The Functional Gut Clinic

Inspection report

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

Ratings

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

Overall summary

This service is rated as Good **overall.**

The key questions are rated as:

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

We carried out an announced comprehensive inspection at The Functional Gut Clinic as part of our inspection programme. This was the first inspection of this independent health service.

The Functional Gut Clinic is an independent service which provides advanced diagnostic and screening procedures, consultations, examination and treatments in alimentary (relating to nutrition) and gastrointestinal (relating to the stomach and intestine) medicine for clients aged 18 and over. The service is provided by clinical scientists, clinical physiologists and trainee physiologists. (A physiologist is a clinician trained to a master's degree level in physiology, anatomy, biochemistry and disease management.) The provider also participates in approved research projects.

This service is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008 for the registered activities, Diagnostic and screening, and Treatment of disease, disorder or injury.

The service manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Seven people provided feedback about the service and all were very positive. Staff were described as professional, caring and knowledgeable and people said they listened and gave good, clear advice.

Our key findings were :

- The service had systems in place to keep people safe and safeguarded from abuse. There were clear guidelines for staff for recognising and reporting safeguarding concerns.
- There were comprehensive recruitment procedures in place to ensure staff were suitable for their role.
- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- Services were organised and delivered to meet patients' needs; patients were supported to live healthier lives. Staff treated patients professionally with respect and understanding.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Staff were encouraged and given opportunities to develop.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- There was evidence of ongoing quality improvement across various areas such as internal key performance indicator monitoring, adherence to regulatory and best practice standards and quality audits.
- Continuous learning and improvement were central to the organisation. Patient needs were used to inform service development and were fundamental to the organisation aims and values.

We saw the following outstanding practice:

- The service had developed home breath test kits for patients to enable them to carry out self-testing at home instead of needing to attend the clinic for a considerable amount of time.

Overall summary

- The provider continually reviewed new evidence related to the care of patients. As part of this, the service worked with referring clinicians and introduced a new programme of testing and consultant prescribing to allow people who would have previously been declined for surgery to have the chance to have the right operation to help their long-term symptoms.

The areas where the provider **should** make improvements are:

- Review the threshold for reporting incidents as significant events to better share learning.
- Review safeguarding contact details in policies to include links to safeguarding teams outside the local area.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser.

Background to The Functional Gut Clinic

The Functional Gut Clinic is situated in central Manchester on the 9th Floor of The Pinnacle, 73 - 79 King Street, Manchester, M2 4NG. The service uses advanced diagnostic and screening procedures to identify and treat alimentary and gastrointestinal problems for approximately 200 adult patients each year who are referred privately.

The team consists of clinical scientists, clinical physiologists and trainee physiologists. A senior clinical scientist (also the service nominated individual), a further clinical scientist, two clinical physiologists, two trainee clinical physiologists and the service manager who is the CQC registered manager are supported by two medical receptionists.

Patients using the clinic are referred by specialist consultants and are directed to a specific diagnostic pathway, with an online or face-to-face consultation with the most appropriate clinician/specialist. The service provides personalised, targeted testing services to patients who are then referred back to the consultant. Pathways of care are described as:

- The digestive health pathway – for those people experiencing gastrointestinal symptoms affecting sports or exercise training.
- The acid reflux pathway – for those experiencing acid reflux during exercise or training.
- The pelvic floor pathway – for people with pelvic floor problems causing gastrointestinal symptoms affecting exercise or training.
- The fitness and wellbeing pathway – for those people who may not experience any gut problems but fail to reach sports or fitness goals.

The clinic in Manchester opened in September 2017 and is the sister clinic to another in central London which is separately registered with CQC and so was not part of this inspection. However, there is integration between the two clinics in all areas of service management and delivery.

There are two clinic rooms available, one currently unused, offering testing services five days a week 8.30am – 5.30pm. On referral, staff contact patients to book appointments and complete any necessary registration forms.

The provider also participates in research projects associated with alimentary and gastrointestinal diagnostics and treatment.

How we inspected this service

Before our inspection we reviewed a range of information about the service, this included patient feedback from the public domain, information from the provider's website and the provider's CQC information return. During our visit we:

- Looked at the systems in place for the running of the service
- Explored how clinical decisions were made
- Viewed a sample of key policies and procedures
- Spoke with a range of staff
- Looked at a random selection of anonymised patient reports
- Made observations of the environment and infection control measures
- Reviewed patient feedback including CQC comment cards

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?

- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Good

Are services safe?

We rated safe as Good because:

The service had systems to keep people safe and safeguarded from abuse. The service had a good safety record and there were systems to assess, monitor and manage risks to patient safety. The service learned when things went wrong and took steps to prevent incidents from reoccurring. Staff had the information they needed to deliver safe care and treatment to patients.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training and were required to sign to indicate they had received and understood it.
- The service had processes and systems in place to keep patients safe and there were systems to safeguard children and vulnerable adults from abuse, although the service did not see any patients under 18 years of age. We saw safeguarding policies in place which outlined who to contact for further guidance in the local area, for instance if staff had concerns about a patient's welfare. Staff we spoke with confirmed this. Only safeguarding contact details were included in service documentation for the Manchester area. However, patients could attend from outside the local area and other safeguarding services were not included.
- All staff were required to undergo annual safeguarding training and we saw that the service effectively monitored this to ensure all staff were up to date with their training. Clinical scientists were trained in safeguarding children and adults at level three and all other staff were trained at level two.
- Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. All staff had trained as part of their induction and annually in equality and diversity. Staff we spoke with were aware of these responsibilities.
- The provider carried out comprehensive staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken for all staff including for those who acted as chaperones; chaperones had also been trained for this role. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). DBS checks for all staff were renewed every two years as part of the service policy. Recruitment systems were routinely monitored in areas such as registration with the appropriate professional bodies and there was an overall service indemnity arrangement in place.
- There was an effective system to manage infection prevention and control (IPC). We observed the premises to be visibly clean and tidy and we saw cleaning specifications were in place. Records were kept to evidence medical equipment was frequently cleaned. Systems were in place to ensure clinical waste was appropriately disposed of and staff had access to personal protective equipment including disposable gloves, aprons and coverings. The senior clinical scientist was the IPC lead and staff received infection control training. There was an IPC protocol in place and we saw records of completed IPC and cleaning audits. An overall IPC audit was conducted annually by an external company and clinical staff peer reviewed staff handwashing techniques.
- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them. We saw assessments for all aspects of health and safety. There was a health and safety policy in place and all staff were trained in aspects of health and safety. Staff had to sign to confirm they had read and understood the service risk assessments.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. We saw calibration records to ensure clinical equipment was checked and working. We saw fire risk was formally assessed, fire drills and weekly fire alarm testing were recorded, and staff had received fire training. There were delegated fire marshals. We saw formal risk assessments in place for the control of substances hazardous to health and for the risk of legionella. (Legionella is a term for particular bacteria which can contaminate water systems in buildings.) The building was newly refurbished, and all safety certificates were in place, for example for fixed electrical wiring.

Good

Are services safe?

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed; staff had designated days of work. This ensured that enough staff were on duty to meet demand. Staff sickness and absence was well-managed with cover from within the service. There were also reciprocal arrangements for staff from the sister clinic in London to work in Manchester if necessary and online support could be provided when needed.
- Managers told us they had not used locum staff at all at the clinic since it opened in September 2017.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis; staff had trained in the management of sepsis and there were flowcharts displayed in treatment rooms.
- There was a defibrillator to deal with medical emergencies which was stored appropriately and checked regularly. The service did not carry emergency medicines or oxygen to deal with medical emergencies and this had been discussed with a CQC specialist medical advisor and an external gastrointestinal surgeon and a risk assessment documented. Risks had been addressed comprehensively; changes had been made to the patient registration form to expand medical information from referrers and a best practice protocol for diabetic patients was adopted. If a patient was not medically suitable to attend the clinic, an alternative hospital-based venue could be used. Staff told us they would call 999 immediately in the event of any emergency. Staff received annual basic life support training and two clinical staff had trained as first-aiders.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place to cover all potential liabilities. A business continuity plan was in place for major incidents such as power failure or building damage. The plan had been tested previously when there was a lift failure and staff told us how this had been managed successfully.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The information needed to plan and deliver care and treatment was available to staff in a timely and accessible way through the service's patient record system and their intranet system. This included patient information such as allergies, health history and investigation and test results.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There were policies in place to protect the storage and use of all patient information. IT systems were password protected and encrypted. Information from paper records was transferred to online systems within 24 hours and then destroyed confidentially.
- The service had an effective mechanism in place to disseminate patient safety alerts to all relevant members of the team. Safety alerts were disseminated by the senior clinical scientist, discussed at meetings when relevant and published on the intranet for clinicians. Action taken as a result of alerts was discussed and documented at team meetings.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. There was an audit system in place to check all referrals had been made in a timely way. Full consent was sought from patients before referrals were made.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The only medicine held on site was Lidocaine nasal spray, a tissue-numbing medicine used prior to a minor non-invasive procedure. We saw stocks of these medicines were held securely and checked appropriately. A patient group direction (PGD) was used to authorise clinical staff to use it appropriately. There was no prescribing carried out at this location.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.

