InHealth Limited

InHealth Clinical Assessment and Treatment Service - North West

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

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

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to InHealth Clinical Assessment and Treatment Service - North West

This service is provided by the In Health North West Clinical Assessment and Treatment Service. It is a mobile endoscopy unit which, at the time of the inspection, was based on a supermarket car park in Oldham near Manchester. The unit had been there since January 2022 but can be moved to other sites dependent on the needs of the commissioning service. The unit received accreditation from the Joint Advisory Group on gastrointestinal endoscopy in 2010 and has retained this accreditation.

The service treated adults over 18 years of age.

The service was for diagnostic gastroscopy, colonoscopy, flexible sigmoidoscopy and polypectomy. It was elective (planned) care for diagnostic and surveillance referrals. The service had undertaken 2770 procedures in 2020 and 2733 procedures in 2021.

The regulated activities are diagnostic and screening and treatment for disease, disorder or injury.

There is a registered manager in place for the service. The service has never been inspected.

How we carried out this inspection

How we carried out this inspection

We reviewed information about this service before the inspection. The inspection site was inspected by an inspector and a doctor with experience in endoscopy and gastro-enterology. We spoke with the lead nurse for endoscopy for the location, the clinical lead nurse for endoscopy for the provider and three nurses including a nurse endoscopist. We also spoke with a consultant endoscopist and a receptionist. We viewed six records including prescription charts and consent forms. We spoke with three patients.

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

Outstanding practice

We found the following outstanding practice:

- The mobile unit was accredited by the Joint Advisory Group (JAG) on gastrointestinal endoscopy. It is the only mobile unit in England to be accredited by JAG and was first accredited in 2010. The four areas for JAG accreditation are clinical quality, patient experience, workforce and training.
- The service had dignity champions who underwent a dignity champion course to support the needs of patients. They had attended a “skills for care” event in 2021. There was a poster in the reception area promoting the role of the dignity champion.

Summary of this inspection

Areas for improvement

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

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Endoscopy

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

Are Endoscopy safe?

Good

Mandatory training

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

All staff including nursing and medical staff received and kept up to date with their mandatory training. The training rate was 96% at the time of the inspection. The provider target for mandatory training was 90%.

The mandatory training was comprehensive and met the needs of patients and staff. Training included infection control, health and safety, medicines management and sepsis awareness. There was immediate life support training for qualified staff and basic life support training for healthcare support workers and administration staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were given protected time for training.

Safeguarding

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Safeguarding training was part of mandatory training and all staff were trained to level two for safeguarding of adults and children and young people. Training compliance for safeguarding was at 96% for the unit.

There was a link nurse for safeguarding who was trained to level four.

If staff had concerns about any patients, they would report this to their manager. The manager would contact the local authority safeguarding adults team appropriate to the individual concerned and the location of the site using the NHS Safeguarding application for contact details. There had been no safeguarding incidents on the unit.

Staff underwent checks from the disclosure and barring service before employment and these were updated as necessary. Records for medical staff were held centrally.

Good

Endoscopy

Cleanliness, infection control and hygiene

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

All areas of the mobile unit were visibly clean and tidy. Non-clinical areas were cleaned by outside contractors and clinical areas were cleaned by staff from the unit. There was a deep clean every three months.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that PPE was plentiful and that staff used it. We also observed staff washing their hands.

There was a link nurse for infection control and one for decontamination.

Hand hygiene audits were carried out every month on five members of staff. In January 2022 and February 2022 there was 100% compliance with the handwashing audit.

There were decontamination policies and procedures for all areas of disinfection and decontamination of the scopes.

Following a procedure, the scope was wiped, flushed and covered. A patient label was attached by the member of staff who carried out the bedside decontamination along with the time and the scope number. The staff member applied a red label to the tray to show that it was dirty and passed it through to the decontamination area. In this area the decontamination staff checked the scope and carried out the manual washing process.

In the decontamination area the patient label was attached to the traceability log sheet which recorded the names of the staff involved in the bedside clean. Other cleaning and decontamination processes took place including a leak test and the scopes were placed into the endoscope washer disinfector. Scopes were rechecked after the washer cycle and then placed into the endothermo disinfector for a high- level disinfection cycle which took about 36 minutes. The endoscope washer underwent a thermal self-disinfect cycle every 24 hours.

