competence (test used to decide whether a child can consent to treatment) to support children who wished to make decisions about their own care. Policies used to support decision making did not refer to Gillick Competence when seeing children and so staff lacked guidance on the test and how to use it, however the policy did make reference to younger children who are able to fully understand a proposed procedure, could give consent ideally with the involvement of their parents.

Are Services for children & young people caring?

Good 

Compassionate care

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Emotional support

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Understanding and involvement of patients and those close to them

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Are Services for children & young people responsive?

Good 

Service delivery to meet the needs of local people

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Services for children & young people

Meeting people's individual needs

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Access and flow

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Learning from complaints and concerns

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Are Services for children & young people well-led?

Requires Improvement 

Leadership

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Vision and Strategy

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Culture

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Governance

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Management of risk, issues and performance

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Information Management

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Engagement






Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Services for children & young people

Learning, continuous improvement and innovation

Children and young people was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Outpatients

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

Are Outpatients safe?

Requires Improvement 

Mandatory training

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Safeguarding

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Cleanliness, infection control and hygiene

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Environment and equipment

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Assessing and responding to patient risk

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Nurse staffing

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Medical staffing

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Outpatients

Records

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Medicines

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Incidents

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Are Outpatients effective?

Inspected but not rated 

We rated effective as good.

Evidence-based care and treatment

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Nutrition and hydration

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Pain relief

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Seven-day services

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Outpatients

Health promotion

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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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Are Outpatients caring?

Good 

Compassionate care

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Emotional support

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Understanding and involvement of patients and those close to them

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Are Outpatients responsive?

Good 

Service delivery to meet the needs of local people

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

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.

The service offered flexible appointment times to meet the needs of patients. Outpatient clinics could be added, for example on evenings, if there had been several requests for late appointments. Appointments for gastroenterology were given a code by the GP and appointments were able to be booked online, this only applied to gastroenterology as all clinicians were able to see patients for this reason.

Access and flow

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Outpatients

Are Outpatients well-led?

Requires Improvement 

Leadership

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Vision and Strategy

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Culture

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

We found that staff were focused on the needs of patients receiving care. For instance, staff told us how the minor surgery in the dermatology unit was financially loss making but it benefited patients who required minor surgery not having to go elsewhere.

Governance

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Management of risk, issues and performance

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Information Management

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Engagement

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

Learning, continuous improvement and innovation

Outpatients was a small proportion of hospital activity. The main service was medicine. Where arrangements were the same, we have reported findings in the medicine section.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance <ul style="list-style-type: none">• The service must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity and include the experiences of service users within this (Regulation 17(2)(a)).• The service must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity (Regulation 17(2)(b)).• The service must maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user. This must include decisions taken in relation to the care and treatment provided and consent including when consent changes and why the person changed consent (Regulation 17(2)(c)).
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment <ul style="list-style-type: none">• The service must ensure that all non-clinical staff receive safeguarding training for adults and children to the correct level, as necessary, to evidence that systems and processes are operated effectively to prevent abuse of service users (Regulation 12(2)(c))• The service must assess, monitor and improve systems and processes to ensure the proper and safe management of medicines (Regulation 12(2)(g))