InHealth Endoscopy Unit Romford

Quality Report

2nd Floor
Lambourne House
7 Weston Road
Romford
RM1 3GL
Tel: 0333 202 0300
Website: www.inhealthgroup.com

Date of inspection visit: 4 January 2019
Date of publication: 01/08/2019

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?	**Requires improvement**
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

InHealth Endoscopy Unit Romford is operated by InHealth Endoscopy Limited as part of a network of locations within a specialist services directorate. The service is a community clinic and provides care and treatment to patients who are medically fit and stable.

The clinic has two preparation (admission) rooms, one consultation room, two procedure rooms, four single recovery bays and a seated discharge area with two reclining chairs. The service is commissioned by Barking, Havering and Redbridge Clinical Commissioning Group to provide colonoscopy, flexible sigmoidoscopy and gastroscopy for routine referrals. The service is co-located with a pathology service and breast screening service, which are operated by separate providers in the organisation's group. Each service has its own registration and we did not inspect the pathology or breast screening services. The clinic has in-house endoscope decontamination facility and trained staff.

The service provides care and treatment to patients referred by the NHS to reduce waiting times.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 4 January 2019.

The service had typically operated four days per week from 8am to 6pm and at the time of our inspection had started to work towards seven-day working. The service had clinical space to accommodate this and the senior team were building staff numbers to ensure expansion was carried out safely.

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.

We have not previously rated this service. We rated it as **Good** overall.

We found good practice:

- 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.
- Processes for safe water management were robust and ensured patient's safety. Staff had taken immediate action where routine testing indicated a risk.
- The service team acted on audits and quality evaluations to continually identify opportunities for benchmarking and improvement.
- Safety and risk management processes were clearly embedded in practice and a strict referral system meant staff saw patients only when they had enough information to provide a safe level of care.
- Staff managed all areas relating to health and safety, such as medicines management and staffing, in line with established processes and protocols. The unit manager ensured protocols were reviewed and updated in a timely fashion to reflect the latest national standards.
- The provider facilitated a no-blame culture that encouraged open discussion of mistakes and reporting of incidents. This included use of the duty of candour, which staff used to ensure patients were kept informed when things went wrong.
- The service had a waiting list and managed this well. In the previous 12 months the service had met the standard six-week referral to treatment time (RTT) in 11 months.

Summary of findings

- Governance processes included all staff and helped the team to assess the quality of the service and to drive development and improvement. The governance structure was being expanded and improved as part of a five-year development plan.

We found areas of outstanding practice:

- The provider was an early adopter of transnasal gastroscopy services, which provided a more comfortable experience for patients and reduced the need for sedation.

However, we also found the following issues that the service provider needs to improve:

- Two members of staff had significant lapses in safeguarding training that required action.
- Although overall standards of infection control were good, there were risks in relation to how staff used the decontamination area and discrepancies between service standards and audit criteria.
- There were some discrepancies between the understanding of the local team in relation to incidents and complaints and the data submitted to us by the provider. Although investigations and learning outcomes were clearly documented, the discrepancies meant there was a lack of assurance they led to embedded new practice.
- There were gaps in the arrangements for risk management, including in the risk assessments used for patients and in environmental maintenance and safety.
- In the previous 12 months the service had cancelled seven patient lists due to a shortage of endoscopists.
- Gaps in documentation for staff competencies and feedback from the staff survey indicated inconsistent supervision practices.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve:

- Implement consistent standards of practice in relation to the safe management of Controlled Drugs (CDs). This should include effective audit processes.
- Provide staff with the tools to monitor patients for deterioration and to respond to urgent clinical needs.
- Implement robust, consistent safety and maintenance processes for emergency equipment.
- Minimise infection control risks through effective, consistent audits and practice.
- Review safety monitoring and training to manage risks associated with major haemorrhages and sepsis.
- Store sufficient quantities of oxygen stored on site to meet patient need, including during unplanned emergencies.
- Actively embed learning from incidents and other safety issues elsewhere in the organisation.
- Require all staff, including agency staff, to fully complete induction and orientation processes and document this.
- Improve local governance systems and administration to include the quality of complaints reponses and staff induction documentation.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Endoscopy	Good 	We rated this service as good because it was effective, caring, responsive and well-led. There were several areas the service needed to address in relation to patient safety.

Summary of findings

Contents

Good

InHealth Endoscopy Unit Romford

Services we looked at:
Endoscopy.

Summary of this inspection

Background to InHealth Endoscopy Unit Romford

InHealth Endoscopy Unit Romford is operated by InHealth Endoscopy Limited. The service is part of an independent sector provider delivering primarily NHS commissioned services in London. It provides endoscopy services for adults and serves a diverse community from across south-east England.

The service is registered to provide one regulated activity:

- Diagnostic and screening procedures.

The service has had a registered manager in post since it opened in November 2017 and the manager in post at the time of our inspection had joined in April 2018.

The service shares some non-clinical spaces with pathology and breast-screening services, which are operated by separate providers in the organisation's group. These have a separate CQC registration and we did not inspect them.

We have not previously inspected this service.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist adviser. The inspection team was overseen by Terri Salt, Interim Head of Hospital Inspection.

Why we carried out this inspection

We undertook a comprehensive inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection, we visited all areas in which care is provided. We spoke with six clinical and non-clinical staff in a range of positions and levels of seniority. We reviewed policies, audits and meeting minutes. We observed the patient process from arrival to departure, looked at a sample of three patients' records and observed care being delivered.

Information about InHealth Endoscopy Unit Romford

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures

Summary of this inspection

The service provides appointments from 8am to 6pm Monday to Friday with some Saturday and Sunday sessions available based on demand and availability of staff.

During the inspection, we visited all areas in which care is provided. We spoke with six clinical and non-clinical staff in a range of positions and levels of seniority. We reviewed policies, audits and meeting minutes. We observed the patient process from arrival to departure, looked at a sample of three patients' records and observed care being delivered.

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

Activity from November 2017 to November 2018:

- Colonoscopy: 1063
- Flexible sigmoidoscopy: 273
- Gastroscopy: 359

A clinical lead endoscopist, three registered nurses, three healthcare support workers and three administration staff worked in the service, led by a unit manager and a deputy manager. Three medical endoscopists and one nurse endoscopist worked in the service under practising privileges. The service had vacancies for two registered nurses and one healthcare support worker although one nurse had been recruited at the time of our inspection.

Track record on safety:

- No never events
- One clinical incident with no harm
- No serious injuries
- No incidences of service-acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- No incidences of service-acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (C.diff)
- No incidences of hospital acquired E-Coli
- No complaints

The service provides non-clinical space to other services in the provider's and these are not included in our inspection report.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as **Requires improvement** because:

- There were risks related to infection prevention and control due to the design of the decontamination area and how staff used it. However, we observed staff controlled these risks well.
- Although training standards overall were good, two members of staff had lapses in safeguarding training that had not been addressed.
- There was evidence staff managed safety incidents well, but this was not always shared between colleagues or other services.
- There were gaps in the management and maintenance of some emergency equipment.
- Staff used appropriate risk assessments, but there was no structured tool to help identify a deteriorating patient. There was also no major haemorrhage kit, no processes for the identification or management of sepsis and limited oxygen available.
- The service did not always follow safe standards when prescribing, giving, recording and storing medicines. We found examples of gaps in documentation of Controlled Drugs that had not been documented as an incident and had not been addressed by an auditor.