On completion of the cycle the scope was placed into the drying cabinet or onto the liner of the storage tray with the flushing connector, buttons, biopsy valve and the label with the decontamination details. The liner was folded- over and a green sticker applied which showed the scope was ready to use.

Scopes were used within three hours or were reprocessed unless stored in the drying cabinet.

Scopes were stored in a specialist storage cabinet for up to a month. The scopes were connected to medical grade air to prevent moisture building up and causing bacterial contamination. There was a clock for each scope indicating the number of hours it had been in the cabinet and when it would need reprocessing. All scopes were stored in the cabinet at the end of the day.

Environment and equipment

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

Good

Endoscopy

The mobile unit was purpose built for the needs of the service. On entry, there was a spacious waiting area with a reception desk. There were toilets in the waiting area. From here patients were taken to the consent admission room, this room had an en-suite toilet. Patients were then taken into the procedure room and then into the recovery room which had two bays.

Staff competencies included the use and basic maintenance of the equipment and disinfection and decontamination of the equipment.

Risk assessments for Control of Substances Hazardous to Health (COSHH) had been completed and staff competencies included and awareness of the COSHH regulations.

The procedure room was suitable for upper and lower gastro-intestinal procedures.

There were eight scopes, one of which was a paediatric colonoscope for adult patients who were very small or slim and in cases where the colon was difficult to negotiate or narrowed. This was for their comfort. All scopes were from the same manufacturer.

There was evidence of regular maintenance and servicing of all equipment. The companies that supplied the equipment provided training to the staff who used it.

We saw that there were standard operating procedures and operating instructions for all the endoscopy procedures undertaken at the unit. These were reviewed and updated at regular intervals.

There was a resuscitation trolley in the recovery room. The trolley was sealed and checked daily to ensure that the seal was intact. We saw that there were weekly checks which were documented and audited. Oxygen and suction were available in all clinical areas.

There was a blood glucose monitor and an international normalised ratio (INR) machine to monitor blood clotting if necessary.

Fridge temperatures were monitored and recorded. This was audited by the service.

Water was supplied to the unit throughout the day when the unit was operational.

Clinical waste was stored in lockable containers. Sharps bins and clinical waste was collected from the unit twice weekly by an external clinical waste company.

Assessing and responding to patient risk

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

Patients were referred into the service by their GP. There were referral criteria which included no patient weighing more than 220 kg, no patients who were medically unfit, had severe heart failure or had a heart attack in the three months before the procedure. The service did not accept patients with a pacemaker or chronic obstructive pulmonary disease for lower gastrointestinal procedures. Patients also needed to be able to transfer to the treatment couch.

Referrals were vetted as part of the audit calendar.

Good

Endoscopy

Following referral, patients were triaged by the service and there were triage guidelines for each procedure. Triage was done by the endoscopy team before the patient was booked in for their procedure.

The service used a World Health Organisation checklist for endoscopy which was completed as part of the patient pathway and kept with the patient record. The completion of the checklist was audited every three months. The January 2022 audit showed 100% compliance.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients were monitored throughout their procedure and the results were recorded in the patient record.

The service did not remove any polyp larger than 2cm.

There was a policy for a major haemorrhage and guidelines for the management of a perforation.

In the event of a deteriorating patient the service would ring 999 for an emergency ambulance and the clinician performing the procedure would telephone the hospital where the patient was being taken to give patient information and details of the procedure. A copy of all documentation from the endoscopy appointment was sent to the hospital with the patient.

Clinical staff had training for sepsis awareness.

Following their procedure patients were given a telephone number to contact if they had any concerns or queries. There was an on- call rota for senior nurses and clinicians who would take the calls.

Following a procedure, the endoscopist would make the patient aware if there were any concerns. Histology was undertaken at a nearby NHS trust and biopsy results were sent to the endoscopist who performed the procedure. If necessary, the patient would then be referred to the most appropriate centre for further treatment on an electronic booking system. Patients were referred on a consultant upgrade urgent referral. They were given a leaflet explaining what would happen next and there was telephone number for them to contact if they hadn't got an appointment within the week.

