Berkshire West Community Endoscopy Service

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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.

Summary of findings

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

Berkshire West Community Endoscopy Services is commissioned by Berkshire West Commissioning Care Group to deliver non-sedation diagnostic endoscopy services for GP practices. The service offers diagnostic endoscopy to people living in Berkshire West including North and West Reading, Newbury, Wokingham and South Reading. The service accepts adult patient referrals and does not see children and young people under the age of 18 years. The service offers clinics on Saturdays and Sundays with some additional clinics on Monday and Friday mornings. There is a booking and administrative team working Monday to Friday mornings to manage referrals. The service is hosted by a private healthcare provider in Reading.

The service carries out two different endoscopy procedures: gastroscopy (thin, flexible tube called an endoscope is used to look inside the oesophagus (gullet), stomach and first part of the small intestine) and flexible sigmoidoscopy (examination of the rectum and the lower (sigmoid) colon using an endoscope). The service is commissioned to carry out between 2000 and 2100 procedures every year.

Facilities include one procedure room, a waiting area, a reception area, a consultation room and a ward area with eight single pods for patients pre- and post-endoscopy.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 29 September 2018. This was the first time we inspected this service since it was registered with the CQC in 2016.

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

We rated the service as requires improvement overall because:

- Compliance with mandatory training varied. The service did not have an overview of medical staff's mandatory training compliance. The safeguarding lead did not have level three adult safeguarding training.
- There were ineffective arrangements for engineer call out for the endoscope washer-disinfector which meant procedure lists had been cancelled.
- Staff did not always make effective use of national guidance designed to reduce the risks of avoidable harm.
- The service did not always use reliable methods to monitor patients during procedures.
- Not all staff were aware of how to access emergency equipment in the event of a patient suffering a major haemorrhage.
- Staff did not always report near-misses as incidents which was not in line with their policy.
- The service did not collect data about patient outcomes to enable benchmarking of their performance against national standards or for internal use to monitor performance.
- Consent processes were not always managed in line with national guidance.
- The service did not have an audit calendar/programme identifying when audits should be carried out.
- The service did not collect and publish data in accordance with Workforce Race Equality Standards.

However, we found areas of good practice:

- There was a good safety track record. There had been no never events and no serious incidents during the last 12 months.
- Endoscope decontamination processes met national standards.

Summary of findings

- There were adequate nursing staff levels to safely meet the needs of patients.
- Patient records were managed in a way that ensured staff had access to up-to-date and accurate information about patients.
- Staff had access to policies, standard operating standards and guidelines reflecting evidence based care and treatment, which had been developed in line with national guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- We observed caring, respectful and compassionate interactions between staff and patients and their relatives.
- Services were planned and delivered in a way that met the needs of the local population. Patients could access the service when they needed to. There were no waiting lists at the time of our inspection.
- The leadership team of the service had the skills, knowledge and integrity to lead the service.
- Staff felt valued and enjoyed working for the service.
- There were systems and arrangements to identify, record and manage risks although these were not regularly reviewed.
- There were systems to engage with patients to capture regular feedback on services.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with five requirement notices that affected Berkshire West Community Endoscopy Services. Details are at the end of the report.

Nigel Acheson
Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Endoscopy	**Requires improvement** 	The service provides diagnostic endoscopy for adults. We rated this service as requires improvement overall. We rated safe and well-led as requires improvement although the service was rated good for caring and responsive. We do not rate the effective domain for independent endoscopy services.

Summary of findings

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Requires improvement

Berkshire West Community Endoscopy Services

Services we looked at
Endoscopy

Summary of this inspection

Background to Berkshire West Community Endoscopy Service

Berkshire West Community Endoscopy Services (hereafter referred to as BWCES) was registered with the CQC in 2016. The service is registered to provide the following regulated activity:

• Diagnostics and screening procedures.

During the inspection, we visited the procedure room, the consultation room and the recovery area. We spoke with nine staff including: registered nurses, health care assistants, reception staff, medical staff and senior managers. We spoke with three patients and two relatives and reviewed three sets of patient records.

The service has a registered manager – Annette Panting who has been in post since February 2016, when the service was registered with the CQC. The registered manager will hereafter be referred to as the service manager.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a nurse specialist advisor with expertise in endoscopy. The inspection team was overseen by Inspection Manager Marie Cox and Mary Cridge, Head of Hospitals Inspection.

Information about Berkshire West Community Endoscopy Service

The service worked from premises leased from an independent hospital through a contractual agreement known as a service level agreement (SLA). The SLA was started in 2016 when the service was established and was reviewed every year. Last review was September 2018.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

Activity (September 2017 to August 2018):

In the reporting period September 2017 to August 2018, the service carried out 1194 gastroscopies and 524 flexible sigmoidoscopies. This amounted to 1718 procedures in the reporting period. All procedures were NHS-funded as the service did not provide privately funded diagnostic procedures. The service only performed diagnostic procedures for adult patients over the age of 18 years.

The service employed a service manager and three other clerical staff. Four GPs with special interest in endoscopy and a consultant surgeon worked for the service under practising privileges. There were six registered nurses, four health care assistants and one decontamination technician who worked on 'as needed' contracts to staff the clinic.

Track record on safety (September 2017 to August 2018):

There had been no never events.

There had been 11 incidents reported on the service's incident reporting system.

There had been no serious incidents causing harm to patients reported.

There had been no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (C. diff) or E-Coli.

There had been no complaints received by the service.

Services provided at the hospital under service level agreement:

Summary of this inspection

- All facilities and equipment were used under a contract with the hosting hospital. This included maintenance of the building and all equipment, clinical and or non-clinical waste removal and access to consumables and medicines.
- All decontamination maintenance was managed by the hosting hospital including testing of water supply.
- Interpreting services were funded by the Clinical Commissioning Group.
- Histology was carried out by a local NHS trust.
- Access to medical staff in the event of a significant clinical incident was included in the contract with the hosting hospital.
- Patient records were archived in a NHS storage facility off site.
- Procedures under conscious sedation were offered under a separate contractcontract amendment with the hosting hospital.

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?

Requires improvement

We rated safe as requires improvement because:

- Staff did not always make effective use of national guidance designed to reduce the risks of avoidable harm. The service did not monitor the use of the WHO checklist effectively to reduce the risk of avoidable harm.
- Not all staff were aware of how to access emergency equipment (haemorrhage equipment) in the event of a patient suffering a major haemorrhage.
- Compliance with mandatory training varied. The service did not have an overview of medical staff's mandatory training compliance. The safeguarding lead did not have level three adult safeguarding training.
- There were ineffective arrangements for engineer call out for the endoscope washer-disinfector, which meant procedure lists had been cancelled. The service was reliant on a service level agreement between the host hospital and the manufacturer.
- Staff did not always report near-misses as incidents, which was not in line with their policy.
- The service did not always use reliable methods to monitor patients during procedures.

However, we also found examples of good practice:

- Nursing staff were compliant with adult safeguarding training and understood their responsibilities to raise concerns if required.
- There were effective arrangements for the prevention and control of infections. We observed staff adhere to national guidance for hand hygiene.
- Endoscope decontamination met national standards.
- The facilities met the needs of the service.
- There was enough staff to provide a safe service.
- Patient records were managed in a way that ensured staff had access to up-to-date and accurate information about patients.

Are services effective?

Not sufficient evidence to rate

We do not rate the effective domain but found the following issues that the service provider needs to improve:

- The service did not collect data about patient outcomes to enable benchmarking of their performance against national standards or for internal use to monitor performance.

Summary of this inspection

- Consent processes were not always managed in line with national guidance. Patients were not always clear about potential risks associated with the procedure they attended for. Nursing staff did not receive training to obtain the consent from patients.

However, we also found examples of good practice:

- Care and treatment was mostly delivered in line with current legislation and nationally recognised evidence-based guidance.
- Staff monitored patients' discomfort during procedures and offered reassurance.
- Staff had the skills, knowledge and experience required of their roles to deliver effective care, support and treatment.