However, we also found areas of good practice:

- The service provided mandatory training in key skills to all staff
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had suitable premises and equipment for procedures and looked after them well.
- Staff completed and updated risk assessments for each patient.
- 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.
- Staff kept detailed records of patients' care and treatment.
- The service managed patient safety incidents well.
- The service used safety monitoring results well.

Are services effective?

We do not currently rate effective and found the following areas of good practice:

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs after procedures and ensured patients had followed appropriate dietary guidance beforehand.
- Staff assessed and monitored patients regularly to see if they were in pain.
- 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.
- Staff of different kinds worked together as a team to benefit patients.
- 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 the Mental Health Act 1983 and the Mental Capacity Act 2005. Clinicians acted diligently to avoid procedures on patients who could not consent or whose mental capacity to understand their treatment was insufficient.

However, we also found the following issue that the service provider needs to improve:

- Although the service measured patient's experience of pain, the methods used for this meant staff could not identify if patients who declined sedation were also those who reported more pain.
- There were gaps in documentation for staff training, induction and probation periods, including for agency nurses. This meant we were not confident the system to monitor competence was robust and used consistently.

Are services caring?

Good

We rated caring as **Good** because:

- Staff cared for patients with compassion and results from the patient survey indicated consistently good standards.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment, including for aftercare and discussing test results.

However, we also found the following issues that the service provider needs to improve:

- Staff collected comfort scores during procedures but did not analyse or act on this information on a rolling basis for future procedures.

Summary of this inspection

- Patient feedback indicated a need for improved involvement from clinicians regarding next steps when patients were waiting for histology results.

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 took account of patients' individual needs.
- People could access the service when they needed it and staff worked to provide highly responsive and flexible access.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However, we also found the following issue that the service provider needs to improve:

- Some patients described gaps in communication when appointments were delayed, which was reflected in survey feedback and complaints data.
- There were inconsistencies in the recording of complaints at a local level and at provider level. This meant we were not assured the provider had consistent oversight of all local issues.

Are services well-led?

Good

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

- Managers at all levels in the service 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, which it developed with staff, patients, and stakeholders.
- 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 by creating an environment for excellent clinical care to flourish.
- 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.

Summary of this inspection

- The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.
- The executive team used governance processes to monitor engagement with patients and referrers and acted on positive and negative comments to continually improve the service.

However, we also found the following issue that the service provider needs to improve:

- Local leadership was demonstrably well-established, and staff felt supported. However, there were inconsistencies in the understanding of senior staff in relation to incidents, complaints and wider operations outside of the local service.
- We observed a supportive working culture and staff spoke positively of the organisation but results from the most recent staff survey indicated several areas for improvement.

Good

Endoscopy

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

Are endoscopy services safe?

Requires improvement

We rated safe as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills to all staff, although not everyone was up to date.

- All staff undertook a programme of fourteen mandatory training modules that reflected the needs of the service, including health and safety, fire safety, infection control, information governance, safeguarding, managing conflict, manual handling and basic life support. New staff completed mandatory training initially as part of their induction and safety orientation, which included procedures for non-clinical emergencies and cardiac arrest.
- At the time of our inspection, seven of nine permanent local staff were fully up to date with mandatory training and the registered manager ensured staff had protected time to complete refresher training. This was scheduled in advance to reduce the risk of lapses in training.
- Mandatory training was delivered through a combination of online learning and practical training sessions and staff spoke positively of both. For example, all staff we spoke with said their training demonstrably contributed to improved standards and said the frequency of training helped to maintain up to date practice.
- Staff worked within an established, up to date compliance training policy that assigned accountability for maintaining training to individual staff, their line manager and the learning and development team (L&D).

Safeguarding

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

- Safeguarding children level 2 and safeguarding adults level 2 were mandatory for all staff. All staff were up to date with child safeguarding training and seven of nine staff were up to date with adult safeguarding. Staff whose training had expired had last completed training in 2015 and we were unable to establish why the registered manager or L&D team had not addressed this.
- Safeguarding training included identifying and responding to risk in relation to female genital mutilation, child sexual exploitation and types of abuse.
- A provider-level safeguarding board met biannually to review safeguarding policies and ensure organisational practice met national standards. The board used information from staff feedback and incidents to inform the raising concerns process and to set improvement goals.
- The registered manager was the named safeguarding lead and was supported by the provider's director of clinical quality and clinical governance lead, who were named safeguarding leads in the organisation. The provider safeguarding lead was training to level 4.
- All staff had access to the provider's up to date safeguarding vulnerable adults policy, which provided guidance for specific circumstances, including their

responsibilities when they found evidence of suspected abuse. All staff were required to maintain a detailed understanding of the policy, which was included in the induction and annual refresher training.

- Non-clinical staff, such as the reception team, had completed safeguarding children training level 2. This was in line with national intercollegiate guidance on child safeguarding. The service did not provide care and treatment to children although they were regularly present in the waiting area accompanying patients.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, there were some inconsistencies in control measures to prevent the spread of infection.

- Antibacterial hand gel was available at the main reception and we saw staff instructed people to use it. Gel dispensers were also located in the waiting room and in each clinical room. We observed consistent use of gel, hand hygiene practices and use of personal protective equipment (PPE) during our inspection.
- The World Health Organisation (WHO) five steps to hand hygiene were displayed at each handwashing sink and we observed staff follow these consistently.
- A registered nurse was the named infection control lead and provided support and guidance to colleagues in maintaining standards of practice.
- Each area in the clinic had an established cleaning schedule, which contracted cleaning staff adhered to each day the service was open.
- Procedures were in place for the safe management of hazardous waste, including storage and disposal, in line with Department of Health and Social Care health technical memorandum (HTM) 07/07
- All staff had up to date infection control training and this was updated in line with the provider's training standards or when national guidance changed.
- Staff carried out a monthly hand hygiene audit using a sample of five episodes of care for infection control standards, although the service provided evidence of just one audit in the previous 12 months, which was from October 2018. The audit assessed standards against National Patient Safety Agency (NPSA) guidance, not WHO guidance, which was on display throughout the unit. The audit found full compliance and there were no noted areas for improvement.
- All staff responsible for decontamination processes had up to date competency-based training and equipment-specific cleaning training based on manufacturer guidance. Healthcare support workers (HCSWs) led the decontamination process. One HCSW was responsible for both the clean and dirty processes and we saw they used well-established processes to reduce the risk of cross-contamination. The service was fully compliant with the Department of Health and Social Care (DH) Health Building Note (HBN) 00/09 in relation to infection control in the built environment and with HBN 00/10 in relation to infection control and flooring. However, there was no segregation between the clean and dirty area, which presented a risk of contamination. The service controlled these risks well and decontamination standards were in line with Department of Health and Social Care (DH) Health Technical Memorandum (HTM) 01-06.
- We saw it was common practice for clinical staff to enter the decontamination area as a route to move between treatment areas. This presented an infection control risk.
- The service had a good track record on infection control management and had no reported infections in the previous 12 months.
- Staff tested the water supply for bacteria daily and did not start seeing patients until they had verified the result. They sent weekly water samples to an external laboratory for more detailed testing. A bacterium had been identified in the water in February 2018 and the team had taken appropriate action. This included following manufacturer guidelines in decontaminating equipment and transferring booked patient appointments to other clinics.
- The service has up to date checks for Legionella. Legionella is a type of bacteria that can grow and present health risks to people through poor water supply management.