Histology results were checked daily by the endoscopists. The receptionist kept oversight of the results for review list to ensure that they are being checked each day. The medical secretaries for the endoscopists monitored the referrals to secondary care to ensure that patients were seen in a timely manner. There was a buddy system in place so that if an endoscopist was on holiday the patients would be followed up by another practitioner.

If a patient did not attend for their appointment and they were deemed a high clinical risk, then they were offered another appointment. If the booking centre couldn't contact the patient, then the GP was informed. If the patient was deemed low risk, then the GP and the patient were sent a letter informing them of the missed appointment and requesting a re-referral if necessary. A patient was never discharged without a clinical review of the referral information.

Staffing

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

Good

Endoscopy

The service had enough nursing and support staff to keep patients safe. There were seven full time registered nursing staff and five part time nursing staff. The service also employed an operating department practitioner on a part time basis. There were four healthcare assistants.

All the nurses were endoscopy trained. Two of the nurses were nurse endoscopists.

Staff turnover was very low on the unit.

Agency staff were used to cover holidays and sickness and we saw that there was an induction checklist for agency staff.

Medical staffing

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

Medical staffing was arranged by the central endoscopy operations team. Some endoscopists were employed by the provider and some worked under practising privileges. There was an employed endoscopist who covered seven sessions every week and another endoscopist who worked two days every week. Agency staff were used if the usual endoscopists were on holiday.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Records were paper records and contained all the information from the patient pathway through the service. At the end of a patient treatment they were scanned into the electronic record. The record stayed with the patient during their time on the unit. Records were shared with the NHS as part of the consultant upgrade pathway if the patient needed a referral to secondary care following treatment.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

There was a medicines management policy and a link nurse for medicines management.

Patients could have sedation if they wanted it. This was administered in the procedure room through a cannula which had been inserted by the nurse in the admissions room. The sedation levels were monitored during the procedure and reversal drugs were available. The service followed national guidelines for the administration of sedation from the British Society of Gastroenterology and this was monitored as part of the Joint Accreditation Group (JAG) for endoscopy accreditation process.

The competency framework included the use and side effects of the medicines used for sedation and knowledge of the reversal agents, their doses and the aftercare needed.

There were several medicines audits which were undertaken on the unit. One of these was responsibilities and prescribing and included the recording of allergies in the patient's documentation. In February 2022, the audit score for responsibilities and prescribing was 96%. For errors and incidents, the score was 100%, controlled drugs were at 98% and stock control was 100%.

Good

Endoscopy

There were controlled drugs on the unit which were kept in a locked cabinet. This was on an internal wall of the unit. The controlled drugs register was appropriately completed and audited.

Medical staff could issue an FP10 prescription if necessary. The use of FP10's was monitored and audited, and the pad had to be signed out by the doctor issuing the prescription.

The nurse endoscopists were nonmedical prescribers. The service used patient group directions (PGD's). These provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients without them having to see a prescriber. This was audited by the service.

Incidents

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

All staff knew what incidents to report and how to report them. There was an electronic incident reporting system and there had been 64 incidents in the year 2020 to 2021. The majority of these were minor office administration incidents.

There had been a serious incident in the past year with a complication during a procedure. The patient complained of severe pain in recovery and was taken to hospital. Following the incident changes were made and early warning scores were done more frequently during procedures and there was additional training for staff. The incident was discussed at the provider governance board so that learning was shared across the organisation. There was also scenario training for staff.

Duty of candour was applied appropriately.

Issues from incidents were agenda items at local staff meetings and at provider level governance meetings.

Are Endoscopy effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

We saw that guidance was referenced from the European Society of Gastrointestinal endoscopy and the British Society of Gastroenterology.

Nutrition and hydration

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

Patients were offered refreshments following their procedure if appropriate.

The aftercare leaflets given to patients informed them when they could restart eating and drinking.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain scores were recorded in the patient record throughout the patient pathway. Following a serious incident, pain scoring had been reviewed and improved.

Patients who had sedation were required to have a responsible adult to accompany them to the procedure and to stay with the patient for 12 hours following the procedure. The advice sheets advised patients about activities such as driving and operating machinery in the 24 hours following the procedure.

