Peterborough Community Endoscopy Clinic

Quality Report

6 – 10 Thistlemoor Road
Peterborough
Cambridgeshire
PE1 3HP
Tel: 0333 202 0300
Website: www.inhealthgroup.com/location/peterborough-community-endoscopy

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Good**
Are services safe?	Good
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Peterborough Community Endoscopy Clinic is operated by InHealth Endoscopy Limited. The service is located within a medical practice and comprised of a purpose built facility with a reception area, admission room, procedure room, discharge bays and a seated recovery area.

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

We inspected this service using our comprehensive inspection methodology. We carried out the short notice announced part of the inspection on 8 April 2019, along with an unannounced visit to the clinic on 15 April 2019.

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.

The main service provided by this hospital was diagnostic and screening procedures through the use of endoscopy.

Services we rate

This is the first time we have rated this service. We rated it as **Good** overall.

We found good practice in relation to this service:

- The service managed staffing effectively and always had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- The service controlled infection risk well and had suitable premises and equipment. Staff kept equipment and the premises visibly clean, and followed best practice in relation to infection prevention and control.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. The service had arrangements to recognise and manage risks to patients, in line with national guidance.
- The service managed patient safety incidents well. During the reporting period there were no never events or serious incidents.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. The service had received Joint Advisory Group (JAG) accreditation in 2014.
- Managers monitored the effectiveness of care and treatment and used findings to improve the service. The intended outcomes overall were being achieved.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Observations showed how staff interacted compassionately with patients who were treated with dignity and respect.
- The senior team were available, approachable and supportive throughout recent senior staffing changes.

However, we found areas of practice that require improvement:

- Oxygen cylinders were not stored safely in line with guidelines.
- The service had a clinical General Practitioner (GP) lead but no dedicated clinical nurse leadership.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Amanda Stanford

Summary of findings

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Endoscopy	Good 	Peterborough Community Endoscopy Clinic provided endoscopy services for adults. We rated this service as Good for safe, caring and well-led and requires improvement for responsive. We currently do not rate the effective domain for independent endoscopy services.

Summary of findings

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Good

Peterborough Community Endoscopy Clinic

Services we looked at
Endoscopy

Summary of this inspection

Background to Peterborough Community Endoscopy Clinic

Peterborough Community Endoscopy Clinic is operated by InHealth Endoscopy Limited. The service opened in 2012. The endoscopy unit is situated on the first floor within Thistlemoor Medical Practice in Peterborough. The service offers a community based endoscopy service using colonoscopy, flexible sigmoidoscopy and oesophagogastroduodenoscopy (OGD).

The service is directly commissioned by the local NHS Commissioning Group, to provide routine endoscopy services to serves the communities of Peterborough and the surrounding area.

The service has had a registered manager in post since November 2018.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector,another CQC inspector, and a specialist advisor with expertise in endoscopy. The inspection team was overseen off site by Fiona Allinson, Head of Hospital Inspection.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the short notice announced part of the inspection on 8 April 2019, along with an unannounced visit to the clinic on 15 April 2019.

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.

Information about Peterborough Community Endoscopy Clinic

The service is registered to provide the following regulated activities:

- Diagnostics and screening procedures.

During the inspection, we visited all clinical and non-clinical areas at the Peterborough Community endoscopy clinic. We spoke with 10 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with five patients and three relatives. During our inspection, we reviewed five sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once, and the most recent inspection took place in November 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (November 2017 to November 2018)

- The service carried out 1781 oesophagogastroduodenoscopy procedures, 813 colonoscopy procedures and 199 flexible sigmoidoscopy procedures; of these 100% were NHS-funded procedures.

Summary of this inspection

A clinical lead, three medical and one nurse endoscopist worked at the unit under practising privileges. Practising privileges is a system which independent organisations use to allow a person to practice in their service. The service employed one deputy sister, three registered nurses, four health care support workers and two patient administrators, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety (November 2017 to November 2018)

- There had been zero never events.
- There had been zero serious incidents causing harm to patients reported.
- There had been 33 incidents reported on the service's incident reporting system.
- There had been no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli.
- There had been three complaints, of which, two had been partially upheld.

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAG) accreditation awarded on 17 November 2014.

Services provided under service level agreement:

- Clinical and or non-clinical waste removal
- Cleaning services
- Interpreting services
- Maintenance of medical equipment
- Pathology and histology carried out by a local NHS trust.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **Good** because:

- The service managed staffing effectively and had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- The service controlled infection risk well. Staff kept equipment and the premises visibly clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient and in line with guidance. They kept clear records and asked for support when necessary.
- The service had arrangements to recognise and manage risks to patients, in line with national guidance. The service recognised that in some patients examinations may be possible only using sedation and/or analgesia and they adhered to safe sedation guidelines.

However, we also found:

- Oxygen cylinders were not being stored safely in line with guidelines.

Are services effective?

Are services effective?

We currently do not rate the effective domain but found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. The service worked with NHS providers to support patient care.

Summary of this inspection

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service's policy and procedures when a patient could not give consent.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic patient records system that they could all update.

Are services caring?

Good

We rated caring as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- The design of the environment and the way staff cared for patients protected patient privacy and dignity.
- Staff provided emotional support to patients to minimise their distress.
- Staff made sure they involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

Good

We rated responsive as **Good** because:

- The service planned and provided services in a way that met the needs of local people. The service worked with commissioners and GPs to ensure patients were referred to the service when appropriate.
- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Are services well-led?

Good

We rated well-led as **Good** because:

- Managers at all levels had the right skills and abilities to run a service providing high-quality, sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action.

Summary of this inspection

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- However, we also found:
- The service had a clinical GP lead but no dedicated clinical nurse lead.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Endoscopy	Good	N/A	Good	Good	Good	Good
Overall	Good	N/A	Good	Good	Good	Good

Good

Endoscopy

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging and endoscopy services safe?