Are services caring?

Good

We rated caring as good because:

- We observed caring, respectful and compassionate interactions between staff and patients and their relatives.
- Patient dignity and privacy was maintained at all times.
- There were arrangements to support patients and their relatives to receive feedback from procedures in privacy.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered in a way that met the needs of the local population. Patients could access the service when they needed to.
- The service took account of individual patient's needs.
- Communication needs were flagged up and there were effective processes to ensure interpreters were available when required.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The leadership team of the service had the skills, knowledge and integrity to lead the service. However, there was not an identified nursing lead.
- The service did not have an audit calendar/programme identifying when audits should be carried out. There was a lack of scrutiny of data collected and this was not used to demonstrate safe practice and meeting key performance criteria.

However, we also found examples of good practice:

Summary of this inspection

- Leaders understood the challenges to quality and sustainability of the service. They were taking actions to resolve challenges and expand services.
- There was a good culture among staff and staff felt valued.
- The service sought the view of patients using their services.
- Staff were involved in making decisions about service improvement initiatives.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Endoscopy	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement

Requires improvement

Endoscopy

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

Are diagnostic imaging and endoscopy services safe?

Requires improvement

We rated safe as **requires improvement.**

Mandatory training

- The service provided access to mandatory training in key skills to all staff. There was variable compliance with mandatory training, which did not assure us all staff were up to date with the latest updates to maintain safety. The service collected information about nursing staff's completion of mandatory training and regular updates in key skills for all staff, which they completed in their usual place of working. Non-clinical staff completed online training and attended a one-day workshop every year delivered by an external training provider. The training attended was dependent on the role of the person. Mandatory training consisted of 15 different topics including manual handling, basic or immediate life support, infection control, safeguarding and data protection. Training compliance varied between 44% and 100% of nursing staff having completed their training within the given time frame. For example, four of nine staff (44%) had completed their mandatory training in fire training and five of nine staff (56%) had completed data protection, conflict resolution and training in Mental Capacity Act. However, all staff had completed their mandatory training or regular update in adult safeguarding and child protection training.
- The service did not have oversight of medical staff compliance with mandatory training. The service did not hold any training records for the medical staff's mandatory training and regular updates but assumed these were completed as part of the GPs annual appraisals which was undertaken in the GPs usual place of working.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. There was a Safeguarding Adults Policy (2018) and a Safeguarding Children Policy (2018). The policies included information and guidance for staff such as information about what abuse is and a flow chart of actions to take if safeguarding concerns were raised. Staff understood their responsibilities to report safeguarding concerns but told us they had never had to make a safeguarding referral for any patient who attended the clinic.
- Staff received training and regular updates about safeguarding, which included female genital mutilation although the level of training staff completed was not in line with their policy. The policy stated all clinically working staff should receive adult safeguarding training at level three. However, all staff had completed adult safeguarding and child protection training at level two in line with national guidance (Royal College of Nursing: Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) and the Intercollegiate Document: Safeguarding children and young people: roles and competences for health care staff (2014). In accordance with national guidance (Royal College of Nursing: Adult Safeguarding: Roles and Competencies for Health Care Staff (2018), the safeguarding lead should receive and

complete adult safeguarding training at level three. The service manager was the safeguarding lead and could be contacted when the clinic was open, if staff had concerns about safeguarding patients.

- The service performed safety checks on all new employees. Staff were checked against the criteria as outlined by the Disclosure and Barring Service, before they started working for the service. We reviewed five staff files which confirmed enhanced checks were completed in accordance with national guidance/ requirements for healthcare workers.

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. In the last 12 months prior to our inspection, there were no incidences of health care acquired infections.
- The clinical areas looked visibly clean. The cleaning of the facilities was the responsibility of the hosting hospital. There were records which demonstrated cleaning checklists were completed by the host hospital staff every day of the week (Monday to Friday). Equipment was labelled with green 'I am clean' stickers and this demonstrated equipment was clean. The cleaning checklists were not completed by BWCES staff at weekends but we saw that staff cleaned equipment they used between each patient.
- Their policy for infection prevention and control did not cover all relevant aspects to provide guidance for staff. The service had an Infection Control Policy (2016), which provided guidance for staff about standard precautions for infection prevention. Staff told us how patients who may have a contagious illness were managed, to avoid contamination and risk to other patients. Staff told us if patients had a known infectious disease, these patients' procedures were carried out at the end of the procedure list. Staff informed cleaning staff from the hosting hospital, so a deep clean of the areas could be completed. However, this was not included in the Infection Control Policy (2016).
- We observed staff following national guidance for hand hygiene. Staff followed national guidance such as National Institute for Health and Care Excellence (QS61: Infection prevention and control: Statement three, 2014) and the World Health Organisation (WHO, 2006): Five moments of hand hygiene, meaning staff washed their hands before and after patient contact. There was an audit programme to monitor infection prevention and control. This included hand hygiene audits, decontamination audit, standard precautions (use of personal protective equipment) and transportation of specimens. Results demonstrated 100% compliance for quarter one and two for all four audits (2018).
- Staff did not always wear personal protective equipment (PPE) when cleaning the procedure room between patients. Staff had access to PPE such as gloves and aprons. We saw staff use PPE appropriately when interacting with patients during procedures.
- Cleaning and decontamination of scopes used for endoscopy procedures was managed well. There were decontamination facilities which met national standards (Health Technical memorandum 01-06 (2016). There were separate pathways for equipment, which ensured clean and contaminated equipment did not cross over.
- Cleaning agents used for decontamination processes were kept in a locked cupboard in the decontamination room in line with Control of Substances Hazardous to Health Regulations 2002. There was adequate lighting and ventilation in the decontamination room. Staff had access to suitable sinks for manual cleaning of endoscopes (tubular instrument used to look deep into the body). Water quality measures were monitored and recorded by the hosting hospital weekly.
- Staff followed national guidance for the use of PPE such as gloves, aprons and visors when carrying out manual cleaning of the endoscopes. We observed staff remove PPE and wash their hands before leaving the decontamination room and enter the clean room for emptying of the endoscope washer-disinfector (EWD). Clean endoscopes were placed in drying cupboards and there were arrangements to ensure recommended standards for use of clean/dried scopes did not exceed the three-hour expiry time in line with national guidance (Health Technical memorandum 01-06, 2016.) Staff from the hosting hospital were responsible for water testing procedures in line with national guidance. Test results were shared with and available to the service manager.
- Clinical waste was handled, stored and removed in a safe way. Staff segregated and handled waste in line with national guidance such as Health Technical Memorandum: HMT07-01 (2013). Further disposal of waste was managed by the host hospital.

- There were effective arrangements to receive and act upon Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and other patient safety alerts. Any alerts with potential impact on the endoscopy service, were discussed in regular quarterly clinical governance meetings. We saw in minutes of a clinical governance meeting held March 2018, that an alert from NHS Improvements about failure to obtain and ensure continuous flow from oxygen cylinders, were discussed with all staff.