Patients could have Entonox gas as an alternative to sedation. This did not require them to be accompanied to the procedure and they could return home on their own.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The mobile unit was accredited by the Joint Advisory Group (JAG) on gastrointestinal endoscopy. It is the only mobile unit in England to be accredited by JAG and was first accredited in 2010. The four areas for JAG accreditation are clinical quality, patient experience, workforce and training.

Outcomes for patients were positive, consistent and met expectations. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and used the information to improve care and treatment.

Outcomes for the endoscopists for the service were recorded on the National Endoscopy Database. The system could identify any poor practice for each endoscopist working for the service and training could be put into place if necessary.

The service was the first community service to offer trans-nasal gastroscopy to improve patient comfort and reduce the need for sedation.

Managers told us that if patients who had a procedure on the unit attended an NHS hospital with complications following a procedure that this would be fed back to them.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Good

Endoscopy

Training was provided in house and there was a training unit in Bristol which was a JAG accredited training centre. There were two nurse endoscopists on the unit who had received training by the service. As part of the nurse endoscopy training, they also were non-medical prescribers. This training had been funded by the provider.

There was a clinical competency workbook covering all areas of the endoscopy pathway and the skills and competencies needed in each part of the pathway. Each competency was assessed against the set performance criteria using a scale from one to five. Competencies were assessed every year by someone who was deemed an expert at level five of the framework. The assessment comprised of an observational and a knowledge assessment.

The nurse endoscopist training programme had been put on hold during the pandemic but was opening again for staff who wanted to develop their role.

Nursing staff were assessed on their core competencies. They rotated through the department daily and had competencies signed off for each area of work including decontamination.

There was a development programme for the health care assistants on the unit.

Managers gave all new staff a full induction tailored to their role before they started work. We saw that there was a comprehensive induction checklist that needed to be signed off by a mentor before they could begin to start work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal rates were at 100%.

There were monthly team meetings for staff on the unit.

Multidisciplinary working

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

The staff on the unit worked together as a team. Nursing staff rotated through different roles during the day to provide care and treatment for patients.

There was low staff turnover on the unit as staff said they enjoyed working there. There were good relationships between medical staff and the staff on the unit.

Seven-day services

The service was not working every day at the time of the inspection, but managers said that the workload was likely to increase after April 2022 and the unit would be operating more often. The service opened at 8am with patients seen through the day and sometimes into the evening dependent on the needs of the service.

Health promotion

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

Patients were given aftercare information relevant to their procedure before leaving the unit.

The service provided advice and information sheets to patients on several conditions including polyps in the bowel, diverticular disease, low fat diets, high fibre diets and indigestion.

Good

Endoscopy

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Mandatory training included the Mental Capacity Act and Deprivation of Liberty Safeguards for clinical staff. Training rates were at 96%.

Consent was a two- stage process and was nurse led on the unit. First consent was done over the phone and the patient brought a completed form when they attended their procedure. Second consent was nurse led and was taken in the pre-assessment area. If patients wanted to speak with the endoscopist they would come to the pre-assessment room.

We saw in the six records we looked at that consent was documented.

The service did not treat any patient who did not have capacity to consent to a procedure. This was part of the criteria for the service.

Are Endoscopy caring?

Good

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

There was a privacy and dignity policy which included standards relating to privacy, dignity, communication, confidentiality and attitudes and behaviours. This was monitored through the quality audits, review of complaints and the staff competency framework.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Privacy and dignity were always respected and patients who were attending for lower gastro-intestinal procedures were given dignity shorts to wear when moving through the treatment rooms. The service had dignity champions who underwent a dignity champion course to support the needs of patients. They had attended a “skills for care” event in 2021. There was a poster in the reception area promoting the role of the dignity champion.

Comfort scores were recorded and were a key performance indicator on the national endoscopy database.

There were thank you cards on the walls of the unit thanking the staff for putting patients at their ease and supporting them during their procedures.

Emotional support

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

Good

Endoscopy

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff competencies included effective communication pre, during and post procedure by utilizing effective listening skills, relaxation skills, reassurance and explanation. Personal, cultural, social and religious needs of patients were also considered.