Good

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Mandatory and statutory training was provided by a combination of e-learning and face-to-face training sessions, including basic life support, infection prevention and control, fire safety, moving and handling, health and safety, equality and diversity, safeguarding children level 2, safeguarding vulnerable adults and information governance.
- The service had a training matrix with a 'traffic light' system which alerted the manager when training was next due to be completed. Staff received email reminders when modules were about to expire and needed refreshing and managers monitored attendance.
- At the time of our inspection, staff compliance was between 92% and 100% for each module. The compliance target was 90%.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.**
- The service had a safeguarding vulnerable adults policy. The safeguarding policy contained definitions of abuse, signs of potential abuse and the roles and responsibilities of staff. The policy contained up to date contact details for the local safeguarding authority and clear guidance on the process staff should follow if they suspected abuse or harm. We reviewed the safeguarding policy which referenced national guidance, it was dated August 2016 and had a review date August 2019. Staff had access to the safeguarding policy on the electronic shared drive.
- Service was provided to patients aged 18 years of age and over.
- All the staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They accessed support from senior staff if needed. Staff were aware of their responsibilities to protect vulnerable adults and children.
- The service had a named safeguarding lead who was trained to level three safeguarding adults and children.
- Safeguarding children and vulnerable adults formed part of the mandatory training programme. Staff we spoke with told us they had received safeguarding training. Records provided by the service showed that 100% of staff had completed adult and children safeguarding level two training.
- There had been no reported safeguarding incidents in the reporting period from November 2017 to November 2018.
- The service ensured new employees had safety checks. These were undertaken by the InHealth corporate group who checked criteria outlined by the Disclosure and Barring Service before staff started working at the clinic.

Good

Endoscopy

Cleanliness, infection control and hygiene

- **The service mostly controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**
- The service had an infection prevention and control policy, which set out staff responsibilities in relation to infection prevention, including hand hygiene.
- Infection control training formed part of the mandatory training programme for staff. Data provided by the service showed that 100% of staff had completed infection control training.
- The service undertook monthly hand hygiene audits to ensure staff were compliant with good practice. This included an observation of staff decontaminating their hands before and after patient contact or wearing gloves. The audit observed the way staff decontaminated their hands and included the solution used and five moments to hand hygiene. We reviewed the audit results from January to March 2019 which showed 100% compliance.
- Hand washing posters were in appropriate areas, demonstrating best practice hand washing techniques.
- Personal protective equipment (PPE) such as disposable gloves and aprons were readily available for staff to use.
- Staff were monitored on their use of personal protective equipment. This included using eye shields when cleaning equipment to ensure staff were not at risk of any cross contamination from used endoscopes.
- Staff used personal protective equipment such as aprons, gloves, gowns and face visors in 'dirty' areas and removed this before moving to 'clean' areas of the room.
- During our inspection, we observed staff were bare below the elbows. Bare below the elbow national guidelines are for all staff working in healthcare environments to follow to reduce the risk of cross contamination between patients.
- Daily checklists for cleaning were seen from November 2018 to January 2019 and all were completed fully. Most areas were visibly clean and well maintained.
- However, on the day of our inspection, the store room where consumables where kept, a number of boxes were stored on the floor which meant the floor could not be cleaned appropriately and there was a visible build-up of dust on the floor. We escalated this issue to the deputy sister and the registered manager. When we returned for the unannounced inspection a week later this was rectified.
- The service had a dedicated infection control lead and a named microbiological lead was provided by the InHealth group to support infection control prevention.
- Staff screened patients for transmittable diseases and referred them to more appropriate services.
- Staff had defined roles and responsibilities for areas of the patient pathway and for decontamination. Staff received additional training and were allocated to roles such as endoscopy care, recovery post procedure and equipment decontamination.
- We saw bedside cleaning take place immediately after the procedure. Linen was single use and disposed of after each patient.
- Endoscopes were cleaned immediately after use and in line with 'Health Technical Memorandum 01-06: Decontamination of flexible endoscopes'. Used endoscopes were passed from the procedure room to the decontamination room through hatches for initial cleaning, testing and decontamination.
- Staff used a system to track and trace equipment at each stage of the decontamination process. Printed information was produced and staff signed and dated the printout at the time of the decontamination of the piece of equipment.
- The drying cabinet was located outside the decontamination room. On the day of our inspection we observed that decontaminated equipment was transported from the drying cabinet in covered trays back into the decontamination 'dirty' area and through doors to the procedure room. We highlighted to the registered manager and the deputy sister the potential risk of equipment being contaminated.

Following our inspection, the registered manager notified us that they had immediately changed the flow within the decontamination room to ensure that the clean equipment was not returned to any 'dirty' area whilst en route to the procedure room. All decontaminated equipment was transported to the procedure room via the recovery room door. We observed this new process when we returned on the unannounced visit.

- Water quality sampling was carried out weekly. This measured the level of bacteria in the final rinse water and if levels were outside of acceptable parameters, the equipment would not be used. Tests we saw showed bacteria levels had been within acceptable ranges.
- Hand cleaning sinks in clinical areas had elbow taps and no overflow waste areas where bacteria could build up. Antibacterial solutions were readily available for appropriate hand cleansing.
- Sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.
- The service had a suitable Control of Substances Hazardous to Health (COSHH) policy and procedures for staff to follow. COSHH risk assessments were in place and up to date. However, we found cleaning products in the staff toilet in an unlocked cupboard which was not stored in line with COSHH legislation. We escalated this with registered manager and the issue was rectified immediately.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well. Any breakdowns were dealt with promptly.**
- The environment met the needs of patients attending the service. There was a one-way flow through the clinic from reception, waiting area, consultation, pre-procedure room, procedure room and recovery area. Toilets were available for patient/visitor use which were suitable for people who had limited mobility or were using a wheelchair.
- The admission room was adjacent to the waiting area and provided privacy for patients during assessments. The pre-procedure room was located away from the waiting area, equipped with changing and toilet facilities for patient use only. Patients were moved to the procedure room which was separate from public waiting areas.
- The recovery area consisted of two individual cubicles and patients were easily observed by nursing staff. A seated recovery area was available for patients to use, once they were deemed fit from the procedure. Drink making facilities were available.
- There were systems to ensure machines or equipment were repaired when required, which were timely. This ensured patients did not experience prolonged delays to their care and treatment due to equipment being out of use. Servicing and maintenance of premises and equipment was carried out through a planned preventative maintenance programme.
- There were processes in place to ensure equipment was serviced in accordance with the manufacturer's guidance. All the equipment we checked was within the service date.
- Equipment used for emergency resuscitation was available in the recovery area and was easily accessible to staff in the procedure rooms. Staff carried out resuscitation equipment checks each day. We reviewed the records for resuscitation equipment checks from January to March 2019, and these were fully completed.
- The recovery area was always staffed by trained nurses and patients were never left alone in this area.
- Waste was handled and disposed of in a way that kept people safe. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.
- There were a range of fire extinguishers, which were strategically placed. All fire extinguishers that we reviewed had been serviced.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.**