Environment and equipment

- The service had access to suitable premises and equipment. The service was hosted within an independent health care provider who owned the facilities and equipment. Arrangements to access and use facilities, equipment and all consumables were included in a contract with the independent healthcare provider. The contract was reviewed annually and was last reviewed in September 2018. It was an open plan unit which allowed for effective patient flow. There was a door which prevented patients entering the procedure room corridor, although access was not restricted by keypad access only. However, patients were escorted by staff when entering the procedure room corridor.
- We reviewed randomly chosen consumables used by the service and found these to be within date and mostly in sealed packaging. We found one item in an open packet, which was immediately replaced when we brought it to the attention of staff.
- There were good facilities for patients to access the service. There were car parking facilities outside of the building. The endoscopy services were carried out on the first floor and there was both stair and lift access for patients.
- There was a succession of rooms (procedure room, decontamination room and clean utility room) that ensured the movement of used equipment in a safe manner. There were effective processes to ensure traceability for endoscopic equipment. Equipment was labelled to ensure information about decontamination was recorded and traceable. This included information about the time of decontamination procedures to ensure usage if the equipment was within the recommend three-hour period. This was in accordance with national guidance such as British Society of Gastroenterology: Guidance for decontamination of equipment for Gastrointestinal Endoscopy (2016).
- Staff had access to emergency resuscitation equipment, which was kept in a tamper evident trolley. We saw records that the emergency trolley was checked every day Monday to Friday by staff working for the host hospital. However, BWCES staff did not check this at weekends.
- The service had access to suitable equipment which was leased from the hosting hospital. Staff told us there were enough endoscopes (tubular instrument used to look deep into the body) to complete procedure lists as planned provided the endoscope washer-disinfector did not break down. However, there were ineffective arrangements to call engineers out in the event of a breakdown of the endoscope washer-disinfector (EWD). Maintenance and access to engineers was included in the contract with the hosting hospital. However, the hosting hospital had changed the maintenance contract for the EWD and this did not include weekend call out duties. This had led to cancellation of procedure lists in September 2017 and remained a recurrent issue. The service manager and the clinical lead were concerned about this and they were working to find an acceptable solution. The service manager and the clinical lead had discussed this with the hosting hospital and were working to find a better solution. The issue was entered as a risk on the service's risk register.
- Equipment maintenance and service was managed by the host hospital. We checked seven pieces of electrical equipment which confirmed these had last been checked and serviced within the last 12 months. The service manager had access to a copy of the asset register list, which showed all electrical equipment was due for re-testing in November 2018.

Assessing and responding to patient risk

- Patient risks were assessed at the point of booking the procedure. This included in particular patients receiving blood thinning medication and patients with diabetes. For example, the service took account of patients with diabetes when booking their appointment to ensure pre- procedure fasting did not have a negative impact on patients' well-being. There was specific information shared with patients and staff assessed the blood sugar level for patients with known diabetes when they were admitted for the procedure.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Administrators followed procedures to

ensure patients had appropriate pre-procedures checks before attending for an endoscopy procedure. The process included information about previous medical history, regular medication and the reason for the referral for endoscopy procedures was correct. The service delivered diagnostic endoscopy procedures and had clear exclusion criteria to ensure patient safety and risks of avoidable harm. These included for example, referrals for patients with suspected cancer, patients under 18 years, referral for therapeutic procedures, patients with chronic gastric bleeding or with anaemia were not accepted. The service accepted patients who were physically well and who could transfer themselves onto the examination trolley without support, although this was not written as a criterion for accepting the referral.

- All staff attended a brief 'huddle' at the start of each clinic to identify and discuss any risks to patients and the smooth running of the procedure list. There were guidelines for staff to follow if a patient required urgent medical attention.
- Medical cover in the event of a clinical emergency was provided by the host hospital through a service level agreement. Medical staff were resident within the hosting hospital during the hours the service operated. Staff were confident about how to access help in emergencies and gave an example of this when a patient had become unwell.
- The service did not always use reliable methods to monitor patients during procedures. The service had arrangements to recognise and manage risks to patients in line with national guidance. Staff monitored patients during procedures and recorded vital observations. Procedures did not take long but we observed patients' blood pressure, heart rate and oxygen saturation was monitored throughout the procedure and recorded at least once. Staff did not routinely carry out any monitoring of patients' vital signs after the procedure before the patient was discharged. We observed one patient who was asked to rest before being discharged, following a procedure where a medical gas (nitrous oxide and oxygen) had been administered. However, staff did not use an alternative method, such as an ear probe, to monitor oxygen saturations in patients who wore nail varnish. National guidance recommends nail varnish is removed as the colour can interfere with the detection of oxygenated haemoglobin, known as oxygen saturation. Patients were not asked to remove nail varnish before their appointment and the service did not have access to an ear probe. We informed the service manager of our concerns at the time of the inspection. Following the inspection, we were not told of any actions taken with regards to the concern we raised. We were informed that that if patients wore dark nail varnish staff would use the probe on the patient's ear or toe. However, using probes that are not designed to be used on either the toe or earlobe can lead to inaccurate monitoring.
- Staff did not always use national guidance designed to reduce the risk to patients during invasive procedures, effectively. The service manager and the clinical lead were not aware of National Safety Standards for Invasive Procedures but the service did have a safety checklist as recommended by the World Health Organisation (WHO). The WHO checklist is an initiative designed to strengthen the processes for staff to recognise and address safety issues in relation to invasive procedures. There was a laminated copy of the WHO checklist available for staff to use as a prompt for safety checks but this was not used as staff had memorised the different checks on the list. Staff then ticked a box on the care pathway to confirm the WHO checklist had been completed. There was a risk that the process was not as thorough as it should be. We reviewed three patient records and found the first stage of the WHO checklist process had not been ticked as completed in one of these. There were no internal audits to demonstrate compliance, which meant we were not assured the WHO checklist was always completed before and after each procedure.
- We were not assured all staff were aware of how to access emergency equipment in the event of an unexpected haemorrhage during an endoscopy procedure. There was a standard operating procedure to provide guidance of actions to take in the event. During the inspection, we found that staff were not aware of how to find the equipment. The doctor stated there was a kit available and the nurse stated the supplies were stored in different areas of the procedure room. We raised this with the service manager during the inspection who stated they would take immediate action to ensure appropriate emergency equipment was readily available. Following the inspection, we were informed emergency equipment in the event of a major haemorrhage, was available in an accessible trolley in the procedure room.

- Staff informed patients of how to access help following the procedure if required out of hours. Staff gave patient specific information about when it was safe for them to eat and drink again following the administration of an anaesthetic throat spray.
- Patients received a written 'Aftercare advice for patients' sheet containing information about usual side effects of the procedure and signs and symptoms to look out for. Patients who had been given anaesthetic (numbing) throat spray received advice about when it was safe for them to eat and drink again following the procedure.

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 six registered nurses and four healthcare assistants employed on 'as and when' contracts and worked part time hours to cover the clinics when the service was operating. All but one of the nursing staff were employed by another healthcare provider and worked additional hours for the service. The required establishment to run the service efficiently required two registered nurses and two healthcare assistants for each clinic. Nurses were rostered to work and the roster was available 12 weeks in advance. If necessary staff swapped shifts and in the event of sickness they arranged cover between themselves, which worked well. We looked at a three-month roster and there were no gaps although it was evident some staff had swapped their shifts to suit their needs. When the service operated additional clinics on Mondays and Fridays for patients requiring conscious sedation, these were staffed by nurses employed by the host hospital. Details of the arrangements for this was included in the contract between the service and the host hospital.
- The service did not have access to bank nurses but used specialised gastroenterology agency nurses if required. The service held a curriculum vitae for all agency nurses who had worked in the services. The last time the service had used an agency nurse was in March 2018.
- There were no staff vacancies at the time of our inspection. The service reported minimal sickness and low staff turnover with most staff having worked there for a long time.
- The service manager and three administrators worked Monday to Friday mornings in an office in a separate building. They all worked part time and their hours counted for 1.79 whole time equivalent. If any of the administrators were on leave or off sick, the others would cover their hours to avoid any disruption to the service.