Environment and equipment

The service had suitable premises and equipment although processes for maintenance and management were inconsistent.

Good

Endoscopy

- A schedule for fire safety checks and maintenance was in place, which included weekly testing of the fire alarm, emergency lighting and electrical systems by the building operator. The service had two designated fire wardens with training to lead an evacuation.
- Staff used an annual fire safety checklist to maintain standards in accordance with the Regulatory Reform (Fire Safety) Order 2005.
- Active service and maintenance contracts were in place for all clinical equipment, which meant equipment was always ready for use. There had been no cancelled or delayed appointments as a result of faulty equipment in the previous 12 months.
- Resuscitation equipment was located in the recovery room and included clinical items for adults and children in an emergency. A designated member of the clinic team checked this equipment on each day the clinical was open. However, the trolley was not secured with a tamper-evident system, such as seals. This meant it was not possible for staff to quickly identify if anyone had accessed the equipment.
- An automatic external defibrillator was included with the resuscitation trolley. All staff were trained on its use although we were unable to confirm the most recent service date and staff could not provide assurance it had recently been serviced. An anaphylaxis kit and two epipens were in date and formed part of the emergency equipment.
- Staff managed sharps in line with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 and waste in line with Department of Health and Social Care national guidance on the management of healthcare waste. Clinical staff were required to demonstrate competence and knowledge of the provider's standards as part of their mandatory training and induction.
- The clinic was purpose-built inside an existing building using Joint Advisory Group on gastrointestinal (GI) endoscopy environmental standards.
- The reception was shared with a pathology and breast screening service that were operated by separate providers in the organisation's group and co-located with the endoscopy service. The manager of each service coordinated building safety and security together and shared emergency management and evacuation plans.
- Staff adhered to an up to date control of substances hazardous to health (COSHH) policy and were assessed on their role-specific understanding of this. The team carried out an annual COSHH assessment to ensure standards remained consistent with best practice.
- The senior team maintained up to date risk assessments for fire hazards, trip hazards, equipment safety and electrical safety.
- Fire safety training was part of the provider's mandatory requirement for all staff and at the time of our inspection each individual was up to date. A named fire warden was in post on each shift and had responsibility for initial evacuation of the clinic, which was part of a shared plan with the adjacent clinic and the building security team.
- Staff used an electronic system to track endoscopes and decontamination. This logged each endoscope to a specific procedure and patient in line with national best practice and this information was stored and tracked digitally.
- Although safety checklists were in place for key items of equipment there was a lack of assurance these resulted in safe practice. For example, the salt tank was almost empty despite a checklist in place to prevent such an event. We spoke with the member of staff responsible for this area and they addressed it immediately.
- We checked safety assurance logs for the plant room and water treatment tanks for the previous three months and found no gaps in recording.
- We were not assured suitable processes were always in place to maintain a safe environment. For example, a plant room with endoscopy equipment filters had a fire door marked with a sign instructing staff to keep it locked closed. However, this door was latched open throughout our inspection. A cold-water storage tank was labelled with a cleaning record sticker. The last recorded clean had been in October 2017 and a repeat clean had been due in October 2018. The manager did not know if this had been completed or why it might have been delayed.
- Staff carried out periodic environmental cleanliness audits although it was not evident they used this process consistently for service and standard improvement. For example, the service provided evidence of two environmental audits that had taken place in the 12 months leading to our inspection. The audits took place in June 2018 and August 2018 and identified overall good standards of cleanliness and

environmental standards. However, there was no evidence the team addressed deficiencies or repeated the audit in a reasonable time frame. For example, in June 2018 the auditor had noted 'not applicable' to a check of the cleanliness of surfaces in the decontamination area and noted there were no hand-washing facilities in this area. The auditor had also noted there was damage or other risks relating to the general condition of flooring but had not noted the action they had taken. In August 2018 the audit noted 100% compliance, but it was not evident how the issues identified in June 2018 had been addressed.

Assessing and responding to patient risk

Staff did not have access to templates for appropriate risk assessments for each patient. However, they kept clear records using systems available to them and asked for support when necessary.

- Endoscopists triaged patients at the time of referral to ensure the clinic had the capability to safely provide care. A clinician reviewed the patient's medical history and assessed their current needs to ensure they were medically stable. They contacted the referring doctor in cases where they could not verify this information fully, which acted as a safety system to ensure patients with elevated risks were referred to more appropriate services.
- Clinical staff saw patients only after they received a medical referral and history from a referring doctor. This was part of a process to ensure safe care and meant the consultant could establish if the service was able to provide safe and appropriate care. Patients were also required to complete a pre-procedure health assessment before staff undertook minor procedures or diagnostics.
- All staff had up to date training in basic life support, which was delivered to comply with Resuscitation Council UK (2010) guidelines. Nurses had training in immediate life support (ILS).
- Standard operating procedures were in place for patient transfers, including for emergency and non-emergency transfers. This included a detailed process to ensure staff followed consent guidelines and made patient's medical information available to the receiving service in an emergency. From November 2017 to November 2018, there were no urgent or emergency transfers out of the service and 15 multidisciplinary transfers. These occurred where staff identified a need for further consultation. Patients were medically fit when attending the service and as such emergency transfers were unlikely. However, all staff demonstrated an understanding of the process.
- An endoscopist was always on site during active list times and a nurse was always on site when patients were in the recovery suite. Nurses carried out independent assessments using the ABCDE (airway, breathing, circulation, disability, exposure) tool and used an emergency procedure in the event a patient needed urgent care. This involved stabilizing the patient and calling 999 for an emergency transfer.
- Processes were in place for the handling of unexpected or significant results from diagnostic tests that required urgent investigation or treatment.
- The clinic did not have a major hemorrhage kit or protocol in place. This meant patients would have limited access to immediate help in the event of a major hemorrhage whilst awaiting paramedics. Staff said in the event of a major hemorrhage they would try to stabilise the patient whilst waiting for a 999 ambulance response. The provider had established a working group to review the need for such equipment and policies and the outcome was pending at the time of our inspection.
- An emergency eye wash and biohazard spillage kit were available in the clinic and staff demonstrated knowledge of how to use this. The equipment was in date and well-maintained.
- A clear and up to date protocol was in place for staff to respond to a deteriorating patient and the senior clinician leading each procedure was responsible for this. Although this meant staff were prepared to provide urgent care, they did not have access to a structured assessment tool with a defined trigger, such as a warning score system.
- Protocols and care bundles were not in place for identifying potential sepsis and staff did not have training in this.
- The service had recently introduced a modified version of the World Health Organisation surgical safety checklist. This reflected international best practice in clinical safety processes. However, during our observations of treatment we were not assured staff used the tool consistently. For example, staff did not document sign-in time, time out or sign-out times. Staff had not yet audited this and were in the process of establishing an audit framework.