- A comprehensive risk assessment was carried out for patients referred to the service. This ensured patients were suitable to be cared for and treated in the community clinic environment.
- There were agreed referral criteria for patients attending for procedures, which had been agreed with commissioning stakeholders. Any patients whose health presented a risk, such as an unstable heart condition, patient weight over 220kg and patients living with dementia which could cause complicated consent processes, were referred back to the referring GP for ongoing care and alternative treatment.
- All patients were screened for risks of being positive to variant Creutzfeldt-Jakob Disease (CJD) at pre-assessment and directed back to the referring GP if required. This prevented any risk of cross infection from equipment.
- Other health conditions were assessed and plans put in place to support the patient. For example, when an appointment was arranged, staff asked questions about a patient's health. If patients were diabetic the appointment would be arranged for a morning to reduce the impact on control of their diabetes and length of time patients needed to be 'nil-by-mouth' in preparation for their procedure.
- Staff completed the World Health Organisation (WHO) checklist at the beginning and end of each procedure and all staff were involved in the process and read from the checklist to ensure no step was missed. The WHO checklist is an initiative designed to strengthen the processes for staff to recognise and address safety issues in relation to invasive procedures.
- Since January 2019, the service conducted a quarterly WHO checklist audit. We reviewed the audit results from January and April 2019. Both sets of audit results showed that the WHO checklist was completed fully.
- Staff used an early warning system for deteriorating patient condition. This involved measuring a patient's vital signs such as temperature, blood pressure, heart rate and consciousness which provided a numerical score. Patient's vital signs were monitored during their procedure. The score determined the actions staff should take in relation to a deteriorating patient, and guidance was available to support staff with this. Following their procedure, staff monitored their condition until they were well enough to be discharged.
- However, on the day of our inspection, staff were not recording patient respiration rate and body temperature. Therefore, the numerical scores for the early warning system were not being completed fully. This meant patients that were deteriorating might not be identified and escalated appropriately. We raised the issue with the registered manager and the deputy sister, who immediately introduced recording of the respiratory rate and monitoring patient's temperature. They also amended the care pathway documentation to introduce the monitoring of patient's temperature and respiratory rate. We saw this in action when we returned for the unannounced inspection a week later. The changes to the process had been shared with all staff through the daily huddle and we saw this evidenced in the daily huddle book.
- There were clear pathways and processes for staff with regards to people using the service who became unexpectedly unwell. If a patient required urgent treatment staff told us they would call 999 for an emergency transfer to the local hospital. There were two emergency transfers in the last 12 months prior to the inspection.
- Staff were able to support a patient whose condition deteriorated and basic life support was needed. All staff were trained in basic life support which was in line with InHealth training policy. In addition, registered nursing staff and clinicians were trained in immediate life support (ILS) which was in line with guidance from the Academy of Medical Royal Colleges – Safe Sedation Practice for Healthcare Procedures October 2013.
- The policy for providing conscious sedation (sedation where patients remain awake) was in line with national standards. Staff had been trained in assessing patient's suitability for receiving conscious sedation. Patients received information before their procedure regarding conscious sedation. Information included advice on not driving a vehicle and to remain with another adult for 24 hours after leaving the clinic.

- The clinic held equipment and medicines to manage any issues of patient oversensitivity to sedation and could reverse the effects if needed.
- Staff met each morning to assess risks for the clinic and patients for that day. These safety huddles included sharing information about health risks of patients attending for procedures and planned activities such as water testing. There was also a huddle at the end of the day to allow staff to raise any concerns about the procedures during the day.
- Staff had access to equipment to deal with an unexpected major haemorrhage during an endoscopy procedure. Although equipment for lower gastro intestinal bleeding was kept in different drawers and not in a dedicated emergency kit, staff knew where to find clips and iced water to control any bleeding. The deputy sister told us patients were carefully screened for any risk of bleeding and all the equipment needed to deal with a major haemorrhage was available but was not kept together.
- There was no major haemorrhage policy in place for staff to use. We raised this with the registered manager who told us that the 'Major Haemorrhage Policy' was in draft format and due to be ratified on the 26 April 2019.
- At the time of our inspection, the staff we spoke with knew what to do in the event of major haemorrhage. However, the written guidance for staff to deal with a major haemorrhage was limited to calling emergency services and did not include specific actions and where to find the clips and iced water. Therefore, there was a potential risk that staff who were unfamiliar with the environment may not be able to easily find the equipment. We discussed this with the registered manager and deputy sister. Following our inspection, the registered manager told us that they had reviewed their processes and provide more specific guidance for staff. When we returned for the unannounced inspection, a dedicated major haemorrhage tray was kept within the crash trolley for staff to use in the event of a major haemorrhage which also included a pathway for staff to use.
- The registered manager had escalated the policy not being ratified until 26 April 2019 to head office, we were told that the Major Haemorrhage Policy was being ratified by the 19 April. In the interim, a pathway had been documented for the staff to follow to manage a major haemorrhage. The information was shared with all staff through the daily huddle over the week and we saw this evidenced in the daily huddle book.
- Both the procedure room and recovery area did not have an emergency alarm cord in the event of emergency or patient collapse. Staff told us they would shout for help.
- Patients were provided with written information at discharge advising them of complications and when to seek further support. This was followed up by a call from clinic staff a few days after their procedure.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- Endoscopies were performed by endoscopists under a practising privilege arrangement. Practising privileges is a system which independent organisations use to allow a person to practice in their service. The organisation monitored the suitability of the practitioner annually, including their ongoing training, appraisals and competencies.
- Staffing numbers followed recommendations from the British Society of Gastroenterology. Weekly capacity meetings assessed appointments over the coming months and managers planned staffing levels and skill mix needed for each day they were operating.
- The service used a safe staffing calculator to ensure the correct mix of staff could be planned in relation to the size and type of lists that they ran. This ensured that the right amount of staff could be planned in advance as the numbers required per shift were not always the same.
- There were enough registered nurses to oversee the care and treatment of patients from initial assessment to discharge from the service. Two members of staff, including a registered nurse, were always present in the procedure room with the endoscopist and in the recovery area.