Medical staffing

- 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. There were arrangements for regular granting and review of medical staff working under practising privileges. This is a well-established process within the independent hospital healthcare sector where a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice. There were four GPs and one consultant surgeon employed with special interest in endoscopy. They worked under 'practising privileges' which were reviewed annually.
- The service manager kept a register of when their five-yearly revalidation was due and who the responsible officer for this was. There were processes to ensure medical staff working under practicing privileges had access to support for revalidation and appraisals.
- Medical staff worked to cover a quarterly rota and were required to work two to three days per month to ensure all clinics were covered.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Administrators obtained relevant information about patients at the point of referral. This included information about patients' previous medical history, medication and the reason for the referral. Patient notes were prepared and stored securely to ensure they were available for each clinic.
- Medical staff completed a detailed investigation report which was shared with the referring GP each Monday for all procedures carried out over the weekend. Patients received a summary of the investigation procedure and findings before leaving the service.
- Patient records were stored securely. Paper-based records were stored in separate office in a cupboard,

which were not fire proofed, and some were stored on open shelves. The service kept patient records on site for one year or longer if patients returned regularly for repeat endoscopy surveillance procedures. Staff files were kept in a locked filing cabinet. Electronic systems were backed up daily and the server was stored in a fire proof safe in the office. Administrators logged and packed records in boxes after one year and arranged for them to be stored in an NHS archive. Staff told us all patient notes could be retrieved if needed. The office was key pad protected and the keys to the cupboard were kept in a locked safe. Only administrators had access to the office.

- Electronic booking record systems were password protected. The administrators worked in an office in a separate building. The administrators took patient referral calls and prepared clinic notes for clinicians. The administrators also processed all patient notes following appointments such as sending procedure reports to the patients' GP, follow up patient referrals and collecting information about patients' blood results.
- Administrators transferred patient records to the hospital building in trolleys designed for this use although they were not lockable. During clinics patient records were stored in a closed but unlocked cupboard by the reception desk. However, there was a receptionist seated at the desk at all times for the duration of the clinic. Following the clinic, patient records were locked away in the procedure room for the administrators to collect on Monday morning.
- The service did not carry out regular documentation audits. Patient records were paper-based. There was an Endoscopy Procedure Care Pathway Report, which was used by nursing staff to ensure relevant information were recorded about the patients' care and treatment. This pathway included a pre-operative assessment, a pre-endoscopy checklist and highlighted alerts such as allergies and contraindicators for the use of medical gases during the procedure (sigmoidoscopy only). However, there was no documentation audit which meant there was no overview of the quality of information recorded and to ensure all relevant part of patient records were completed.

Medicines

- Medicines management kept patients safe from harm. The service used only a few medicines such as a throat spray to numb the throat and a medical gas (nitrous oxide and oxygen). These were prescribed by the endoscopist. The service did not use any other medicines or controlled medicines for their weekend clinics. The throat spray used was within its expiry date and was administered using a single use disposable squirting applicator.
- Registered nurses administered rectal enemas under a patient group direction (PGD). Staff who administered the enemas as a PGD, had received training and assessed as competent. We reviewed the PGD and found this was last reviewed in March 2018. All staff who were competent to administer the enema had read and signed the PGD.
- Access to and use of all medicines were included in the contract with the host hospital. The service did not prescribe or supply any medicines for patients to take home. If new prescriptions were required this was documented in a detailed post-procedure report, which was shared with the patients' GPs.

Incidents

- The service managed patient safety incidents well. There were arrangements to report incidents, near-misses or non-clinical incidents. There was a Clinical Incident Policy (2018) providing a framework for reporting and managing incidents. Staff used paper-based 'significant event reporting forms', which included a description of the incident, identified learning outcomes and an action plan to ensure service improvement actions were carried out. Neither the policy or the incident reporting form referred to or prompted staff to apply duty of candour when required.
- Providers of healthcare services 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. However, there was a separate Being Open (Duty of Candour) Policy, 2016 providing guidance for staff and staff we asked had a good working knowledge of duty of candour.
- Staff did not always report near misses, which was not in line with their policy. The service had not reported any serious incidents to the Care Quality Commission between August 2017 and September 2018.
- Staff had completed 11 incidents reports that were non-clinical or did not cause serious harm to patients

between July 2017 and September 2018. Seven of these were incidents about the environment or equipment, two were related to infection control issues, one was electronic communication error and one was about external disruption to services. However, staff did not incident report all incidents or near-misses. Some near-misses were logged in a communication book, which was shared with staff from the hosting hospital. For example, staff did not always incident report a temporary breakdown of the endoscope washer-disinfector. We reviewed data that demonstrated 48 procedures were cancelled because of equipment failure between August 2017 and September 2018.This meant there was not a complete overview of all incidents including near-misses within the service.

- All reported incidents were investigated by the service manager. We reviewed five incident investigations. This included identification of opportunities for learning and how learning and outcomes were disseminated to other staff. Learning from incidents was shared in quarterly clinical governance meetings.

Are diagnostic imaging and endoscopy services effective?
(for example, treatment is effective)

We do not rate the effective domain for independent endoscopy services

Evidence-based care and treatment

- The service provided care and treatment based on national evidence-based guidance. For example, the service offered non-urgent gastroscopy for patients in line with national guidance from the National Institute for Care and Excellence (NICE): QS 96 Dyspepsia and gastro-oesophageal reflux disease in adults (2015).
- Staff had access to a standard operating procedure (SOP) to follow for advice about patients receiving anticoagulation (blood thinning) therapy. The guidance reflected national guidance provided by the British Society of Gastroenterology: Endoscopy in patients on antiplatelet or anticoagulant therapy, including direct oral anticoagulants (2016), although the national guidance was not specified on the SOP.
- The service manager was responsible for checking and updating standard operating procedures (SOPs) to ensure this reflected national guidance. We reviewed three and found these were all within their expiry date. However, the SOPs did not reference the national guidance they were based upon or reviewed against.
- The service carried out ad hoc audits to review compliance with national quality standards, which was shared with staff in quarterly clinical governance meetings. For example, the service carried out an audit for compliance with national guidance for Barrett's Oesophagus Surveillance Programme in 2016. The results demonstrated compliance from 71% (histology confirmation) to 97.5% (presence of suspicious lesion noted) across ten different parameters. Results demonstrated less than 90% compliance in five parameters. The audit was used to review practice and updating their Barrett's Surveillance policy. There was a plan to repeat the audit after three years meaning the audit should be repeated in 2019.
- Some staff were not aware of how to access policies and standard operating procedures (SOP). These were available for staff in a folder in a cupboard in the procedure room. However, when we asked for the SOP for major haemorrhage, staff told us this could be obtained from the service manager. This meant we were not assured all staff knew how to access relevant guidance if required.
- Staff provided information for patients when they were discharge about how and when to seek help if they felt unwell following the procedure. This information included symptoms that many patients experienced as well as information about symptoms that required them to seek medical assistance straight away.

Nutrition and hydration

- Staff offered refreshments to patients following their procedures if it was safe to do so. There was access to free tea, coffee and hot chocolate or cold drinks for relatives who accompanied patients to their appointment. Patients who had received local anaesthetic/throat spray received information about when it was safe for them to eat and drink following the procedure.

Pain relief

- Staff took actions to manage patients' discomfort during procedures. Staff monitored patients' comfort during procedures. Patients attending for a gastroscopy was given an anaesthetic throat spray to numb the throat

and reduce discomfort during the procedure. Patients who required repeated and regular gastroscopies were offered appointments on Mondays and Fridays where conscious sedation could be administered safely to alleviate discomfort associated with the procedure.
- Patients attending for a flexible sigmoidoscopy were offered a medical gas (Nioxide and Oxygen) to alleviate discomfort.
- The endoscopist recorded patients' comfort score following the procedure. This was by asking them to score the degree of comfort (on a numeric scale) they felt during the procedure and recorded the perceived comfort score by the endoscopist. However, it was not clear how this information was used. Staff informed patients clearly of how to communicate that they wanted the procedure to be abandoned if it was too uncomfortable for them to carry on.