- We were not confident there was enough emergency oxygen stored on site to provide urgent care to a patient if they deteriorated. There was one oxygen cylinder in the procedure room and one bottle in a main corridor. Each recovery room had an oxygen cylinder for emergency or therapeutic purposes. A third oxygen cylinder was empty and there was only one bottle of sedative gas on site. We spoke with the manager about this who said the local fire service had advised the clinic not to keep back-up oxygen on account of fire safety rules.
- We observed consistent use of the patient identification policy. This was in place to prevent staff carrying out treatment on the wrong patient. In the waiting room a member of staff carried out an additional identification check when a patient did not respond convincingly to their name. This avoided a potential case of mistaken identity. Staff followed a similar procedure when speaking with patients on the phone and required them to confirm key personal information.
- Clinical emergency procedures were displayed in the clinic and were based on Resuscitation Council (UK) guidelines relating to cardiopulmonary resuscitation (CPR).

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.

- One clinical lead endoscopist was based in the clinic and worked substantively for the provider. Other endoscopists provided sessions under practising privileges. Practising privileges are arrangements with clinicians employed substantively elsewhere that enable to them to provide services for other organisations. A responsible officer registered with the General Medical Council (GMC) managed endoscopist's performance and competencies and maintained a practising privileges policy.
- Registered nurses led clinical processes and roles were well-defined. On each shift the admissions and recovery processes were nurse-led and either two nurses or one nurse and one one healthcare support worker (HCSW) were always present in the procedure room.
- The service had vacancies for two registered nurses as the team worked to extend opening times and had recently appointed to a nurse post. The registered manager was a nurse and covered shifts to reduce the risk of clinic cancellations.
- Clinical staff provided a telephone advice service for patients, which they could access if they became unwell and needed advice after a procedure.
- The service employed a clinical lead endoscopist, two registered nurses, three HCSWs and three administrators. Three medical endoscopists and one nurse endoscopist provided care and treatment under practising privileges, which the clinical lead maintained.
- The service had no staff turnover in the previous 12 months and had vacancies for two registered nurses and one healthcare support worker (HCSW).
- From September 2018 to November 2018, agency nurses covered 98 shifts, bank nurses covered five shifts and bank HCSWs covered six shifts. In the same period there was no sickness absence amongst nurses, 1.2% average sickness amongst HCSWs and 6% average sickness amongst the administration team.
- The registered manager planned staffing levels on a weekly basis in line with capacity and demand and increased staffing levels when needed.
- The clinic was part of a network operated by the same provider, which meant there was potential for staff from other clinics to provide cover during periods of short staffing. However, this did not always work in practice and in July 2018 the service cancelled seven lists due to a shortage of endoscopists.
- The service used Joint Advisory Group (JAG) on gastrointestinal endoscopy staffing guidelines to plan the appropriate skill mix of staff to safely carry out planned procedures. For example, the registered manager planned staffing based on the complexity of procedures, bowel scope and the level of sedation planned.
- Registered nurses and healthcare support workers were trained to provide care in specific areas of the service as part of a multi-skilled approach to delivering the service.
- The provider had established procedures in place for the recruitment of staff with the appropriate skills and experience to safely provide care. This included a disclosure barring service (DBS) check, which is used to check a person's criminal record. All staff working for the service at the time of our inspection had a DBS in place.

- Safety measures were in place to ensure agency nurses did not carry out biopsies until they had worked with the clinic for at least four weeks and completed in-house competencies. In addition, the manager would not run a shift without a substantive nurse from the provider on site.
- In the event of unexpected short staffing, the clinician in charge of the shift used an established standard operating procedure (SOP) to carry out a risk assessment to continue offering appointments. Where the skill mix or numbers of staff fell short of the required minimum to ensure patient safety, staff followed the procedure to cancel and reschedule patients.
- The registered manager was leading a workforce plan to enable expansion of the service and ensure it remained reliable. The provider worked to a target skill mix of 40% unskilled/non-qualified staff and 60% qualified staff. At the time of our inspection the location had 45% unskilled staff.

Records

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

- Staff used an electronic system to record endoscopy result and to send the details to the patient's GP or referring doctor. This formed part of an individual clinical record that also contained the patient's referral information and medical history.
- Staff adhered to the Information Governance Alliance Records Management Code of Practice for Health and Social Care (2016). This meant they handled and managed records in line with best practice standards in relation to quality, security and sharing information for clinical purposes.
- Staff used a picture archiving and communication system that meant records and diagnostic results were readily accessible on site and could be shared electronically with referring doctors.
- Clinical staff adhered to standards set out in the medical records policy, which the clinical quality team reviewed annually.

Medicines

The service did not always follow safe standards when prescribing, giving, recording and storing medicines. However, patients received the right medication at the right dose at the right time.

- The regional operations manager was the named accountable officer for controlled drugs (CDs) and the registered manager was the service lead for the safe and secure handling of medicines. The regional operations manager carried out periodic audits on the management and safety of CDs.
- We reviewed the documentation for CDs held in the clinic and found staff had not always signed when they had dispensed the medicines. Although this was audited, the manager had not recorded missing signatures as incidents. The most recent audit indicated endoscopists did not always sign when administering CDs, which was noted as an area for improvement.
- A multidisciplinary medicines management group managed medicines safety at a provider level and met quarterly.
- A pharmacy advisor was available on-call to provide advice and guidance during service operating hours. However, the registered manager did not know who this individual was or what their key role was. This meant we were not assured of pharmacist oversight in the service.
- Nurse endoscopists used patient group directions (PGDs) to administer sedatives and other medicines in line with the provider's established policy. PGDs are processes that enable staff with certain qualifications and training to administer medicines for specific conditions and under defined circumstances. All the PGDs were up to date and were due for review imminently by the provider's pharmacist.
- Systems were in place for the safe storage and disposal of medicines. This included temperature-controlled, secure storage with restricted access.
- The unit manager was the responsible person for the safe and secure handling of medicine and audited stock monthly. They carried out a daily check of the temperature of medicine storage areas to ensure they were maintained within the safe range recommended by manufacturers. This included the fridge used to store chilled medicine. From January 2018 to November 2018 there were no gaps in recording and the storage temperature had been consistently maintained.
- Staff managed patient's prescriptions in line with guidance from the British National Formulary.

- Emergency medicine for anaphylaxis was kept on site as part of the emergency equipment and the unit manager ensured the stock was in date.
- Clinical staff undertook additional training in medicines management to help identify potential side-effects in advance and plan appropriate interventions. This included training specific to the medicines commonly used in endoscopy and strategies to counteract sedation.

Incidents

The service managed patient safety incidents well although there was limited evidence of sharing of learning and outcomes.