- Administration and health care support workers provided care to patients which was within their level of expertise.
- The service had one bank nurse which they called on if there was an unexpected shortage of staff. They were offered the same training as regular staff and competencies were monitored.
- The service reported a low level of sickness and low turnover rate of staff. Most staff had been with the service since it had moved to its new premises in 2017.
- There was a 0.5 whole time equivalent vacancy for nursing staff.
- The clinic manager position had been vacant for over two years. The registered manager told us that they had shared the role with the deputy sister. The post was successfully recruited into at the end of 2018 but due to personal circumstances the successful applicant couldn't take the position.
- Recruitment followed processes which were led by the InHealth group. The regional manager and service leads took part in the employment process. The corporate human resources department followed up with ensuring new recruits met the standards for the role including disclosure and barring system checks and agreed levels of qualifications and experience.

Medical staffing

- **The service had enough medical endoscopists on every shift, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**
- Endoscopies were performed by three medical endoscopists under a practising privilege arrangement. Practising privileges is a system which independent organisations use to allow a person to practice in their service. The organisation monitored the suitability of the practitioner annually, including their ongoing training, appraisals and competencies.
- The service had an in-date version controlled practising privileges policy which outlined the responsibilities that staff managing and working in the service should adhere to.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**
- Individual patient records were managed in a way that ensured staff had access to up-to-date and accurate information about patient needs.
- The service used paper and electronic patient records. An electronic patient record was generated at the point of the patient's booking appointment. Each patient was assessed by a registered nurse before their procedure and relevant health information was recorded on the electronic system. This system was password protected and could be viewed by all clinic staff which included medical history, medication and reason for the referral.
- At the end of each clinic all paper patient records were scanned to the electronic patient record and the paper records sent for secure archiving. Each patient was provided with a written report of their care and treatment before they left the clinic on the day of their procedure. GP summaries were sent electronically or if unable to do so they were sent by post. This included any samples sent for testing and when results would be expected.
- The service undertook audits of patient records each month to ensure scanned copies of records were held within the patient record. The electronic record consisted of mandatory fields that had to be completed by staff before they could move on.
- We reviewed five individual patient records and found them to be accurately and fully completed providing information on care provided and individual needs for the patient.
- Endoscopists used an electronic reporting system, which included providing GPs with patient reports as well as tracking and tracing purposes regarding decontamination.

Medicines

- **The service followed best practice when prescribing, recording and storing most medicines. Patients received the right medication, in the right dose at the right time.**

- Management and oversight of all aspects of medicines management was overseen at provider level by a multi-disciplinary 'Medicines Management Group', which met on a quarterly basis. Pharmacist support and guidance was provided by InHealth's Consultant pharmacy advisor.
- We reviewed the meeting minutes for the quarterly meeting and saw how safety alerts, adverse events and incidents were reviewed and action identified. The minutes also included patient group directives (PGD) updates, controlled drugs (CD) management and policy and document reviews.
- Controlled drugs (medicines controlled under the misuse of drugs legislation) were administered in line with national recommendations. They were within their use by dates and stored at appropriate temperatures. Single use medicines were disposed of after use.
- The service used a small number of controlled drugs and stored them safely. We saw all drugs in the controlled drug (CD) cupboard were in date, checked daily and signed for. The CD record book and order book were locked away when not in use.
- Patient group directives (PGD) are written instruction for the supply and/or administration of a named licensed medicine for a defined clinical condition. The use of PGDs allows a registered health care professional to administer a prescription-only medicine to a group of patients who fit the criteria without them necessarily seeing a prescriber.
- The service had a PGD folder which we reviewed. At the time of our inspection, the registered nurses had received the training and were waiting to be signed off by the Inhealth group pharmacist.
- However, on the day of our inspection the admission nurse was using a pre- signed sticker by the endoscopist for the administration of infacol, a prescription-only medicine. This was against best practice guidance and we escalated the issue to the deputy sister. Following our inspection, the registered manager responded by acknowledging that the practice was not correct and had stopped with immediate effect. All the pre-signed stickers were destroyed. The service introduced a process whereby the endoscopist would review the patient notes and sign for the medication prior to admission. This was an interim measure until staff were trained and signed off against the PGD competencies. When we returned for the unannounced inspection, we saw the interim process was in place and the registered manager told us that the PGD competencies were going to be signed off within two weeks.
- Oxygen cylinders were not stored safely. Six full oxygen cylinders were stored in the consumable store room. The cylinders were on the floor, not chained to the wall or in a designated crate as recommended by Health and Safety Executive, 2013. We escalated the issue with the registered manager who told us that work is under way to redesign the store room in order to accommodate designated crates for the oxygen cylinder. However at the time of the inspection, there was no date for when this work was going to be completed. Following the inspection an action plan was submitted by the service indicating that this work would be completed by 30 April 2019.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.**
- There was a process for staff to report incidents and near misses. This was set out in the Adverse Event (incident) reporting and Management Policy October 2017, which was provided by InHealth group and was within its review date.
- There were no never events reported for the service from November 2017 to November 2018. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- From November 2017 to November 2018, there were no serious incidents reported for the service. Serious incidents are adverse events, where the potential for learning is so great, or the consequences are so significant, that they warrant using additional resources to mount a comprehensive response.

- The service was working with commissioning bodies to develop a system to inform the service about any patients who were admitted to hospital following their endoscopic procedure and their outcome. Any admissions the service was made aware of were discussed at monthly unit meetings.
- There had been two patients transferred to the local NHS hospital prior to their procedure at the service from January 2018 and March 2019. We saw appropriate records and learning identified from these incidents and actions taken by the service. For example, following the first transfer of patient, it was identified that the ambulance service was unable to get a trolley or ambulance stretcher into the lift. As a result of this incident, the service took a number of actions including changing the process when calling 999 that information must be given to the call handler that the lift was not suitable for a stretcher or trolley. The service also replaced the emergency evacuation chair to one that was more appropriate to help evacuate patients that might be unconscious.
- There had been 33 incidents reported from November 2017 and November 2018. Records we reviewed showed these had been rated in terms of risk to safety and resolved. These incidents were subcategorised as; 12 booking issues, five clinical, 10 equipment, five health and safety, and one information governance.
- Incidents were reviewed weekly at the Complaints, Litigation, Incidents & Compliments (CLIC) meeting. The CLIC team analysed incidents and identified themes and shared learning to prevent reoccurrence at a local and organisational level.
- All incidents were reported electronically and reviewed by the registered manager. Staff told us that any information and learning related to incidents was cascaded down through the daily safety huddle, emails and the monthly complaints, litigation, incidents and compliments (CLIC) newsletter
- The service monitored any incidences when the duty of candour was implemented, of which there were none during the reporting period. Duty of candour is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014 that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- During the inspection, we spoke with four members of staff regarding duty of candour. All four staff members could tell us their understanding of the requirements of the duty of candour regulation. The registered manager could explain the process they would take if they needed to implement the duty of candour following an incident which met the requirements.