Patient outcomes

- Managers did not monitor the effectiveness of care and treatment or use the findings to improve them. The service did not collect data which enabled benchmarking of their performance against national standards or for internal use. The service did not collect applicable data in line with the British Society for Gastroenterology Quality and Safety Standards (2007) or as required by the Joint Advisory Group (JAG, 2005). For example, the service did not collect data such as numbers of procedures carried out by each endoscopist or patient outcome data such as admission to hospital within eight days of endoscopy procedures, 30-day mortality or complications during procedures.
- Medical staff recorded patients' comfort scores on individual patient records but this data was not collated and analysed to benchmark and review each endoscopist's performance outcome in comparison with peers.
- Patients received information about the outcome of the procedure following the appointment. The endoscopist saw each patient following the procedure to discuss the outcome and discuss further follow up if required. Patients who had a particular type of test known as a Clo test (a rapid diagnostic test used to for the diagnosis of a bacteria in the gut) received the result immediately following the procedure.

Competent staff

- Staff had the skills, knowledge and experience required of their roles to deliver effective care, support and treatment. There were systems to ensure professional registrations were checked annually. At the time of our inspection, staff records showed all registered healthcare professionals' professional registration had been confirmed within the last 12 months.
- Staff were supported to gain additional qualifications. There was one nurse who had an additional post registration qualification as a nurse-endoscopist although they did not carry out endoscopy procedures for Berkshire West Community Endoscopy Services (BWCES). The service manager was not aware of any other post registration courses completed by registered nurses. The clinical lead told us a member of staff had been supported to gain a vocational qualification to expand the scope of their role.
- All registered nurses worked in endoscopy units and worked for the service as an additional job. All nursing staff had undertaken competency training and assessment to ensure they were competent to carry out their role. This included training of specific medical devices or equipment. There was an induction policy and programme to support new employees. This included an induction checklist for temporary nurses (agency nurses). There were specific decontamination competencies which staff had to complete and have signed off before carrying out decontamination of endoscopes (tubular instrument used to look deep into the body).
- Nursing and administrative staff received annual appraisal. At the time of our inspection all nursing and administrators had received an appraisal within the last 12 months. These were carried out by the service manager who encouraged all staff to participate or lead on service improvement projects. However, there were no formal process to support three-yearly revalidation if nurses did not have a substantive post and received support by another healthcare provider.
- Endoscopy procedures were carried out by GPs with a special interest in endoscopy and one endoscopist was a consultant surgeon. The service manager was kept informed about when their five-year revalidation was due. We checked the medical register (General Medical Council) to confirm all medical staff registration status.
- There were no formal arrangements for regular annual peer supervision although this could be arranged if required. Annual appraisals for medical staff were

carried out in their usual place of working. The service kept a copy of the appraisal documentation. The clinical lead had sought advice from the General Medical Council to maintain active registration in the UK. The GPs with special interest in endoscopy did not carry out endoscopy procedures as part of their usual GP role. However, the service did not collect data to review individual endoscopist performance against key performance indicators and to provide supportive feedback. We discussed this with the clinical lead who was confident the GPs carried out more than 100 endoscopy procedures (of both gastroscopy and flexible sigmoidins) a year as recommended by the Joint Advisory Group (2005).

- Additional training was not always provided for staff to carry out extended practices to their roles. For example, there was no additional training for nurses to obtain consent or chaperone training for non-registered nurses who acted as chaperones. Data from a patient survey carried out between October and December 2017, demonstrated most patients (78%) of those who provided feedback had completed the consent form in the admitting room with the nurse. We were not assured registered nurses had sufficient training to gain consent from patients for endoscopic procedures in line with national guidance (British Society of Gastroenterology: Guidance for Obtaining a Valid Consent for Elective Endoscopy Procedures (2008), Point 6.

Multidisciplinary working

- The service manager told us there were good working relationships with referring GPs. Administrators contacted patients' GPs if there were incomplete data to review and accept referrals or if the service had other concerns about the referral or after care. Administrators sent out detailed procedure investigation reports every Monday for procedures carried out over the weekend or on the same day for patient procedures carried out on Mondays and Fridays.
- The service made referrals to the local NHS trust for onwards treatment and care as required. These referrals were time critical for patients to have further tests or commence treatment, and to meet referral to treatment targets. The service kept a register of all onwards referrals to ensure the multidisciplinary team had received and actioned onwards treatment referrals.
- The service worked with a laboratory in a nearby NHS trust for the processing of samples taken during endoscopy procedures. Test results were returned to the service within two to three weeks. The responsible endoscopist reviewed the test results and sent a letter to both the patient and their GP to inform them of the findings.

Health promotion

- Endoscopists gave information to patients about life style changes that may help to alleviate their symptoms when this was applicable. The information was discussed with the patient after the procedure and written information leaflets were given to patients to take away. This information was also available from the service's website.
- Information about general health for children, women, men and senior citizens was also available from the service's website.

Consent and Mental Capacity Act

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent. There was a separate consent form to be used for patients who lacked capacity but staff told us they had never used this form. Nurses were required to check capacity informally and inform the endoscopist if they had concerns. The final decision if a procedure should go ahead for a patient lacking mental capacity to consent, was made by the endoscopist. There was also a specific form to be used if an interpreter had facilitated language support during the admission check. This form required both the patient and the interpreter to sign.
- Patients were not always clear about potential risks associated with the procedure they attended for. In a patient survey (2017), 11 (9%) patients were not sure about the risks associated with the procedure they attended for although 91% stated they were informed. The data demonstrated most patients (78%) had signed their consent form in the admitting room with the nurse, 27 patients (19%) had signed the consent form at home and four patients (3%) had signed the form in the procedure room with the doctor. This process is referred to as a single-stage process and was not in line with national guidance (Royal College of Surgeons, 2016). This guidance recommends consent is discussed and obtained in advance of the procedure to ensure patients

have an opportunity to change their mind, also known as a two-stage process. A more recent patient survey carried out between April and August 2018, demonstrated 99% of patients who returned the questionnaire said they had been informed of any potential risks associated with the procedure. This survey did not include information about consent.

- Consent processes were not always managed in line with national guidance. Patients often signed the consent form in the admission room with the nurse. During the inspection, we did not observe any discussion with patients about consent but nurses ensured the consent form was signed. Staff told us if patients asked to speak with the endoscopist before the procedure this was arranged without any problems. The consent form did not include specific data about risks so patients could make an informed decision. For example, the consent form used terminology such as "a very small risk of haemorrhage or perforation of the gut" but did not include statistical values to help patients determine the level of risk.
- We observed the endoscopist and the registered nurse re-affirm consent with the patient in the procedure room. The endoscopist explained the procedure to the patient and the reasons why the procedure was needed.
- Patients could withdraw their consent at any point before or during the procedure. We observed staff giving patients information of how to communicate during the procedure if they wanted to withdraw from the procedure due to discomfort.
- Staff compliance with training and regular updates of Mental Capacity Act (2005) (MCA) was low with 44% of staff having completed the training. This training was delivered as a 'once' only meaning that once staff had completed it, they did not have to complete any further updates. We found four of nine staff had received and completed the training. Training in MCA included information about Deprivation of Liberty Safeguards (DoLS). Staff had awareness of MCA and DoLS but told us they did meet any patients within the service who lacked capacity.
- Staff did not receive specific training in dementia awareness although we were told this was included in adult safeguarding training.

Are diagnostic imaging and endoscopy services caring?

Good

We rated caring as good.

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff cared for patients with compassion. We observed staff interact with kindness and with a caring attitude to all patients attending on the day of our inspection. We heard staff introduced themselves to patients at each stage of their journey through their appointment.
- Patients and their relatives told us staff were kind and gave them the information they needed. They told us "it is a good service" and "staff are kind and professional".
- Staff communicated with patients in a manner that suited their needs and took time to interact with patients to answer their questions. We observed one member of staff kneeling to ensure they had eye contact with the patient while asking additional questions about arrangements for the patient following their appointment.
- We observed staff being mindful to respect and maintain patients' privacy and dignity. Staff were courteous and 'knocked' before entering pods where patients were getting changed. There was signage to prevent unauthorised staff entering the procedure room while patients received their procedure. There were effective processes to ensure single sex changing and toilet facilities. There were facilities to separate female and male patients and access to gender specific toilet facilities. There were eight pods used for patient to change into a gowns and dignity shorts (specific disposable shorts designed to maintain patients' dignity while undergoing intimate endoscopy examinations). Staff encouraged patients to wear a dressing gown to protect dignity when wearing open-back gowns.
- Staff took account of patients' specific wishes regarding gender of staff looking after them on the grounds of cultural or religious beliefs. However, all the endoscopists were male but arrangements could be made to ensure nursing staff looking after the patient were all female if required.