Two of the nurses on the unit had received training in advanced communication skills from a nearby specialist cancer hospital. This was a two- day workshop and included breaking bad news to patients. There were plans to further develop this type of training in house.

Patients were taken into an office area away from the clinical treatment area if staff were going to break bad news to them to ensure privacy and confidentiality.

Understanding and involvement of patients and those close to them

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

The service philosophy was patient focused to provide high standards of care for carers and their families and to alleviate patient anxiety and make sure that patients were comfortable and treated with dignity and compassion.

Due to the pandemic carers and relatives could not stay with patients during their treatment but staff could keep them informed of the progress of the patients.

Following treatment patients were asked to feedback about the service; 97% of patients said that their treatment had been very good.

We spoke with a patient following their procedure. It was their second visit to the unit. They had no complaints about the service and said on both visits they had not experienced any pain or discomfort and their treatment had been very good.

Quotes from friends and family survey included “staff were amazing and friendly. I was anxious but they made sure I was comfortable. 100% happy”, “all staff were very reassuring and made me feel really relaxed. I had full confidence in them all”.

Are Endoscopy responsive?

Good

Service planning and delivery to meet the needs of the local people

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

The service worked with local commissioners to plan and organise services, so they met the changing needs of the local population. The unit was on a supermarket car park in Oldham but could be moved to other locations as necessary.

Good

Endoscopy

Facilities and premises were appropriate for the services being delivered. The unit was purpose built for endoscopy procedures and was well set out with patients moving through a series of rooms for their procedure. Toilets were available in the waiting room and in the pre-assessment room. Consent was taken in the pre-assessment room.

Patients were contacted about five days before their appointment to go through their procedure and check if they had any questions or special requirements. They were also reminded about the location of the unit.

Patients with diabetes were offered the first appointments in the morning or afternoon sessions.

Meeting people's individual needs

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

There was a lift so that people with limited mobility could access the unit. There were also parking spaces next to the unit for disabled people. Toilets were wheelchair accessible.

There was a hearing loop for patients with hearing loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We saw on the day of the inspection that an interpreter had been booked to support a patient who was having a procedure. The service had developed flash cards in different languages that they used during the procedure if they needed a patient to move or take up a different position.

Patients were given follow up appointments if necessary before they left the unit. Any patient who was moved onto the consultant upgrade pathway was given a leaflet with a contact number.

Access and flow

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

The service was for diagnostic gastroscopy, colonoscopy, flexible sigmoidoscopy and polypectomy. It was elective procedures for diagnostic and surveillance referrals.

The first available appointment within four weeks for a routine scheduled referral was 100% for January 2022 (91 patients) and 100% for February 2022 was 100% (82 patients).

For referral to treatment times non admitted patients starting treatment within a maximum of 18 weeks from referral was 96.9% for January 2022 and 98.6% for February 2022. The percentage of service users on incomplete referral to treatment pathways waiting no longer than 18 weeks from referral was 98.9% for January 2022 and 98.3% for February 2022.

The percentage of service users waiting less than six weeks from referral for a diagnostic test had been 87.9% in December 2021 and January 2022. An improvement plan had been put in place and in February 2022 it was up to 96.2%.

Good

Endoscopy

Booking and scheduling was done by the patient referral centre (PRC). Patients were referred from their GP's to the PRC. They were triaged by the service and then an appointment letter was automatically sent out. There was also a pack with an information leaflet about the procedure, a consent form, a health questionnaire and a map with instructions about how to get to the unit.

Bowel preparation with instructions was sent out from the unit by the qualified staff. This was checked against the prescription chart which the clinician completed at triage. Patients could also collect the bowel preparation from the unit.

Patients were contacted about five days before their procedure so that they could ask any questions and the service could check their medical details. Patients attended for their procedure on their appointment day.

Learning from complaints and concerns

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

The service clearly displayed information about how to raise a concern in patient areas. There was a poster in the waiting area about the complaints system for the service.

Managers told us that there had been four written complaints in four years. Changes had been made to the service following one of the complaints.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Are Endoscopy well-led?

Good

Leadership

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

There was a clear management structure with lines of accountability and responsibility.

There was a lead nurse who was responsible for the management of the unit and held professional accountability for the nursing staff. The day to day operational management of the endoscopy unit was the responsibility of the senior nurse with the lead nurse's approval and support.