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

We currently do not rate the effective domain for independent endoscopy services.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- Staff followed National Institute for Health and Care Excellence (NICE) guidelines and quality standards of the British Society of Gastroenterology (BSG) for those patients who were diabetic or had clotting conditions and took blood thinning therapy.
- Patients were offered non-urgent gastroscopy 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).
- The service had received Joint Advisory Group (JAG) accreditation in 2014. JAG is a national organisation which assesses details of how endoscopy services are delivered and monitored. Endoscopy services provide evidence to JAG and once the required standards are achieved, receive an accreditation to practice.
- We saw how the service complied with JAG accreditation standards such as aftercare. The service provided information for patients on discharge about how and when to seek help if they felt unwell following the procedure, which was in line with JAG

clinical quality domain (QP6). This information included symptoms that may be experienced as well as information about symptoms that would require urgent medical assistance.

- The service contributed data to the audits carried out by JAG. This included inputting data electronically to the JAG database daily. There were standard activities endoscopists needed to undertake to provide assurance they were following best practice guidelines. These results were compared nationally and individual endoscopists could gain feedback from the audit to identify where they needed to improve. At the time of our visit, all results for endoscopists in the service had been above the national standards.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs.**
- Patients were advised before their appointment when they needed to stop eating and drinking to ensure the procedure could go ahead. Diabetic patients were given early appointments to reduce the amount of time they needed to be nil-by-mouth.
- There was tea, coffee, hot chocolate and fresh water freely available for patients and their relatives who accompanied them to their appointment.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain.**
- Staff assessed patient's pain using a number score between one and ten, with ten being the most pain. Staff described how they observed patient's facial expressions and body language to recognise when a patient was experiencing discomfort. We saw patients being asked about their pain or discomfort throughout the procedure and staff provided patients with pain relief when necessary. Nasal spray was used to numb the nose and throat before Oesophagogastroduodenoscopy (OGD) procedures which reduced the gag reflex making the procedure more comfortable for the patient.
- Annual patient survey results from June 2018 indicated comfort levels patients had experienced. Of 87 responses eight had experienced severe pain, 16 moderate pain, 40 mild pain and 23 patients experienced no pain.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.**
- As the service had achieved Joint Advisory Group (JAG) accreditation in 2014, endoscopy outcomes / key performance indictors and individual endoscopist's outcomes were audited on a quarterly basis using the Global Rating Scale (GRS) as identified by JAG. The principal purpose of GRS was to improve the quality of patient care across a range of measures based on clinical quality and patient experience.
- The clinical lead, and individual endoscopists had access to real time outcome data using the recently developed National Endoscopy Database (NED). This could be downloaded daily for individual endoscopists.
- All endoscopists were performing above the expected standard. For example, the caecal completion rate was 96% (against a target of 95%), polyp detection rate was 31% (against a target of 15%), and polyp recovery rate was 100% (against a target of 90%). Results were reviewed by clinical leads who provided clinical support to endoscopists if results fell below national benchmarks.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance.**
- Staff had the right skills and knowledge to assess patient needs and provide care for patients undergoing endoscopy procedures at the clinic.
- Staff received annual appraisals, had learning needs identified and were supported to revalidate their professional registration when required.
- At the time of inspection, 100% of staff had received an appraisal.

- Managers monitored attendance at training and ensured staff were up to date with the competencies they needed to complete.
- All new staff received an induction, were allocated a mentor and attended training in skills required to care for patients undergoing endoscopy procedures. Staff attended training in their area of work such as decontamination, administration nursing and endoscopy.
- The service used agency staff in the event of staff shortage. Agency staff were required to complete an induction checklist, which included orientation to the unit, patient flow, staff facilities, resuscitation and emergency equipment, fire exits, meeting point, location of extinguishers, and introduction to the staff on duty that day. They would join the daily safety huddle, would be assigned to a supervisor on the day and allocated to a specific area.
- Staff received training in the decontamination of endoscopes (END21) and procedures within the decontamination room. At the time of our inspection, 10 out of 11 staff had completed this training. We were told agency staff did not work in the decontamination room.
- Endoscopists working under practising privileges had their performance monitored and number of procedures performed over a year to ensure they had enough experience to continue practising effectively. They worked across other clinics within the InHealth group of endoscopy services. The clinical lead and medical director reviewed training compliance and performance before renewing practising privileges.
- There was a corporate practising privileges policy, which was in date and version controlled. The corporate clinical quality maintained the records of all endoscopists and this included references, and disclosure and barring checks (DBS).

Multidisciplinary working

- **All staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.**
- The service had a contract with a local pathology laboratory for processing all their samples taken during endoscopy procedures. Test results were returned to the service within a maximum of five weeks but usually within two to three weeks. Results were sent to individual endoscopists to review the test results and then sent to the patients GP and the patient to inform them of the findings. If there were any concerns identified then a referral was made to the patient's local NHS trust for ongoing discussion and treatment.
- We reviewed five sets of records and saw communication from GPs to the service which included referrals and past medical history. Once a procedure had been completed then the discharge letter was sent electronically to the GP surgery.
- The service audited 10 patients per endoscopist twice a year to ensure results were received and then sent on within a specific time frame. We reviewed audits from October 2017 to April 2018 results and found all 10 patients had had their results either onward referred or closed within a five-day period.

Seven-day services

- The service generally operated a flexible four days per week Monday to Friday between 8am and 6pm and did not operate at weekends. There was no on-call service at weekends and patients were advised on actions to take if there were any concerns.
- The registered manager told us that regular discussions were held with the local commissioning groups to monitor contracts and waiting list.

Health promotion

- Endoscopists and nursing staff provided information for patients on life style choices which might relieve their symptoms when it was appropriate. We saw this was provided in written format for patients to take home to read.

Consent and Mental Capacity Act

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.**
- Staff understood their roles and responsibilities under and the Mental Capacity Act 2005 and could explain

the importance of informed consent. Nursing staff had received training on obtaining consent from patients. At the time of our inspection, 100% of nurses had completed this training.