- Staff offered a chaperone for patients who wished to have somebody with them during the procedure. There was a Chaperone Policy (2016), which was available on the service's website. The policy stated all patients were entitled to a chaperone during any consultation, examination or procedure where this is considered a requirement. The policy stated a family member may act as chaperone however, this was not in line with national guidance (Medical Protection, 2016), which states family members or friends should not undertake this role.
- The service gained feedback from annual patient surveys. We looked at results from the latest survey (June to August 2018). The survey was sent to 200 patients with a return rate of 51% (102 returned questionnaires). The results demonstrated 77% (78 patients) thought the care was excellent, 17% (18 patients) thought care was very good and five patients (5%) thought care was good. The survey included information about privacy and dignity and results showed 94 patients (92%) thought their privacy and dignity was excellent, six patients (6%) thought it was very good and two patients (2%) thought it was good.
- Staff encouraged patients to complete the Friend and Family Test (FFT). Results were available on the service's website. We looked at FFT results from August 2017 to September 2018. The service received FFT feedback from 622 patients. The overwhelming majority (569 patients) 91% were very likely to recommend and 49 patients (8%) were likely to recommend the service. Three patients were neither likely or unlikely to recommend the service and one patient was extremely unlikely to recommend the service. Narrative feedback from patients i in the FFT included: "made to feel like a person and not a number" and "Excellent - quickly organised tests & exceptionally efficient, kind & caring staff".

Emotional support

- We observed staff to be sensitive to and aware of when patients were anxious about the procedure on arrival. Staff kept patients informed and did all they could to ensure patients did not have long to wait and we observed staff giving assurance to patients during the procedures.
- Feedback from a patient who completed the friends and family test stated: "All the staff were lovely, when I was feeling so anxious. I can't thank them enough for looking after me & keeping me calm".

Understanding and involvement of patients and those close to them

- The endoscopist provided feedback about findings straight after the procedure. This information included findings, information about aftercare or onward follow up or treatment. If the findings included a diagnosis of suspected cancer or if patients requested their next of kin to be present, staff arranged for feedback to be provided in the admissions room. This was a room where discussions could be held in private and support provided if patients received a serious diagnosis.
- A patient survey carried out between April and August 2018, demonstrated 77% thought information the service provided prior to the procedure was excellent and the remaining 23 % thought it was good. This was similar to the previous patient survey, which demonstrated 95% of those patients who took part though the information was helpful and sufficient.

Are diagnostic imaging and endoscopy services responsive to people's needs? (for example, to feedback?)

Good

We rated responsive as good.

Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of local people. The service operated under a contract from the local Clinical Commissioning Group. There were agreed referral criteria for patients attending for procedures, which had been agreed with commissioning stakeholders. GPs referred patients for community based diagnostic endoscopy to provide an alternative for patients and a shorter waiting time. Patients were referred either as high priority or for routine investigations.
- The service did not always use collected data to review and explore trends and potential impact of service planning. For example, the service recorded patient

outcomes for patients referred as high priority patients for suspected cancer diagnosis. Data demonstrated there was an increased number of patients who were diagnosed with a suspected cancer when comparing year on year data. During a 12-month period from April 2017 to March 2018, 11 patients had a potential cancer diagnosis. In comparison, the trend appeared to be increasing with seven patients attending during the five months from April 2018 to August 2018 with a potential cancer diagnoses. We discussed this with the service manager who seemed unaware of this trend and had therefore not explored the potential impact on services provided. However, this was a relatively small number of all procedures carried out by the service.

Meeting people's individual needs

- The service took account of patients' individual needs. Patients were referred by their GP using an electronic referral system. Patients received a referral confirmation letter containing their unique booking reference number and password. Once this letter was received, patients could telephone the booking team and book an appointment to suit their needs and preferences within an agreed priority framework depending on the severity of their symptoms. Patients received written information ahead of their appointment which included specific instructions and information about what to expect.
- The service offered conscious sedation for patients who required repeat gastroscopies. These patients were those who had repeated gastroscopies as part of a Barrett's Oesophagus (BO) Surveillance programme (monitoring of cells in the lining of the food pipe for early detection of potential cancer). Patients were offered appointments on Mondays or Fridays when the procedure could be carried out under light sedation. The service had seen 33 patients on the BO surveillance programme between September 2017 and August 2018. There was a specific policy for endoscopists to follow to ensure correct data was obtained in line with British Society of Gastroenterology standards (BSG: Guidelines on the diagnosis and management of Barrett's oesophagus, 2013). Patients were admitted for a day case procedure under the care of the hosting hospital although the endoscopic procedure was carried out by medical staff working for the Berkshire West Community Endoscopy Services (BWCES). BWCES had a contractual agreement with the host hospital to provide this service.
- The service was well signposted and all patients were greeted by a receptionist on arrival. There was a waiting room with adequate seating for patients. There were individual pods where patients could get changed and access to toilet facilities.
- There was good access to the service including for patients with restricted mobility. The clinic was situated on the first floor within the hosting hospital. There was a lift providing easy access for patients. However, the procedure room was small and would not easily be accessible to wheelchair users. Staff told us patients had to be able to position themselves on the trolley. However, the contract with commissioners did not include mobility issues in the exclusion criteria.
- Relevant information about patients' communication needs were identified, flagged up and reasonable adjustments implemented to ensure patients had the information they required. We observed patients being supported by interpreters during the inspection. If patients required an interpreter, this was identified at the point of booking and was arranged ahead of the appointment. The service had a website with offered access to some information in more than 100 different languages. It was easy to find the translation option and ensured most patients could access information about the service. Information about specific procedures was only available in English on the website. Written information could be sent out in different languages if required. Interpreters were also used to help disseminate pre-procedure instructions such as how to administer an enema before arriving for the procedure. Nurses could also administer enemas for patients when this was required.
- The service accepted patients without discrimination, including on the grounds of protected characteristics under the Equality Act, 2010. The exclusion criteria did not include patients with additional needs although it was rare that patients living with dementia or a learning disability was referred to the service by their GP. The service monitored rejected referrals and data from April 2017 to March 2018, showed there were 65 rejected referrals for gastroscopy and 39 rejected referrals for flexible sigmoidoscopy. The main reason for rejection was that the patient no longer required the procedure, other reason included patients past medical history which included some of the exclusion criteria or if blood test results showed patients were anaemic.