Good

Are services safe?

- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. Service achievements against performance indicators were monitored regularly and published on the intranet. Indicators were aligned to organisation strategic objectives and reflected both clinical and operational delivery. This allowed the service to carry out quality reviews and audits to aid improvement.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. They told us leaders and managers would support them if they did so. The clinic had had no significant events recorded since it opened in September 2017. The clinical governance lead was a secondary care consultant and the service was under the impression that a significant events log should include only those that meet the GMC standard. However, staff told us of events that had happened at the clinic that had led to service improvements that had not been documented as significant events. We saw evidence incidents had been discussed at meetings and action taken to address them and this had been shared with all staff. For example, some patients had attended the clinic accompanied by children under 18 years of age which was against the service policy. The letter to new patients was changed to clearly state this was not allowed and all staff were reminded to ask for proof of age if they were uncertain.
- There were comprehensive systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. For example, we were told of an incident when a person visiting the clinic had experienced panic symptoms as a result of travelling in the lift. Staff were trained in how to deal appropriately with this in case it happened again.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.
- When there were unexpected or unintended safety incidents the provider policy allowed for the service to give affected people reasonable support, truthful information and a verbal and written apology.

Good

Are services effective?

We rated effective as Good because:

Clinicians delivered care in line with best practice guidelines. They had the necessary skills and qualifications to do this and the performance of the service was constantly monitored to aid improvement. Staff training and development was recognised as being integral to the service. The service supported patients to live healthier lives.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service).

- The provider assessed needs and delivered care in line with relevant and current evidence- based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines and the British Society of Gastroenterology (BSG) best practice guidelines. The senior clinical scientist was involved in producing guidelines and pathways with the Association of Gastrointestinal Physiologists (AGIP). There were relevant clinical protocols and standard operating procedures which were stored on the shared online system.
- The provider had specialised in offering advanced diagnostic and screening procedures in alimentary (relating to nutrition) and gastrointestinal (relating to the stomach and intestine) healthcare. The service expected to see about 200 patients during 2019, more than double the number for 2018. All these patients were referred privately by consultants.
- The clinic only offered diagnostic services. Patients' assessments were tailored according to each patient and included their clinical needs and their mental and physical wellbeing. The service carried out advanced medical investigations, analysed the results and developed a diagnostic report which was sent back to the consultant for further treatment options. Patients were also given a copy of the report.
- There was an option for patients undertaking breath tests to carry them out in their own home if that was preferred. The service had developed a system to send out complete kits for these tests by post that could be delivered easily through standard post boxes. Patients could then return the completed tests to the service through the normal postal system. This avoided the need to attend the clinic for a period of approximately two hours. A clinician from the service had carried out the process in their own home first to assure themselves the process would work well for patients; this had been recorded as an online patient information video and patients were directed to this.
- We saw no evidence of discrimination when making care and treatment decisions.
- We reviewed examples of medical records which demonstrated that patients' needs were fully assessed, and they received care and treatment supported by clear clinical pathways and protocols.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- Achievement against service performance indicators was recorded on the service intranet and in paper form, for example, referrals actioned within agreed timescales. This provided a mechanism to monitor performance against standards. We saw minutes of meetings that confirmed achievement was discussed and areas for improvement indicated.
- There was a comprehensive quality improvement programme in place and we saw examples of audits which were used to drive service improvement. For example, we saw regular audit of patient pathways and clinical protocols to ensure best practice was followed.
- There were six-monthly peer reviews carried out between clinicians to ensure care was appropriately delivered and accurate reports made.
- Staff undertook monthly audits of patient booked appointments to review any opportunities for improvement.
- Continuous patient feedback was used to provide information on patient satisfaction with the service.
- The provider participated in approved clinical research projects to look for new ways of providing patient care and treatment.
- Clinicians continually reviewed new information relevant to the treatment of patients with alimentary or gastrointestinal problems. They looked at ways of providing innovative care and treatment for patients.