- Information and consent forms were sent through the post before the procedure, which was a practical way of ensuring that patients had enough time to read and consider the required information. This was outlined in the General Medical Council's document 'Consent guidance: legal framework' and BSG's 'Guidance for obtaining valid consent for elective endoscopic procedures'.
- The information sent to the patient included details of how data from their procedure would be used and stored nationally and how they could withdraw consent for this. The information was discussed again with the admitting nurse when they attended the clinic for their procedure. The endoscopist checked consent was given by the patient when they were in the procedure room. This also gave the patient time to withdraw consent at any stage.
- We observed staff explaining procedures using simple language and diagrams to inform patients what they could expect to happen and any risks of the procedure. Explanations were provided at each stage of the procedure and time was given for patients to ask questions.
- We reviewed five sets of patient records and saw all consent had been fully signed and completed.
- The annual patient satisfaction survey from June 2018 demonstrated 100% (89) of patients said that they were informed of the risks and complications associated with their procedure. The survey also asked to rate the amount of information given to them by the admitting nurse and 93% (81) said it was very good, 5% (4) said it was good or 2% (2) satisfactory.
- Staff received training on obtaining consent from patients. At the time of our inspection, 92% (12/13) of staff had completed this training.
- The referral documentation requested information from the GP about the patient's ability to consent to procedures. Staff told us that if there were any issues regarding a patient's capacity to consent then the decision would be made by the GP at referral. If, for some reason, a patient attended the unit without having capacity then staff told us they would refer the patient back to the GP. Staff told us this had never happened.

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. We saw staff caring for patients with compassion. Staff introduced themselves to patients and asked how the patient would like to be addressed by staff during their stay and documented this on the patient record for colleagues to be aware. All interactions we saw were kind and caring to patients and colleagues. The patient experience was a high priority for all staff and discussed at team and unit meetings.
- This service gathered patient feedback in a variety of ways. We observed patients were given feedback comment cards in recovery prior to discharge. The annual patient survey results for June 2018 showed that 72% of patients found the service to be excellent, 24% very good and 4% found it to be good.
- Reception staff greeted patients as they entered the clinic and checked personal identity without being overheard by other patients or visitors. Identity bands were provided at this stage and patients were asked to check the details were correctly documented.
- Patients were provided with private space to discuss their condition with nursing and endoscopy staff before their procedure. The clinical area was inaccessible to the public and there was space for patients to change in private and have access to private toilet facilities.

- Dignity shorts were provided for patients undergoing lower gastro-intestinal procedures. Baskets were provided to hold personal belongings, which stayed with the patient during their time at the clinic.
- During the procedure, we observed how care was provided with sensitivity. Staff monitored the patient and made sure they understood any explanations as well as monitoring their comfort at each stage of the procedure.
- The recovery area, which was segregated into cubicles allowed privacy but was still easily observed, staff continued monitoring the patient with care and compassion.
- Patient survey results for June 2018 showed that 84 out of 85 (99%) of patients felt their privacy and dignity was respected during the procedure and in recovery.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff understood the impact the procedures and potential diagnosis could have on patients. There was a non-clinical room which was accessible from both the clinical area and the waiting room. This room was used to provide private space to discuss results and suspected cancer diagnoses. The process for suspected cancer diagnoses was to refer patients to specialist cancer nurses at the local NHS trust and this was explained to patients and their relatives.
- Patients we spoke with told us that 'everyone was so lovely' and 'helped reduce their anxiety during the procedure'. We saw a patient who was so anxious when they arrived at the clinic. By the time they went through the admission process, into the procedure and finally in the recovery cubical they felt so relieved and relaxed and asked to speak with the inspection team. They said, 'staff were supportive and helpful throughout the process and put me at ease'.
- Time was given to patients and they were not rushed through any part of the process. Staff discussed what patients needed to do when they left the clinic depending upon their procedure and provided written leaflets for patients to take home.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Staff communicated with patients in a way they could understand. We observed staff describing procedures in plain language. Patients were offered the opportunity to view their procedure on a screen but there was no pressure to do this and the patient decision was respected.
- Endoscopists ensured patients were able to understand the outcomes of their procedure and provided feedback about findings directly after the procedure.
- The service provided follow up phone calls to patients after procedures and answered any further queries.
- The service actively sought patient feedback and this were reviewed by staff. Annual patient surveys were undertaken and included how patients felt they were treated, information they received and discomfort they experienced. Some comments from this feedback included "during the uncomfortable procedure the nurse was very encouraging and informative. Made it much more bearable", "very caring and re-assuring and answer any questions".
- Comments and survey results were discussed at team and unit meetings. Negative comments were also highlighted to identify where processes could be changed to improve the patient experience.
- Clinic staff actively encouraged patients to complete the NHS Friends and Family survey by providing patient feedback forms before they left the service. Patients could return forms in a number of ways. They could return them to staff, place in a box within the clinic or feedback on the internet after leaving the clinic. Results for January, February and March 2019 showed 100% of patients who responded were 'extremely likely' or 'likely' to recommend the service to their friends and family if they needed endoscopic treatment.

Are diagnostic imaging and endoscopy services responsive to people's needs?

Good

Endoscopy

(for example, to feedback?)

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- **The service was planned and provided in a way that met the needs of local people. The service worked under a contract with the local clinical commissioning group.**
- There were agreed referral criteria for patients attending for procedures, which had been agreed with commissioning stakeholders.
- To meet contractual requirements the service was expected to meet key performance indicators (KPIs).
- The majority of patient feedback was positive and managers believed more patients could benefit from their services and the shorter waiting times they could offer. To support this belief, service managers were contacting local NHS hospitals and GP surgeries to ensure they were aware of the choice available.
- Patients were greeted when they entered the service and accessed a comfortable waiting area, there were toilet facilities available for people to use.
- There was adequate seating areas within the service, it was well lit and patients and visitors had access to free refreshments.
- A lift was available to facilitate ease of access to patients with additional mobility needs. The service and all areas within the service were accessible to wheelchair users.
- The service was accessible to all patients. The service was within a short distance of public transport. There was ample car parking facilities for patients to use, with designated disabled parking.