Requires improvement

Endoscopy

Access and flow

- Patients could access the service when they needed to within the times the service operated. There were no waiting lists at the time of our inspection. The service had the ability to increase capacity to meet demand if required by offering additional clinics. Data demonstrated 80% to 95% of available procedure slots had been utilised from April to August 2018. Appointments were staggered throughout the day to avoid patients having to wait long once they had arrived. Patients we spoke with confirmed they had been seen almost immediately if not before their appointment time if they had arrived a little early. We observed the admission nurse keeping patients informed of waiting times as required.
- GP referrals were managed well to ensure patients were seen in a timely manner. GP referred patients for either a priority appointment (two to three weeks waiting time) or as a routine appointment (six to eight weeks waiting time). Referral pathways have been agreed with commissioners and secondary care. All referrals were vetted to provide assurance they were in line with agreed criteria. All onward referrals were made in accordance with agreed protocols, these were generally suspected cancers
- Planned procedures were sometimes cancelled for non-clinical reasons. Data demonstrated 67 gastroscopy procedures and 85 flexible sigmoidoscopy procedures were cancelled between August 2017 and July 2018. Of these, 48 procedures were cancelled due to equipment failure. Gastroscopy procedures were cancelled in eight of 12 months. The highest number of cancellations were in September 2017 with 22.7% of planned procedures being cancelled. Flexible sigmoidoscopy procedures were cancelled in 11 of 12 months with the highest number of cancellations 15 (46.9%) in September 2017. All patients had been offered other appointments within agreed timeframes.
- Staff contacted patients who did not turn up for their appointment and re-arranged these. If patients did not turn up more than once, staff informed the referring GP. The service monitored how many patients did not attend (DNA). We reviewed data from September 2017 to August 2018 and found DNA rates were low. During this period 11 patients (0.9%) did not attend for gastroscopy and 10 patients (1.9%) did not attend for flexible sigmoidoscopy appointment.
- The service had referred 15 patients to another health care provider in the 12 months from September 2017 to August 2018. These referrals were made to ensure patients received the correct treatment in a timely manner and at the right place. There had not been any transfers of patients because of clinical emergencies during this time.

Learning from complaints and concerns

- There were processes to ensure patients and their relatives could make a complaint or raise a concerned if required. There were leaflets on display on the reception desk and a poster in the waiting area. There was a Complaints Policy (2017) providing guidance for staff of how to resolve concerns raised by patients and the process for handling a formal complaint. The service had not received any complaints in the reporting period between September 2017 and August 2018.

Are diagnostic imaging and endoscopy services well-led?

Requires improvement

We rated well-led as requires improvement.

Leadership

- Managers had the right skills and abilities to run a service but there were some gaps within the team. There was a leadership team although this did not include an identified nurse lead. The senior leadership team (SLT) comprised of the clinical lead, the service manager and the finance manager. The clinical lead did not live and work in the UK and we asked staff what impact this had on leadership. Staff we spoke with did not express any concerns and stated the clinical lead visited and worked in the service twice a year. We saw there were weekly telecon meetings and through speaking with the clinical lead it was evident that although they lived abroad they were aware of all aspects of the business. They explained it had been hard work and required “thinking outside of the box” to provide clinical leadership from abroad. However, they felt they had proven this could be done successfully with the use of communication technology.
- The service manager was resigning as the registered manager and taking up a role as a senior administrator.

A new service manager had been recruited and was in the process of induction to the service. We met the new service manager, who had been in post for five days at the time of our inspection. They were yet to apply to become the registered manager with the CQC.

- There was no identified nursing leadership. This was not in line with national guidance from the British Society of Gastroenterology (2007) who recommend there are identified medical and nurse leads within services that provide endoscopy. This meant there was no one with overall responsibility and leadership for nursing staff and to lead nurse-led quality measures. For example, reviewing of standard operating procedures to ensure these reflected current evidence based standards.
- Leaders understood the challenges to quality and sustainability of the service. The clinical lead expressed concerns relating to maintenance of the endoscope washer-disinfector and was exploring additional arrangements to ensure service could be delivered safely without interruptions or cancellations. We discussed the activity level of delivered procedures with the service manager. The service had carried out fewer than the anticipated number of procedures over a 12-month period from September 2017 to August 2018. They explained they were looking at options to expand the services they offered to increase the number of procedures they carry out.
- There were weekly telecon meetings known as progress meetings, between the clinical lead and the service manager. The progress meeting included operational issues such as contract activity, staff issues, incidents and forward planning and service development. The meetings were minuted and followed a set agenda. In addition, there was a telecon meeting every two weeks between the finance manager and the clinical lead. Staff told us leaders were approachable although they were not often working at weekends when the service operated. The service manager could be contacted at weekends when the service was operating if required. The service manager communicated with all staff through secure NHS emails to ensure all staff were updated in a timely way to develop shared learning and education in good safety practices.
- Operational leadership on the days when the service was operating, was provided by the most senior nurse on duty. The endoscopist was responsible for clinical decisions made including decisions about transfers or referrals to other healthcare providers.

Vision and strategy

- The service had a clear statement of purpose setting out aims, objectives and values. This was also available for patients to see on their website. The service had a business plan, which was last reviewed in February 2018. The business plan reflected the statement of purpose and did not set out goals and ambitions for developing the service although both the clinical lead and the service manager spoke about this. We were told about plans to develop the services they offered.

Culture

- Managers across promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The service had a set of values which included: “being caring and compassionate, actively listening, be respect, understand and respond, value team members and be a ‘can do’ service to provide a service of choice for all patients”. Staff were aware of the values of the service and all staff we spoke with said they enjoyed working in the team. Staff felt valued and recognition was given to those that worked beyond what was expected. For example, a member of the administrative team worked beyond what was expected of them and had been rewarded with a higher salary.
- The clinical lead and the service manager promoted a positive culture and valued staff. We asked them what they were most proud of and they answered without hesitation the staff and teamwork. The clinical lead was especially proud of the cohesive team which promoted staff to be open and honest with each other.
- Staff told us they liked working for the service and many had worked there for a long time. They were required to attend two clinical governance meetings every year and the service paid them for the hours they attended. Staff met for a meal after each meeting and the service treated all staff to a meal out once a year. The service also paid for staff meals at lunchtime so all staff could eat together.
- We were told new jobs were advertised to ensure equal access for all staff including staff with protected characteristics. However, the service manager told us new jobs were rarely advertised because staff continued

to work for the service for long periods. New staff were recruited to ensure they would fit in well with the existing team and were employed on their merits to promote equality and diversity.

- During the inspection we highlighted an area that required action to improve the safety of patients. The service manager responded positively to this feedback and assured us they would take immediate action to make the required change. This demonstrated a culture open to improvement.
- Staff were encouraged to be open and raise concerns. There was a Raising Concerns Policy (Whistleblowing), 2015, which included contact details for a national whistleblowing helpline if staff considered they needed external advice. We saw a copy of this policy, which should have been reviewed in May 2018 so was just outside of its planned review date. The service did not have an identified Freedom to Speak Up Guardian at the time of our visit. The service did not have a Freedom to Speak Up Guardian in line with national guidance (NHS England: Freedom to speak up in Primary Care, 2016).
- There were processes to address behaviour and performance issues that were inconsistent with the vision and values.

Governance

- The service had a governance structure which demonstrated accountability and communication pathways to ensure effective sharing of information. The clinical lead held overall responsibility of the service. The finance manager, the endoscopists and the service manager all reported to the clinical lead. The service manager managed nursing and administrative staff including carrying out their annual appraisals. Staff were aware of their roles and whom they reported to.
- We were not assured there was an oversight of auditing or performance as set out in the commissioning contract. The service was commissioned by the local Clinical Commissioning Group (CCG) with a standard NHS contract agreed April 2017 for a three-year period. The contract included quality requirements including regular reporting of data and the service met with the CCG for an annual contract review. We reviewed minutes of the annual review from July 2018. The minutes showed there was a lack of clarity between the expectation of regular reporting of quality requirements and what the service reported/the format this was reported in. We discussed the requirements as set out in schedule four of the contract with the clinical lead who seemed unaware of the requirements set out in the contract. For example, the service was asked to submit evidence of accuracy of documentation every six months but this was not identified as part of the audit calendar for 2018/19. We asked for evidence of when documentation audits were last submitted to the CCG. The audit calendar/programme for 2018/19 detailed three audits only which included a decontamination audit and quality/safety audits of gastroscopy and flexible sigmoidoscopy. However, these audits were different to the audit plan shared with us after the inspection. Following the inspection, we were advised the service would comply with reporting requirements to the clinical commissioners with immediate effect.
- The service held quarterly clinical governance meetings and all staff were required to attend two each year. There was a set agenda for these meetings which included: infection prevention and control, medical alerts, training, patient feedback, incidents and audits.
- Staff records demonstrated all staff underwent appropriate pre-employment checks when they were employed. We reviewed five staff files which held information such as employment history, photo identification, references and Disclosure and Barring checks. All staff had a public indemnity insurance paid for by the service. In return, staff were required to work at least two shifts every month.