The team of endoscopists consisted of consultants on practising privileges contracts, employed consultants and employed nurse endoscopists were responsible for the medical care of patients including clinical documentation and completion of requisitions for diagnostic and any further investigation procedures required. There was a clinical lead endoscopist for the organisation.

Good

Endoscopy

There was a practising privileges policy and all practitioners who provided clinical care or services were managed through the policy. There was an InHealth responsible officer who was responsible for carrying out medical appraisals and revalidation. The policy stated that applicants for practising privileges would be currently employed or have recently been employed in a substantive post in the NHS. Practitioners could only carry out procedures or provide services which they regularly carried out as part of their substantive role.

When applying for practising privileges there was a pre-eligibility check and then an interview followed by an application form with evidence requirements. Following receipt and validation of the information and evidence this was forwarded to the director of clinical quality for consideration and/or approval. The director of clinical quality would make the final decision.

Practitioners had to provide evidence of appropriate insurance covering their scope of practice.

There was strong leadership at operational level and this was supported by senior clinical leadership. Managers were clinically trained and understood the needs of the service.

A member of staff told us that they were on a leadership course which was funded by the provider. They said that the skills that they had learned supported their role. They were enjoying the course and hoped it would provide more career opportunities with the provider.

Vision and Strategy

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

The service had a philosophy and four values which were trust, passion, care and fresh thinking. These were shown on posters around the unit.

At the time of the inspection there was a provider restructure underway and so the strategy was put on hold.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a culture of patient safety and effective teamwork at the hospital. All the staff who worked there said that it was a great place to work. There were opportunities for career development, and we saw that several staff had been developed into new roles.

Staff completed equality and diversity training as part of their mandatory training and all policies were equality impact assessed so that they did not disadvantage anyone and they advanced equality, diversity and inclusion.

Staff had reported in a staff survey that they were unhappy with training and training opportunities. This had been addressed by the provider and staff told us that the training had improved and there were more opportunities to develop.

There was very low staff turnover at the unit.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance structures, processes and systems of accountability to support the delivery of good quality services and safeguard standards of care.

The provider held monthly governance meetings. Agenda items included incidents and root cause investigation reports, a risk register review, reviews of policy and standard operating procedures.

Any themes and trends from the different locations could be identified at this meeting and disseminated across the organisation.

There were staff meetings at a local level so that information could be fed up and down the organisation.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were systems in place to identify and manage risk in the service. There was a risk register that identified the current risks with mitigating actions in place. Leaders were aware of the risks and were able to verbalise them.

The risk register was divided into sections including operational, health and safety, legal, financial and information governance. Risks were owned by specific managers and the register showed actions with review dates with mitigation of the risk.

Every three months the head of endoscopy mobiles reviewed the risk register with the executive team.

Managers told us what the risks were to their service which corresponded to the risk register.

There was a corporate business continuity plan. The mobile unit had back-up generators in the event of a power outage.

Information Management

Good

Endoscopy

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

The service had clear performance measures and key performance indicators (KPIs), which were effectively monitored.

The service had introduced an endoscopy governance dashboard in January 2022 which was an agenda item on the clinical governance meetings' agenda.

There was a confidentiality policy and a Caldicott Guardian for the organisation. The policy stated the roles and responsibilities of all staff in data protection and data retention. Staff had training in data security training as part of mandatory training.

The service reported to external bodies including the Care Quality Commission and the Joint Advisory Group on gastrointestinal endoscopy.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

People who used the service were actively engaged and involved when planning services. Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. The service used the results of the survey to improve the service.

Following each procedure patients were asked to complete a patient feedback questionnaire. Comments could remain anonymous. Patients were also asked to complete the friends and family test. We saw that 97% of patients were very satisfied with the service.

Part of the Joint Advisory Group (JAG) accreditation was based on patient feedback and comfort scores.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a culture of performance improvement at the hospital with staff trying to improve patient safety and patient experience.

Staff on the unit worked hard to maintain their accreditation to the JAG on gastrointestinal endoscopy. They were proud of their achievements.

The unit was the first mobile unit to introduce trans-nasal endoscopy. This improved comfort for the patient.