Meeting people's individual needs

- **The service took account of individual patients' individual needs.**
- The service had referral criteria which advised referrers of health conditions that would not be suitable for treatment at the clinic. This was to ensure patient safety was maintained. Patients needed to be mobile enough to transfer to a trolley for their procedure without the need for lifting and to have stable health conditions.
- Some adjustments were made so that patients with a disability could access the clinic. The admission criteria identified that patients needed to have enough mobility to transfer to the procedure trolley. Patient areas in the clinic had wide doorways which allowed wheelchair access to all areas. There was a lift for patients to attend the clinic which was located on the first floor.
- The service's website gave people useful information about the service it provided, its other clinic sites and the referral processes. There was also patient advice sheets in English, Arabic, Hindi and pre-procedure advice sheets in easy read. Easy read is an accessible format of providing information designed for people with a learning disability.
- The service could provide information to patients in large print or braille information, and could also access an interpreter service.
- The registered manager told us that information in other languages were in the process of being produced to support patients in the local community whose first language was not English.
- Staff could contact translation services for patient's whose first language was not English.
- Information was provided on discharge. Leaflets provided for patients contained links to other sources of support if patients felt they needed further support.
- Patients received clear instructions before their appointment. This included information about how long they should remain nil by mouth prior to their procedure and specific information about taking medicines for diabetes and patients on anticoagulants (blood thinning medicines). This was written in simple language for all patients to understand.
- For those patients who were diabetic, they were offered the first appointment in the morning, to reduce any impact fasting may have on their blood sugar control.

- Patients were assessed by registered nurses before their procedures and time was allowed for patients to ask questions. Patients with communication difficulties were identified at the point of booking and additional time was allowed for the appointment to accommodate the additional support needed.
- Patients were provided with verbal and written information about their procedure before they left the clinic and when they would expect to receive the results of any tests undertaken. In the June 2018 patient survey, all respondents said that they had received explanations and a written information. The majority of the respondents (92%) were clear about how they would get their results.

Access and flow

- **People could access the service when they needed it.**
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Weekly capacity and demand meetings allowed staff to review demand on the service. The service aimed to see all patients within six weeks of referral. Bookings could be prioritised on account of clinical need.
- The service had a system of seeing patients in order of date referred and could override the system if there was clinical urgency.
- Service managers reviewed attendance rates and trends in demands for the service. There had been an increase from 622 GP referrals from January to March 2018 to 824 referrals for from January to March 2019.
- At the time of our inspection, 100% of patients were seen within 14 days of initial referral.
- Referral pathways had been agreed with commissioners. All referrals were assessed by a clinician to provide assurance that they were in line with agreed criteria. Onward referrals were made in accordance with agreed protocols and were generally suspected cancers.
- Procedures cancelled by the service were monitored. From November 2017 to November 2018, there had been seven procedures cancelled due to non-clinical reasons. Five of these were due to a machine breakdown or equipment failure.
- Patients were seen as close to their appointment times as possible. Waiting times in the clinic could vary due to some procedures taking longer than anticipated. This information was communicated to patients at their assessment and using a white board in the waiting area which was updated by staff.
- The annual patient survey captured if patients had a delay in their procedure and if they were informed of the reason. The results from the June 2018 survey showed that 31% (30 out of 96) responded they had a delay, 65% (62 out of 96) responded there was no delay and 4% did not know if there was a delay. The survey also asked if they were given a reason for the delay in procedure and 34% (23 out of 67) responded yes, 7% (5 out of 67) responded no and the remaining 58% (39 out of67) responded as not applicable.
- To prevent patients not attending appointments, they received text messages as a reminder of their appointment. Patients who did not attend for appointments without informing the service varied from four to eight patients a month for the period from January 2019 to March 2019. There was no pattern identified and clinic staff managed the patients who did not attend by informing their GP of their non-attendance and advised the GP to re-refer should the patient wish to rebook for the procedure.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- From November 2017 to November 2018, the service had received 420 compliments and three complaints.
- We reviewed the three complaints received and two of these had been partially upheld. Learning was shared at team meetings, daily huddles and quality meetings.
- There were processes to ensure patients and their relatives could make a complaint or raise a concerned if required. There were leaflets and posters on display in the waiting area.

- The complaints we reviewed followed the InHealth group complaints process/policy. This provided guidance for staff of how to resolve concerns raised by patients and the process for handling a formal complaint.
- The registered manager also reviewed and responded to comments made by patients which were not formal complaints. These were responded to by contacting the patient to apologise and discuss their experience. All outcomes were discussed at unit meetings to share learning points.

Are diagnostic imaging and endoscopy services well-led?

Good

We rated well-led as **good.**

Leadership

- **Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care.**
- There was local leadership at the service who received leadership, management, governance and support from the InHealth group.
- The unit manager role has been vacant for two years. During this period the service has been managed by a non-clinical regional operations manager who was the registered manager for the service. The registered manager was supported by the deputy sister in the service for the day to day clinical operations of the service.
- The service had a clinical lead who was a GP endoscopist. The clinical lead was supported by the InHealth endoscopy medical director and was responsible for ensuring safe and effective care through the provision of professional leadership and clinical oversight to all endoscopists within the unit.
- The service did not have a dedicated clinical nurse leadership, except the deputy sister. Whilst this was not in line with the JAG GRS which identified that the leadership team should include nursing managerial roles
- The regional operations manager told us that the vacant unit manager role was being reviewed and various options were being explored to recruit into the post.
- The regional manager and deputy sister were aware of challenges to quality and sustainability of the service they provide without a dedicated unit manager. However, the regional manager had dedicated one-day a week to do purely managerial work. During the inspection we saw the regional manager and deputy sister worked well together and had processes in place to review and manage the challenges they faced.
- The regional manager reported to the InHealth group at monthly performance meetings and attended the clinic at least weekly. Meetings at the clinic were held to forward plan their activity. This included ensuring suitable staff were available to cope with demand.
- During capacity and demand meetings the leaders were able to share information from other locations about workloads for other clinics and staff availability. Team meetings were held to update staff and gather their views.
- Staff told us leaders were visible and approachable to all staff in the service. Staff knew who their line managers were and said they felt they could approach any of the service leadership team for support if they needed it.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff.**
- The service had a clear statement of purpose to provide safe, effective and timely community endoscopy services for adults. Quality and sustainability were the service's top priorities.
- There was a business plan for 2018 – 2020, which set out how they planned to sustain the quality of the service, expand service provision and use effective procedures. They worked closely with commissioners to streamline referral systems and were in the process of discussion of offering new services.