- Staff recognised incident-reporting criteria and knew how to use the reporting system. However, effective systems were not in place to learn from incidents that took place elsewhere in the provider's network of clinics.
- An incident and adverse event reporting system was well established, and staff demonstrated good knowledge of this. The system was evidence-based and provided staff with clear guidance on reporting responsibilities, including when external bodies needed to be informed of an event. However, we were not assured the senior team were proactive in identifying learning from near-misses, incidents and instances of non-compliance to improve safety standards. For example, staff said they always reported equipment failures as an incident but did not receive feedback or learning points afterwards.
- There were inconsistencies in the information given to us on site and that provided by the service. For example, staff locally said that from November 2017 to November 2018 there had been two reported incidents. However, the service provided the incident tracking document, which detailed 33 incidents in this period. Of these, 12 related to equipment failure or non-availability, including two appointment cancellations caused by the lack of equipment suitable for immuno-compromised patients. Ten incidents related to a booking issue or clinic cancellation, four incidents were categorised as clinical incidents and two were health and safety incidents.
- A named investigator was assigned to each incident and documented key outcomes and the level of risk the incident had presented to the organisation, staff and patients. This helped the senior team to monitor on-going safety in the service and to identify trends in relation to levels of risk. One incident related to a bacterium found in the water supply. A second incident related to a power failure that resulted in the loss of memory in scope decontamination equipment. In both cases staff responded appropriately to rectify the situation and to keep people safe. All the staff we spoke with knew how to report an incident, adverse event or near miss and understood the provider's reporting criteria.
- An up to date adverse incident management policy was in place and the registered manager used this to embed an open culture of reporting incidents and discussing concerns. The policy established a no-blame approach to incidents, which the senior team used to ensure staff could report incidents without fear of reprisal. A critical incident policy supplemented this and guided staff in the event an incident resulted in harm to a patient or to the team. This included criteria for the use of the duty of candour and as part of the process for the notification of safety incidents.
- The registered manager coordinated learning from health and safety audits and staff feedback to lead a programme of preventative measures to reduce the risk of incidents.

Safety Thermometer (or equivalent)

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The manager used this to improve the service.

- Staff carried out a quarterly health and safety checklist as part of the clinical governance lead's annual audit programme.
- The registered manager and clinical staff monitored safety daily to improve practice.

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

We do not currently rate effective.

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.

- The team planned to achieve accreditation by the Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy. JAG accreditation means the service has been assessed and evaluated against a range of quality, safety and service best practice standards. The team had completed two global ratings scale (GRS) census reports as part of their work towards accreditation. GRS is the evaluation a quality scale used to demonstrate standards of practice and care. The service planned to achieve accreditation in summer 2019.
- The service contributed data to the national endoscopy database, which contributed to benchmarking of standards. They started this in July 2018 as part of the work towards seeking future JAG accreditation and was in its pilot phase at the time of our inspection. This meant the service was reviewing the first wave of data, which had not yet been released.
- The provider held ISO 9001:2015 accreditation for providing industry-standard clinical care. The registered manager ensured local standards of care and safety met the requirements of the accreditation, which denotes practice in line with national standards.
- We observed staff take patients' pulse readings using an oximeter on their finger. This did not meet NHS Improvement recommendations issued in December 2018 that pulse readings should be collected by using an ear probe. Staff were unaware of this directive and the registered manager said they would review it with the senior team.
- The provider had an established system of rolling audits to benchmark standards of care internally and with national guidance. This included medicine and equipment stocktakes, washer disinfection and scope logs and the vetting of patient referrals. For example, the service had 16 audits due in November 2018, all of which had been completed on time. Staff used audits for a range of purposes. For example, some audits were used to maintain good local standards, such as fire protocols. Other audits were in place to benchmark clinical practice against national standards and guidelines, such as an audit to measure decontamination processes against those set by the Institute of Healthcare Engineering and Estate Management.
- The clinical lead reviewed the clinical outcomes of patients treated by endoscopists working under practising privileges on a weekly basis and provided feedback. Clinical and operational policies were up to date and staff delivered care and treatment in line with these. Clinical policies such as the intravenous sedation policy had a staff roles list to guide standardised practice. We observed staff followed these in practice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs following procedures.

- Staff offered patients refreshments on site and the waiting room had a fresh drinking water system.
- Where staff recognised patients as being at risk of malnutrition or dehydration they offered snacks and gave advice on maintaining healthy eating.
- The recovery area included water, juice, tea, coffee and snacks. Staff ensured patients had a drink and snack before they left the clinic to address light-headedness associated with some procedures.
- The service issued patients with pre-procedure requirements for nutrition and hydration, including bowel preparation packs and instructions for fasting.

Pain relief

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

- Staff asked patients about pain during pre-assessments, during and after treatment. They documented pain using an established scoring system and documented this in the patient's records. Staff prescribed pain relief medicine where needed and used adapted communication tools to understand the pain levels of patients with complex needs.
- Staff established multidisciplinary pain management plans for patients with long-term, chronic pain with referring doctors.
- Sedation was available, and staff worked with patients to identify the most appropriate level and route of sedation for their individual needs and planned procedure. Where pre-assessments had found a need for communication support, staff ensured they fully understand the patient's ability to communicate pain.
- Patients had the opportunity to report on their levels of pain during procedures through an on-going patient survey. In 2018, 50% of patients said they experienced no pain during their procedure. Of the 50% who did experience, 39% said this was mild, 6% said it was

moderate and 5% said it was severe. However, only 63% of patients had opted for sedation and it was not possible to identify from the survey whether the patients who reported pain were the same patients who declined sedation.
- Where patients reported pain during a procedure, clinicians reviewed records to identify potential improvements in pre-screening and discussions about sedation.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

- The service provided diagnostic results immediately after screening, which meant patients could review their treatment options with their GP or referring doctor at their next appointment. Where results, such as histology results, required further scrutiny, they told patients when to expect these.
- The service's statement of purpose detailed the focus on ensuring patient outcomes consistent with current best practice guidelines and meeting expectations.
- The clinical lead reviewed the GRS scores for individual endoscopists periodically to ensure consistent standards of care and contributed this data to the national endoscopy database as a strategy to benchmark patient outcomes. From November 2017 to November 2018 endoscopists achieved a 98% overall completion rate for cecal intubation. This was better than the minimal rate of 90% and aspirational rate of 95% set by JAG, the Association of Coloproctology of Great Britain and Ireland (ACGBI) and the British Society of Gastroenterology Endoscopy (BSGE). In the same period the polyp detection rate was 31%, which was significantly better than the national minimal standard of 15% and aspirational standard of 20% set by JAG, BSGE and ACGBI. The polyp recovery rate was 99%.
- The provider set key performance indicators to ensure diagnostic reports were produced and shared with referring doctors in a timely manner. The registered manager audited report turnaround times and the clinic had achieved 100% report completion within 24 hours in the previous 12 months.

Competent staff

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

- The provider operated a competency-based induction programme for new staff and each individual was assigned a mentor for this period. Mentors assessed new staff on role-specific competencies at the end of their induction and the provider set a minimum achievement standard. Where new staff failed to meet this, mentors carried out a review of performance with the regional team to ensure the individual had additional support.
- Staff were required to successfully complete a competency-based workbook that demonstrated their knowledge and skills before they were able to practice without supervision. This system ensured staff had the time they needed to develop and demonstrate professional competencies in line with the provider's standards. All the provider's education programmes were competency-based, role-specific and structured around the clinical needs of the service.
- Clinical staff completed up to 20 competency-based training modules based on their role and responsibilities. For example, nurses completed training competencies in monitoring patients during procedures, administering medicines and providing recovery care. Healthcare support workers completed competencies progressively based on their level of experience and responsibility. Competencies were based on JAG guidance and every member of staff was up to date with their required training.
- Permanent staff provided a structured orientation and induction for bank and agency nurses, which included competency checks of their clinical knowledge. This ensured competent practice was consistent regardless of the employment status of individual staff.
- All clinical staff had undergone an appraisal in the previous 12 months. Senior staff followed an established procedure to structure appraisals, which enabled each individual to reflect on their achievements and identify their planned progress in the coming year. However, one endoscopist said they did not undergo regular supervision and results from the most recent staff survey indicated staff did not feel they had access to regular supervision.