Effective staffing

Good

Are services effective?

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had a comprehensive induction programme for all newly appointed staff. There was comprehensive organisational information available for all new staff and a three-month probation period with regular support and ongoing assessment.
- Clinicians were registered with professional organisations including the Health and Care Professions Council (HPCP) and the British Society of Gastroenterology (BSG). Evidence of clinicians' professional qualification was retained in individual staff files.
- All staff had received an appraisal within the last 12 months and three staff had started recently and were not due an appraisal, although there had been regular one-to-one meetings to assess progress. Staff we spoke with informed us they received regular coaching, mentoring and support. The trainee physiologists were supported by assigned buddies and mentors and assisted in all patient treatments; they did not carry out patient treatments on their own. They told us there were opportunities for discussion with mentors at every clinic.
- All staff had received ongoing training relevant to their role. This included safeguarding children and adults, infection control, basic life support, health and safety, equality and diversity and fire safety training. Staff told us they were supported in their continued professional development and were given protected time to carry out training.

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Diagnostic reports were sent back to the consultant, so they could decide if a patient needed further examination or treatment. Copies of these reports were also provided to patients. The majority of reports were shared with referring consultants within 24 or 48 hours of testing.
- When a patient contacted the service, they were asked to consent to the details of their consultation being shared with their NHS GP. If the patient did not agree then, in case of an emergency the provider discussed this again with the patient to seek their consent.
- Correspondence was shared with external professionals in a way that ensured data was protected. Passwords were required in order to access documents shared with external providers.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Clinicians encouraged and supported patients to be involved in monitoring and managing their health.
- They discussed changes to care or treatment with patients as necessary.
- The service provided diagnostic testing to support patients on tailored pathways of care to improve everyday living.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance .

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service had a consent policy in place and all staff had received training on consent.
- We were told that any treatment including fees was fully explained to the patient prior to the procedure and that people then made informed decisions about their care.
- The service monitored the process for seeking consent appropriately; there were monthly and quarterly audits of the consent process.

Good

Are services caring?

We rated caring as Good because:

Staff treated patients with kindness, respect and compassion. People were involved in decisions about their care. The service respected patients' privacy and dignity.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- There were no patients booked on the day of our inspection, but we received feedback from patients through our patient comments cards which was positive about the way staff treat people.
- Staff we spoke with were passionate about their work and demonstrated a patient centred approach.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave people timely support and information. Patients undertaking testing at home over a period of time when the clinic was closed were given a contact telephone number for the service to use if needed.
- We received seven completed comments cards all of which indicated that patients were treated professionally and with respect. Staff were commended for being knowledgeable, for listening, being caring and for giving good, personalised advice.
- The service gathered patient feedback through customer feedback forms, a comments and suggestions box in the waiting area and by general feedback provided during appointments. Feedback was continuously monitored and response rates for surveys given out were approximately 26% at the time of our inspection.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Patients were provided with a report of the results of the testing procedures. Any referrals to other services, including to their own GP, were discussed with them and their consent was sought to refer them on. Feedback through comments cards indicated people felt listened to and staff explained everything well.
- There was printed information about the various tests and procedures available in the patient waiting area in the form of leaflets and in the service guide for patients. This information was also available online. There were also videos of procedures available which could be sent to patients in advance of appointments to further explain proposed tests.
- The provider website was in the process of being redesigned to give a better patient experience.
- The service provided patient education events such as one for people suffering from irritable bowel syndrome and was in the process of producing educational videos.
- We saw results of patient feedback to the service which indicated high levels of satisfaction with the service.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. There were screens provided in treatment rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. There was also a very large screen in the service general area that could be used to screen windows if needed.
- Patients were given a robe to use during procedures when necessary to maintain privacy and dignity. These were used once for each patient and then stored for collection for laundering.
- The service had arrangements in place to provide a chaperone to patients who needed one during consultations.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

The service organised and delivered services to meet people's needs. Patients had timely access to services, sometimes with a choice of home testing. The service took account of patients' needs and complaints and concerns were taken seriously.