- InHealth had a corporate Clinical Quality Strategy up to 2020 which set out the mission and key priorities. The strategy was aligned to local plans with the needs of the relevant population.
- Staff we spoke with were aware of the service strategy and plan.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Although there has not been a unit manager for two years, staff told us they felt supported by the regional manager and deputy sister, this was reflected in the culture and communications we observed.
- Managers encouraged a culture of openness and engagement and we saw minutes of team meetings, which included staff comments and how managers had dealt with their comments.
- We observed staff interactions that were respectful and inclusive between all levels of staff. There was a freedom to speak up guardian assigned to the service. This was provided by named staff in the InHealth group. A freedom to speak up guardian is a requirement for organisations which provide NHS funded care and should provide an avenue for staff to raise concerns if they are uncomfortable to do so with their manager. Staff were aware of this role, but stated they could raise any concerns without fear of retribution even if concerns were about more senior staff and were confident appropriate action would be taken.
- A system of staff appraisal was followed and updated appropriately with training needs identified. Staff were trained in each area of the clinic which allowed them to support each other. We saw staff working together and communicating the needs of the patients to provide a smooth pathway for the patient. All staff we spoke with were focussed on the needs of the patient and improving the experience for them.

Governance

- The service systematically improved service quality and safeguarded high standards of care by creating an environment for good clinical care to flourish.
- There was a defined structure to support delivery of the service. There was a clear framework/policy at corporate level which identified what information should be collected, reported and shared to all areas.
- Information was gathered and discussed at the monthly clinical governance meeting which was presented to the executive teams at corporate level. This report included an overview of the whole of the InHealth services, and included clinical performance monitoring, incidents by modality, risks and friends and family feedback.
- Relevant information at location level was discussed at the bi annual governance meetings (Quality Circle meetings) which engaged all staff in the unit. We reviewed minutes from these meetings which included actions from previous meetings and a standardised agenda including reviews of guidelines and patient information, Global Rating System (GRS) reviews and audits, adverse event and complaints.
- The unit staff also met monthly and reported on decontamination, nursing and administrative issues, complaints and performance and patient survey feedback.
- Managers had oversight of service performance using the InHealth audit processes. We saw a comprehensive annual audit schedule which included infection control, controlled drugs, peripheral intravenous cannula care, and decontamination audits. This also included annual reports of Global Rating System and BSG safety outcomes.
- The manager monitored training compliance and appraisals and encouraged staff to complete these within the required timeframe.
- Staff had specific responsibilities and knew what they were. There was a decontamination lead, infection control lead and health and safety lead. Any issues regarding these subjects were discussed with the individual leads.
- The service followed policies which were provided by InHealth group who reviewed them at agreed dates. Policies we saw were within their review dates.

- Endoscopists contributed to the global rating scale (GRS) for the Joint Advisory Group for Gastroenterology. The medical clinical lead reviewed these results and raised issues if they were outside of what was considered to be normal parameters. Audits were also undertaken on how long endoscopists took to provide final reports. These were reports produced once the histology results had been received.
- Processes to ensure endoscopists holding practising privileges had appropriate professional indemnity insurance was undertaken by InHealth Group corporate services. They would liaise with the service if there was a problem and endoscopists would not be given lists until it was resolved.

Managing risks, issues and performance

- **The service had systems to identify risks, which included plans to eliminate or reduce them and cope with both the expected and unexpected.**
- Risks were identified and in most cases mitigating actions developed to manage them. For example, the risk of not storing oxygen gases cylinders was identified in November 2018. However, at the time of our inspection in April 2019, the issue was still not resolved. The bracket was broken and oxygen cylinders were not stored securely which could result in cylinders being knocked over. Therefore, we were not fully assured that this risk mitigation was acted upon and risks rectified in a timely manner.
- Risks placed on the local risk register were scored for level of risk and actions taken to reduce the risk were documented. They were assessed for how often they should be reviewed and were updated accordingly. Items on the risk register were consistent with what managers had raised as issues for the service. Risks and performance were standing items at the monthly user group meetings and we saw notes of the discussions.
- The service had a comprehensive risk register, which included business specific risk, health and safety and environmental risks. Staff were confident to report any risks and the registered manager monitored and fed back on actions needed. Risks which were felt to be significant to the wider organisation were fed into the InHealth risk register.
- InHealth had a business continuity plan which covered actions to take in the event of technical and IT failures and issues with decontamination services and staffing.

Managing information

- **The service collected, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- Records were scanned and stored electronically, in line with British Society of gastroenterology and Joint Advisory Group (JAG) accreditation standards. Electronic records were created at receipt of referral. Once the procedure was completed and all reports and clinical records loaded into the electronic system, an email was automatically generated to the patient's GP with a copy of the report.
- 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 relevant healthcare providers.
- Staff received training on the local electronic records system and information governance. At the time of our inspection all staff had completed their training.

Engagement

- **The service engaged well with patients to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- Patient feedback was gathered in a variety of ways. We observed how patients were given feedback comment cards in recovery prior to discharge, which included a free text area and the NHS Friends and Family Test.
- Information was also gathered during the annual endoscopy patient survey which included questions mandated by JAG on pain score and other areas relevant to an endoscopy service. The information was then sent for collation and analysis by an external company and results communicated via the intranet.
- We reviewed patient satisfaction survey results for July 2018. In total, the service received 100 responses.

Feedback was mostly positive and included comments such as “found them to be very efficient and helpful”, “were very kind as I was so nervous” and “very organised”.

- Negative and positive comments were reported by the patient survey. Whilst the negative comments were not treated as official complaints, they were still investigated and actions taken when necessary.
- Friends and family feedback, complaints and compliments were discussed with commissioners during monitoring meetings. Complaints were analysed and responses documented in the meeting minutes.
- The patient satisfaction survey results were included in the monthly clinical governance report. Included in the report were how many returns were received.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.**
- Managers of the service explored how they could extend their service. The service was in early discussion with the commissionaires and local NHS trust, looking into the possibility of offering services to reduce the waiting time of routine endoscopy procedures at the local NHS trust.
- Managers encouraged staff to produce learning tools for their colleagues. These were placed on a notice board for all staff to access. The subject matter was refreshed every couple of months and focussed on a variety of subjects such as infection control prevention.

  Administration staff produced and updated an information pack on all administration tasks to maintain a well organised clinic. We saw this being used on the day of inspection as the administrative staff was off sick and the regional manager had to step in and run the front office.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider arrangements for storing all oxygen cylinders safely to prevent their risk of falling.