- Staff responsible for decontamination undertook competency training, assessments and updates with the manufacturers of the equipment they used.
- The service was in the process of increasing clinic hours and had contracted agency nurses to deliver care whilst increasing the permanent staff base.
- A qualified endoscopist led each patient list and the service required each individual to hold JAG accreditation or equivalent. Both nurse and medical endoscopists provided treatment, with support and oversight from the clinical lead.
- All staff had completed an appraisal in the previous 12 months and all clinical staff had undergone a check of their professional registration. Each member of the permanent team had a personal development plan they reviewed periodically with the registered manager.
- We looked at the training and development records of three members of staff and found varying levels of completion. For example, one member of staff did not have a completed six-week probationary review. One member of staff had checked all items on their induction plan but none of the entries were signed or dated. One member of staff had a PGD competency form in their file, but this was not signed or dated. We spoke with the manager about this who had other records of assurance staff had completed most of the items that were missing signatures and dates. However, such inconsistencies meant it was not always clear staff had completed appropriate development or key probationary tasks.
- We looked at the induction records of seven agency nurses who had recently worked in the service. The provider required them to complete an induction process on day one followed by a competency assessment on policies and procedures at the end of their first week. All nurses had documented the completion of the first day induction but only three had completed the first week induction competencies.
- Staff underwent an on-going competency assessment programme to ensure they remained up to date with the latest practice standards. This included practical assessments of biopsies.

Multidisciplinary working

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.

- Processes were in place to ensure staff could refer patients to secondary care services when their condition could not be fully managed in the community primary care setting.
- The provider had a dedicated referrer line as part of the patient referral centre. This meant referring professionals could obtain information on advice on the most appropriate centre for treatment and expedited appointments.
- After each procedure the endoscopist sent a summary of their findings to the referring doctor and a copy to the patient's GP, if these were not the same person.
- Staff were proactive in engaging with referring doctors when they needed more information about the patient's history. This was part of a process to only carry out procedures where they had enough information to carry out treatment safely and meant referring doctors remained involved in the process.

Seven-day services

- The service was equipped to offer a seven-day service from 8am to 6pm and had offered a four-day service since opening in November 2017. The manager was gradually increasing the staff team and expanding the service towards its full seven-day capability.

Health promotion

- The provider adhered to a duty of care for patients to promote their general health and safety to minimise unnecessary risks to their health.
- Staff provided advice and signposting to health, wellbeing and holistic services as part of planned care and treatment. This was part of a wide-ranging service that aimed to support and empower patients to make healthier choices.

Consent and Mental Capacity Act

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Good

Endoscopy

- Clinical staff were trained in the Mental Capacity Act (2005) and assessed patients for their capacity to retain information before carrying out procedures. This was in line with the provider's policy. Where clinicians were not assured of a patient's mental capacity they cancelled the procedure and referred the patient back to their doctor. By following this procedure, they had detected early-onset dementia in a patient who had been unaware of their condition and avoided a potentially dangerous and distressing procedure. In another instance, a clinician had referred a patient to secondary care for further treatment because they could not retain information sufficiently to consent to a procedure and had extensive undisclosed existing morbidities.
- Clinical staff obtained and documented consent prior to each procedure and adhered to best practice guidance from the General Medical Council (2013) for intimate procedures, including offering a chaperone. Where they identified barriers to obtaining full consent due to language understanding, staff arranged for an interpreter to assist with the process.
- An up to date policy was in place that staff used as best practice guidance to obtain valid and informed consent. The policy was based on the principles of the Mental Health Act (1983) and the Mental Capacity Act (MCA) (2005). A separate policy provided guidance on obtaining consent from adults with reduced capacity, which included details of how to establish best interests care within the MCA.
- We observed staff use appropriate positive patient identification before they delivered care or discussed personal details and provided each patient with an identity bracelet.
- The provider sent out specific procedure information by post, e-mail or fax to patients in advance of their appointment with a consent form for them to complete and bring with them. We observed staff review the consent procedure with patients after a positive identification and before they carried out a procedure.
- The service had a withdrawal of consent policy, which patients could act on at any time, including if they were under sedation.

Are 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.

- The service had established standards for dignity and respect, which all staff demonstrated good awareness of.
- We observed all staff spoke to patients with a caring attitude, dignity and respect. This was in line with the provider's privacy and dignity policy, which established seven key standards for staff to follow. For example, one key standard was the need to respect personal boundaries and space. We saw staff adhered to this, such as when they collected patients from the waiting room and assessed whether the patient was comfortable with a formal or informal approach to being escorted and to communication.
- One patient we spoke with said, "The service is 10 out of 10. They're absolutely brilliant." The clinic had received cards and notes of thanks from happy patients and their relatives and staff displayed these in the clinic. One patient noted, "You made a procedure I was terrified about go smoothly and I can't thank you enough."
- The service gathered continual feedback from patients through a satisfaction survey. In 2018, 100 patients participated in the annual patient survey. The results indicated overall high standards of satisfaction with the service. For example, 100% of patients said staff respected their privacy and dignity during their procedure and in recovery and 97% agreed with this during their preparation. In addition, 91% of patients said their experience had been good or excellent.
- Privacy and dignity were embedded in the statement of purpose and detailed the standard of service patients could expect, which also acted as a framework for care delivery. This included providing assistance that was discreet and dignified and ensuring private areas were available for consultation and treatment.

- Care and compassion were embedded in the service mission and values and senior staff adhered to its principles when developing and delivering the service.
- Staff demonstrated strategies to ensure patients were treated with privacy and dignity. For example, they used en-suite preparation rooms and offered patients a choice of gown or dignity shorts before their procedure. Space for private conversations was readily available and staff utilised individual recovery spaces following procedures to ensure conversations remained confidential.
- Staff used the NHS Friends and Family Test (FFT) to obtain continual feedback on patients' experience of the service. The team had adapted the FFT to provide digital access using an internet link and a QR code. A QR code enables anyone with a smartphone to access the survey by scanning the code. A paper-based survey was also available and reception staff encouraged patients to complete the version they were most comfortable with. From November 2017 to November 2018 the service achieved a 99% recommendation rate and no respondents said they would not recommend the clinic. Patients commented positively on their experience with the reception team and 100% of respondents said they had been dealt with promptly and efficiently.
- In addition to on-going FFT feedback, staff surveyed a random sample of 100 patients each year to explore more in-depth themes of satisfaction and areas for improvement. The team displayed outcomes from this using a, 'You said, we did' display.
- During our inspection we observed staff delivered care in line with the provider's privacy and dignity policy. This outlined key standards for staff to follow when communicating with patients and their relatives.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Patients received diagnostic results on the same day as screening and clinical staff provided emotional support and guidance when results were upsetting or unexpected. There was a dedicated area for difficult discussions.
- We observed staff deliver care with gentle, empathetic communication.
- Staff signposted and referred patients to counselling and psychotherapy services when they needed more structured support in dealing with a diagnosis or treatment.
- The senior team encouraged and empowered staff to deliver care with sensitivity and empathy and to adapt this to individual needs when patients needed more intensive emotional support.
- One member of staff was present during each procedure to act as an advocate for the patient. This meant they were dedicated to monitoring the needs of the patient and to providing emotional support to reduce anxiety during procedures.