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- Patients' individual needs and preferences were central to the planning and delivery of tailored services. Services were flexible, provided choice and ensured continuity of care.
- The provider understood the needs of their patients and improved services in response to those needs. Clinicians had recognised that breath testing could be done in patients' own homes where preferred. Breath testing involved taking samples of breath over a period of time of up to two hours so a prolonged visit to the clinic could be avoided.
- The facilities and premises were appropriate for the services delivered. There were facilities in place for people with disabilities and for people with mobility difficulties. There were also translation services available.
- Staff were aware the nature of some tests could be seen as embarrassing by patients and took every opportunity to put patients at their ease and offer full explanations. Patients acknowledged this on the comments cards we received.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to appointments following consultant referral. The service triaged referrals to determine the appropriate treatment within 24 hours of receiving the referral and contacted patients to arrange a suitable appointment time.
- The clinic was open from 8.30am to 5.30pm every weekday and patient appointments were available usually within the week of contacting the patient.
- Waiting times, delays and cancellations were minimal and managed appropriately. Appointments were audited monthly. Appointments were cancelled only in emergency situations, for example when the lift in the building failed and patients or staff were unable to use the stairs or preferred to rebook.
- Referrals and transfers to other services were undertaken in a timely way. There were performance indicators in place for this and these were monitored to ensure compliance. Test results and reports were usually available within 24 or 48 hours of patient attendance at the clinic.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously, and their policies indicated they would respond to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available; how to make a complaint was included in the patient information folder in the clinic waiting area along with a copy of the complaints procedure. Every patient who attended the clinic was encouraged to complete a feedback form. The clinic manager was the lead member of staff for managing complaints and told us complaints would be reported through the organisation's quality assurance system. The service policy allowed for staff to treat patients who made complaints compassionately.
- The complaints policy included details for patients of any further action that may be available to them should they not be satisfied with the response to their complaint. There was a duty of candour policy in place as well as a whistle-blowing policy.
- The service had not received any complaints since it opened in September 2017. Learning and any themes from complaints received at the sister clinic in London were shared with staff across the organisation through meetings and on the service intranet.
- Staff used any comments or suggestions on patient feedback forms to make improvements. For example, one patient had commented biscuits should be available in the patient waiting area, particularly if patients were waiting for long periods of time during testing. The service supplied biscuits following this request.

Good

Are services well-led?

We rated well-led as Good because:

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Patient satisfaction was highly positive, and staff felt encouraged, respected, supported and valued. Governance systems were strong and there were clear and effective processes for managing risks, issues and performance. Leadership drove continuous learning and improvement and innovation was celebrated and shared externally with other organisations.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- There was a clear, visible leadership structure in place that supported and managed services.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff we spoke with told us managers were open and listened and supported them in their roles and responsibilities. Staff told us they were inspired by leaders.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service; staff development was encouraged. The service actively recruited trainee physiologists to undertake integrated master's degree training and structural doctorate training to become specialised qualified physiologists.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The provider ethos was to understand and exceed patient expectations, to motivate and invest in the team and acknowledge their value and to encourage all team members to participate in achieving the service aims and objectives. These objectives included mutual support in achieving patient expectations, maintaining the highest professional and ethical standards, responding to the need of patients, practitioners and staff and encouraging innovation, ambition, enterprise and continuous improvement.
- The service was continually involved in looking for new and innovative treatments for patients; they demonstrated how satisfactory patient outcomes were central to the organisation.
- The service had a realistic strategy and comprehensive five-year supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. They demonstrated to us how they promoted these values in their everyday work with colleagues and patients. Patient comments cards demonstrated how this had been achieved.
- The service monitored progress against delivery of the strategy. Staff took every opportunity to review performance. There was a comprehensive audit programme in place to review all aspects of service delivery.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service. We found there was a strong commitment towards ensuring that there was equality and inclusion promoted across the workforce. Staff spoke highly of the support they had received to develop their roles. Leaders told us the ethos of the service was that all staff and their opinions were valued highly.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values. Staff told us this would be done in a supportive way to aid improvement. Staff good practice and achievement was celebrated through the service intranet.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. Openness, honesty and transparency were demonstrated when responding to incidents and every opportunity was taken to learn from patient feedback.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence these would be addressed.

Good

Are services well-led?

- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year and there were additional formal face-to-face conversations with line managers and mentors. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff were given protected time and funding for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. Staff were invited to whole-team bonding events every six months.
- In early 2019, the service had involved staff in defining the clinic's identity and what it stood for. The overwhelming feedback received from staff was that the service was patient-centred, and helped patients understand their (often long-standing) symptoms. As a result of this, the service defined their identity as "We help patients deal with problems they may have been dealing with for a long time".
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams. Staff were encouraged to engage with colleagues from the sister clinic in London and there were online meetings and other face-to-face whole team events. The intranet was shared across the two clinics and used to promote shared discussion and learning.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Governance was shared with the sister clinic in London. The London clinic's Improving Quality in Physiological Services (IQIPS) accreditation, managed by the United Kingdom Accreditation Service (UKAS), was renewed in 2018 for a further four years. (This accreditation is a professionally-led assessment and accreditation scheme that is designed to help healthcare providers ensure patients receive consistently high-quality services, tests, examinations and procedures delivered by competent staff working in safe environments.) All the Manchester service systems and governance policies and procedures were based on those for the London clinic and staff told us the Manchester clinic accreditation was to be applied for in 2020.
- Staff were clear on their roles and accountabilities. There was a strong organisation structure at national, regional and service level that was clearly communicated to all staff. Staff we spoke with during our inspection were aware of their responsibilities as well as the responsibilities of their colleagues and managers.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Policies and procedures were aligned with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They were reviewed regularly and updated when necessary and were available to staff online and in paper copy.
- Staff attended a variety of meetings as part of their roles. There were frequent staff and leadership meetings. We saw meetings were governed by agendas and minutes with standing agenda items.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The service had processes to manage current and future performance. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality. Comprehensive ongoing monitoring of service achievement and risk supported quality improvement.
- The provider had plans in place and had trained staff for major incidents. Staff we spoke with were aware of these plans which had also been recently tested.

Appropriate and accurate information

Good

Are services well-led?

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. All patients attending the clinic were encouraged to feedback formally to the service. Staff were also encouraged to report any comments made verbally by patients relating to the service whilst attending the clinic.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. Learning points from incidents and complaints at the sister clinic in London were shared with the service and vice versa. Staff were encouraged to attend online meetings to do this and there was a shared intranet where all discussions were recorded.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses. Risks to service delivery were appropriately and comprehensively identified at service, local and national level.
- The service policies allowed for data or notifications to be submitted to external organisations as required.
- There were sound arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture. For example, following a series of staff "awaydays", the service changed its public-facing information on its literature and website to be clearer, more informative and easier to read for patients. This work was in progress at the time of our inspection.
- The provider was the main sponsor of the Irritable Bowel Syndrome (IBS) Network event in Sheffield to improve patient education. We saw part of a video produced by the service to help educate patients about IBS including contributions from patients.
- Staff could describe to us the systems in place to give feedback. There were regular formal meetings with managers and staff told us managers were open and approachable. The provider had a whistle-blowing policy in place and continually sought feedback from staff.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

There was a focus on continuous learning and improvement. The service participated in research projects and continually looked for ways to safely incorporate innovative treatments into services offered. We saw evidence of the following innovations:

- The service had developed home breath test kits for testing for hydrogen and methane for patients to enable them to carry out self-testing at home instead of needing to attend the clinic for a considerable amount of time. They had put together kits that fitted through standard letterboxes to make postage easy, both to and from the patient. The system had been tested by a clinician from the service before being rolled out to patients. We saw approximately 70% of patients were choosing to use this method of testing.
- The provider constantly reviewed new information related to the management of patients with functional alimentary and gastrointestinal problems. They had noted evidence related to patients taking oral iron in relation to the production of methane gas and had funded a three-year PhD project to examine this prospectively and look at potential probiotic therapies.
- Similarly, the service had reviewed information from the British Society of Gastroenterology related to patients who were indicated as needing surgery but had been deemed physically unsuitable. They looked at evidence of studies of some exempted patients who had been prescribed a certain antibiotic for a four-week period before surgery who were then able to have the recommended operation. They worked with referring

clinicians and introduced this option to patients tested as suitable in the clinic. This allowed people who would have previously been declined for surgery to have the chance to have the right operation to help their long-term symptoms.

The provider facilitated further service developments and shared learning by planning multidisciplinary team (MDT) meetings with staff and stakeholder membership to focus on one area of patient care:

- We saw terms of reference and membership of a pelvic floor MDT had been agreed and was planned to start in 2020.
- A further MDT focussing on patients with reflux problems was also planned with the terms of reference and membership to be agreed in November 2019.

In addition:

- Senior clinical staff represented the service on national committees for the British Society of Gastroenterology and on national training courses.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared across two clinics and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The service had developed a national gastrointestinal physiology training programme to meet outstanding training needs within the Healthcare Science workforce. The first graduates completed the course in September 2019 and were employed in the London sister clinic.