Managing risks, issues and performance

- The service had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected but there were not effective arrangements to review risks regularly. The service had a risk register, which included business specific risk, health and safety and environmental risks. In addition, there was a business continuity plan which covered actions to take in the event of technical failures, issues with decontamination services and/or loss of communication including IT failure. The risk register was reviewed annually and was next due to be reviewed in November 2018 (unless there were significant changes). However, it was not a 'live' document demonstrating risks were added, reviewed and acted upon but rather held what could be classified as potential risks to the business. A review of new and emerging risks was not a standard agenda item for weekly progress meetings or the quarterly governance meeting.

- We spoke with the clinical lead and the service manager about their biggest concerns about the service. The clinical lead spoke of issues about the maintenance contract of the endoscope washer-disinfector which was on the risk register. The service manager did not have any concerns.
- There was a Risk Policy (2018), which aimed to provide a framework to minimise risks to patients and staff. The framework included business continuity, auditing, workforce checks, serious incidents, complaints and patient satisfaction. The policy stated all staff were responsible to assist in the identification and reporting of workplace related risks and to work in a manner that reduced risks.

Managing information

- The service did not always collect, analyse, manage and use information well to support all its activities, using secure electronic systems with security safeguards. The service was awaiting installation of an electronic patient reporting tool which would ensure the service was compliant with electronic recording of endoscopy procedures in line recommendations from the British Society of Gastroenterology and Joint Advisory Group (JAG) accreditation standards (2005). The service had purchased software to install this but there were some ongoing challenges regarding compatibility with the IT server used by the hosting hospital. This had delayed the implementation of new and updated recording of endoscopy procedures.
- The service was compliant with the General Data Protection Regulations (2018). All patients received, signed and returned an information sheet setting out how information about them was collected and shared with other and relevant healthcare providers. Information stored electronically was secure. Computer access was password protected and we observed staff logging out of computer systems when they were not working on screens.
- The service had arrangements to safeguard confidentiality of patient identifiable information. The clinical lead was the Caldicott Guardian and there was a Caldicott Policy (2015), which provided guidance for staff to ensure patient identifiable information was processed fairly and lawfully.
- The service did not collect, report or publish Workforce Race Equability Standards in line with legislation. The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This became a requirement for independent health providers in 2017 when the providers NHS contract exceeds £250K per annum.

Engagement

- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. The service sought the view of patients using their services. We reviewed patient satisfaction surveys from October to December 2017 and April to August 2018. In total, 249 patients had returned a questionnaire. Feedback was mostly positive and included comments such as" excellent from beginning to end" and "staff were lovely, excellent service, care could not have been better". Some patients (12 responses) offered suggestions of improvements which included not having a food programme on the television in the waiting room when patients were fasting before their procedure (8 responses). As a result, staff were now more mindful of the television channels when the television was switched on. Staff told us of other examples of changes in response to comments from patients, which included access to newspapers in the waiting areas and improved toilet facilities.
- The service encouraged patients to provide feedback by completing the Friend and Family test (FFT). Results were accessible on the service's website and included narrative feedback from patients.
- Feedback from patients were collected in an annual patient survey. We looked at the survey carried out between October 2017 and December 2017 which included feedback from 142 patients which was a response rate of 47%. Most patients (101 patients) had had a gastroscopy and 34 patients had attended for a flexible sigmoidoscopy, two had both procedures and five patients were unsure about which procedure they had had. The survey asked patients about the degree of discomfort felt during the procedure they had. Most patients (64%) who had a gastroscopy felt mild discomfort while 11% had experienced significant discomfort during the procedure. For patients attending for flexible sigmoidoscopy, 71% experienced no discomfort with eight patients (2%) had experienced discomfort several times or significant discomfort. As a

result of the patient survey staff told us patients attending for flexible sigmoidoscopies were offered a medical gas to alleviate discomfort but this could not practically be administered for patients attending for gastroscopies.

- All staff were invited to attend quarterly clinical governance meetings. There was an expectation all staff attended two of four meetings every year as part of their employment contract. Although staff had to attend in their own time, they received their hourly pay for the duration of the meeting. We reviewed minutes of meetings, which demonstrated most staff attended and were involved in decisions made about service improvement. Staff were encouraged to engage with audit activity. Minutes of the clinical governance meeting held in March demonstrated staff were included in deciding what audits should be carried out. Staff also received feedback on incidents, audits and other quality measures as applicable.

Learning, continuous improvement and innovation

- The service was exploring opportunities to extend their services. The service manager had been invited to a gastroenterology workshop to explore how to take community endoscopy services forward.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure compliance with WHO safety checklist are carried out in line with the National Standards for Invasive Procedures and that compliance is audited.
- Improve data collection to enable analysis of individual endoscopists and to enable benchmarking against other and similar services.
- Develop and implement an audit calendar/ programme to ensure data is collected, analysed and presented to provide assurance that key performance indicators are met.
- Improve mandatory training compliance for nursing staff. Collect and evidence data to demonstrate medical staff have completed mandatory training and sufficient endoscopy procedures to maintain competence.
- Review processed to obtain informed consent from patients. Review the consent forms used to ensure patients can make an informed decision with regards to risks associated with endoscopy procedures. Ensure nursing staff have the necessary training to support the consent process.

Action the provider SHOULD take to improve

- Review nursing leadership to ensure nurse-led quality measures are carried out to deliver safe patient care.
- Encourage and audit the use of personal protective equipment (PPE) when cleaning the procedure room between patients.
- Review processes for staff to check emergency equipment, such as the resuscitation trolley, on commencement of procedure lists.
- Re-iterate the importance of immediate access to emergency equipment in the event of a major haemorrhage during an endoscopy procedure.
- Review processes for the safe monitoring of all patients during endoscopy procedures.
- Review the level of safeguarding training for the safeguarding lead to ensure this meet national guidance.
- Review arrangements for regularly review risks entered onto the risk register as part of clinical governance arrangements.
- Consider how to demonstrate evidence-based guidance is reflected in standard operating procedures.
- Enhance staff awareness of how to access policies and standard operating procedures.
- Review processes for how informed consent is obtained in line with national guidance.
- Consider provision of dementia training.
- Collect and publish data to evidence compliance with Workforce Race Equality Standards (2014).
- Review the Chaperone Policy to comply with national guidance.

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	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The consent forms did not hold specific information that allowed patients to make an informed decision to consent.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was not a specific WHO checklist although staff 'read out' (from memory a laminated set of questions in line with the WHO checklist). We looked at three patient records of which the first stage of the WHO checklist was not ticked as completed. There were no internal audits to demonstrate compliance. The service manager and the clinical lead did not have sufficient knowledge of National Standards for Invasive procedures (NatSSIPS). Equipment used for monitoring of pulse oximetry was not always used in line with manufacturer's guidance.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not collect data which enabled benchmarking of their performance against national standards or for internal use. The service did not collect

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Requirement notices

applicable data in line with the British Society for Gastroenterology Quality and Safety Indicators for Endoscopy (2007) or as required by the Joint Advisory Group (JAG, 2005).

Arrangements for auditing were not efficient and no there were no effective audit calendar/programme.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (2) (a) Staffing** Compliance with mandatory training varied between 44% and 100%. **Regulation 18 (2) (b) Staffing** Patient surveys demonstrated most patients signed their consent form in the admission room with the nurse. Nurses did not receive any training in consenting patients. **Regulation 18 (2) (c) Staffing** The service was unable to demonstrate endoscopist completed mandatory training, and did not audit the number of procedures to demonstrate their competence.