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.

- Clinical staff involved patients in care and treatment planning and discussed options and potential downsides to treatment before proceeding. This ensured patients had realistic expectations of the outcomes of their care and remained involved in on-going decision-making.
- Involving patients in their care was a key element of the service's statement of purpose. This directed staff to provide care only when they were satisfied the patient understood the treatment plan. The directive paid attention to detail of the patient experience, such as instructing staff to establish how each patient wished to be addressed. We saw staff routinely adhered to this in practice.
- The provider was an early adopter of the NHS England 'Always Events' methodology, which enabled staff to work with patients to design services and information resources based on their individual needs.
- Staff paid attention to detail when communicating with patients and considered individual preferences. For example, staff asked patients and their relatives how they wished to be addressed and noted this so all staff communicated consistently.
- Staff used a comfort score system during procedures to ensure they understood how patients were feeling, in line with Joint Advisory Group (JAG) audit standards. Although staff documented this in patient records they did not analyse them on a rolling basis, which meant

they could not provide feedback or action plans to the patient's referring doctor. After our inspection the provider told us these results were analysed on a bi-annual basis.

- Staff ensured patients were informed of the findings of procedures at each step. After a procedure the operating clinician provided a report for the patient with key information and provided printed information on lifestyle changes and considerations that could help relieve their symptoms.
- Staff ensured patients were informed of the findings of procedures at each step. After a procedure the operating clinician wrote to the patient with key information and provided printed information on lifestyle changes and considerations that could help relieve their symptoms.
- The results of the 2018 patient survey indicated staff consistently involved patients in their care and treatment. For example, 98% of patients said staff explained test results to them afterwards and 98% said they were provided with a copy of their examination reports. Of the patients who needed to wait for histology results, 88% said they understood how they would receive this. Staff flagged this during our inspection as an area for improvement and were addressing the need for more consistent communication in this area. In the survey 100% of patients said staff introduced themselves, 100% said they had the opportunity to discuss their procedure and ask questions beforehand and 100% said the clinician provided enough information ahead of their procedure. Patients were less pleased with information in relation to delays and only 81% of patients whose appointment was late said they were given a reason for this.

Are endoscopy services responsive to people's needs?

(for example, to feedback?)

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

- Staff were demonstrably committed to developing the service to meet the changing needs of patients. This included monitoring local, regional and national health trends to ensure the service remained viable and competitive.
- The service provided pathology results within five working days and shared these with referring doctors immediately. Staff scheduled patients into return appointments the next day to discuss results if needed. The local team carried out a twice-annual turnaround time for pathology audits results to ensure expected standards were maintained.
- Senior staff monitored requests from NHS services to identify opportunities for patients on waiting lists. For example, they increased the availability of certain types of appointments in line with trends in demand.
- The senior team planned the procedure list on patient need. For example, they arranged for patients at risk of infection to be seen at the start of the session and for patients at risk of transmitting infection to be seen at the end of the list. Where patients had additional or complex needs, the service provided extended appointment times.
- A laboratory was based in the same building as the clinic and the service sent all samples there under a service level agreement. Staff documented and tracked each sample and there had been no instances of lost or delayed samples in the previous 12 months.
- Standard operating procedures were in place to enable the clinic to carry out procedures with patients who presented with an increased risk of infection.
- The service had developed a standardised referral form that required referring professionals to include information to help staff plan to meet needs. This included information on communication challenges and language needs.

Meeting people's individual needs

The service took account of patients' individual needs.

- Staff were trained to provide individualised care that they adapted to each patient's cultural and communication needs. For example, staff recognised when some patients valued being addressed formally and when others preferred a more informal approach.

- Patients could request a male or female clinician for procedures and the service had a chaperone policy in the event they could not secure a patient's first request.
- Staff arranged for telephone interpreters to support patients who did not speak English during appointments. This meant they were assured of effective consent and safeguarding procedures where communication barriers existed and had the opportunity to facilitate effective discussions directly with patients who did not speak fluent English that related to difficult news, such as a terminal diagnosis.
- The service had an up to date discrimination prevention policy that was compliant with the Equality Act (2010) and ensured staff delivered care without prejudice to protected characteristics. All staff undertook equality and diversity and person-centred care training and there was a clear care and treatment ethos based on individualised care.
- Staff proactively contacted patients who did not return for planned follow-ups after a diagnosis or treatment.
- Staff used the electronic pathway to document information that helped them deliver tailored, individualised care. For example, staff noted where patients had needs in relation to language, hearing, sight and mobility. Where the referring doctor noted this in advance, staff prepared for their appointment by offering additional support.
- The recovery bay was equipped with toilet facilities and a range of refreshments, which staff encouraged patients to have before they left the clinic. There was a dedicated quiet room reserved for discussing challenging or difficult test results.
- Staff facilitated longer sessions for patients with a hearing impairment or who were deaf, and the registered manager arranged for a British Sign Language interpreter to be present. Staff facilitated trained service dogs and all areas were accessible by wheelchair.
- The service had a private discussion room for endoscopists to discuss bad news and for multidisciplinary meetings to take place.
- Staff provided patients with a care journey booklet that included detailed and easy-to-understand information about their care. This included photographs of each clinical area and equipment they were likely to see, with a straightforward explanation of each. The booklet included an explanation of what would happen in each area and what would happen after the procedure.
- Processes were in place to provide care and treatment for patients living with dementia or a learning disability. This included tools to help staff adapt communication so that the patient understood what was happening and to help staff be confident they had consent for the process.

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.

- The service operated as a community clinic and provided care to patients whose needs were within the scope of the service. Clinical staff carried out triage of referrals to ensure the clinic could meet their needs ahead of attendance.
- The service operated to a standard six-week referral to treatment time (RTT) and the electronic booking system managed this automatically. Clinicians reviewed each referral to ensure patients with urgent needs were prioritised and scheduled extended clinic times to meet patient needs.
- Where a patient was unable to attend within six weeks of their referral, staff returned them to their referring doctor.
- The provider had a centralised electronic patient referral system and a dedicated centre team that coordinated bookings.
- In November 2018 there were 199 patients waiting for an examination or procedure. This was within the limits of the service to meet RTTs and a centralised team coordinated appointments to minimise waiting times.
- From November 2017 to November 2018 the service cancelled one appointment for non-clinical reasons. This was a double-booking due to an administrative error and there was no impact on care. In the same period there were no treatment delays.
- Patients accessed the service on referral from their GP or another medical practitioner. Appointments were on a pre-booked basis only and patients could typically access the service within six weeks of referral. Staff planned the service to be responsive without delays for assessment or treatment.

- Four recovery beds were available in individual bays with nurse supervision. This meant patients had private recovery space without the risk of a mixed-sex accommodation breach.
- The registered manager, operations support manager and regional operations manager carried out a weekly capacity and demand meeting to review waiting times and referral to treatment (RTT) times. From November 2017 to November 2018 the service was compliant with the RTT standard of six weeks in 10 months.
- The service sent a reminder text message or called each patient three days ahead of their appointment to confirm attendance. Reception staff maintained an up to date information board in the waiting room that included delays to specific lists and the reason(s) for these.

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.

- The service had an established complaints policy that was displayed in the waiting area and was readily available on the website. All staff were trained in use of the complaints procedure and could signpost patients to the appropriate process to follow. The registered manager offered to meet with complainants and staff used this as a strategy to deescalate concerns and issues when they occurred. The service set an initial acknowledgement time of 48 hours and a full response and resolution time of 20 working days from the date of receipt. The manager had met these standards in each complaint received in the service.
- The director of clinical quality maintained oversight of the complaints policy, which included guidelines for escalating a complaint to adjudicators and external independent investigators if a complaint had not been resolved internally.
- It was not clear the service accurately and consistently recorded and tracked complaints. For example, from November 2017 to November 2018 the service recorded three formal complaints in the tracking system. However, there were seven complaints stored locally, which we reviewed during our inspection. In the same period the service reported 660 compliments. The registered manager reviewed compliments to identify themes, which had included the quality of care and the knowledge of staff. The service had responded quickly to each complaint, apologised and provided a full and appropriate response. Of the seven complaints, the manager had upheld one. In each case the manager explained the reasons for their decision in their written response following an investigation. For example, a GP had written to the clinic to make a complaint about the cancellation of a procedure for one of their patients. The investigation found the patient had not used any of the bowel preparation sent to them and had not brought an escort with them. This meant the endoscopist was unable to carry out the procedure. Other complaints regarding cancellations occurred when patients had not disclosed they were taking blood-thinning medicine during the triage stage and another instance where a patient made a request for a specific gender of staff at the start of the appointment, which the service could not fulfil.
- A complaints and compliance manager led corporate governance in relation to complaints and maintained an overview of local complaints and the outcome as part of the provider-level process.
- All staff completed customer care and complaints training as part of their mandatory package.
- Staff said they learned about complaints and learning points during safety huddles.

Are endoscopy services well-led?

Good

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

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- A clinical lead and regional operations manager had overall responsibility for the service and the registered manager had responsibility for the day-to-day running of the service. The unit manager worked clinically and provided leadership for the nursing and healthcare support worker teams. The established leadership structure meant staff always had a point of contact for support or escalation.

- Staff spoke positively about leadership and said the registered manager and regional manager was accessible and supportive.
- The registered manager, clinical lead and regional operations manager formed a triumvirate leadership team with defined areas of responsibility. The provider's medical director led clinical supervision and professional leadership processes and maintained clinical oversight of all endoscopists. The provider's medical director provided support to the clinical lead and the senior clinic team were accountable to the executive team through an established leadership support structure.
- The provider organised services into directorates and endoscopy was based in the specialised services directorate.
- All staff we spoke with were positive about local and provider-level leadership. They said the manager was supportive and accessible and they had regular communication with the senior leadership team.

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 and patients.

- The service had a well-established vision and strategy that formed part of the statement of purpose. This was credible, had been developed by permanent members of the provider team and established the standards of quality the service aimed to achieve. Part of the standards required staff to ensure the patient was always the focus of their activity and to ensure they continually sought feedback.
- There was a robust and realistic strategy to deliver the service's priorities and to ensure care was sustainable. For example, the operating strategy included planning for consistent staffing levels and capacity management in line with trends and planning in the local health economy.
- All staff we spoke with had good knowledge of the service's core values and understood their role in achieving them. The core values centred on providing a high-quality service with rapid access and results.
- The provider reviewed the vision and strategy annually and updated it in line with service achievements and challenges and the needs in the local population.
- The provider had an established clinical quality strategy with a goal completion date of 2020. This incorporated the service philosophy and outlined the ambitions of the service for development and growth.
- The service was actively part of the provider's five-year clinical quality strategy, which included four key priorities centred within quality improvement activities. The strategy was designed to apply to all services within the provider's network, including community endoscopy services provided from this location.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- Staff delivered care and treatment to meet the overarching mission of the provider; to ensure patients had access to reduced waiting times, timely diagnoses and improved care experience.
- Care services were underpinned by a quality policy that detailed the objectives of the organisation and its commitment to professional standards and to meeting patient's expectations. Staff spoke positively of this, which demonstrably contributed to their motivation and the standard of care they delivered.
- The service had adopted professional values and teamwork competencies based on best practice standards from Joint Advisory Group (JAG). All clinical staff had completed this although the service did not offer it to the administration team.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

- Staff used an overarching clinical governance framework to provide assurance of service quality in line with provider standards and targets. The registered manager and clinical quality team led the application of the framework through a governance committee structure, with oversight from the director of clinical quality.
- A medical director for diagnostics and director of clinical quality maintained oversight of local governance and integrated this with the rest of the provider through a corporate management structure.

- The risk and governance committee led governance processes at provider level and staff from this clinic represented the service. The committee worked to a 'board to floor' principle that meant the group shared issues and safety concerns directly with all staff as a strategy to share risks and identify solutions.
- The clinical quality subcommittee produced a quarterly report based on 12 key indicators in the service, including performance, feedback and staff development. These groups and processes operated at provider-level and included the local service and those in the group.
- The governance committee structure enabled seven specialist groups to contribute to the governance framework and ensure they shared information and learning to support quality monitoring and improvement. These included medicines management group and the water safety group. Each group had a standardised agenda for meetings and produced an attendance log and minutes for each meeting.
- The manager attended a bi-monthly regional meeting with colleagues from other services in the clinic's network. This enabled them to compare safety and operational performance with similar clinics and discuss good practice and opportunities for development.
- A team of three administration staff worked in the service with support from the provider's central teams. This team supported day to day administration, operations and non-clinical governance. The team also supported data collection and audit administration for the clinical team.
- The whole clinic team joined a bi-annual governance meeting, called a quality circle meeting. The team used this to discuss overall performance as well as the track record on global ratings scale (GRS) scores as they worked towards achieving Joint Advisory Group (JAG) on GI Endoscopy accreditation.
- The registered manager maintained a comprehensive local record of third-party contacts of organisations responsible for the maintenance and upkeep of specific equipment and provision of services. The clinic was based in rented premises and facilities, recycling, cleaning and water quality were handled by different organisations. Records held by the manager meant staff had easy access to points of contact in the event of an equipment or service failure and formed part of consistent local governance processes.
- Clinical governance processes with the provider's lead pharmacist were not robust. The registered manager was unaware of the pharmacist's oversight of medicines management, where they were based or their plans to update PGDs. We were able to resolve this by speaking with the regional manager but there was a need for improved local clinical governance in this area.
- The provider had reviewed organisational governance and committee structures in 2018 as part of a five-year clinical quality strategy. This resulted in increased oversight from the central teams through an expanded committee system. This included a safeguarding board and a management of doctors group.
- Although centralised governance systems were well established and demonstrably functioned well, this was not always reflected in local processes. For example, governance systems had not identified significant gaps in training and induction records or in the quality of complaint responses.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- The provider used a five-step quality assurance process to standardise how they identified and measured quality in the service. This included using quality monitoring reviews and continuous quality improvement in addition to performance based on feedback, audit and patient outcomes.
- The service focused on patient experience and staff measured care and feedback using national benchmarks, including the National Institute for Health and Care Excellence (NICE) quality standards for experience.
- The registered manager maintained oversight of all risks to the service using a risk register, which the senior provider team monitored as part of organisational governance. The provider used a combined corporate, functional and local risk register to track all risks, including those relating to more than one clinic in their network. Corporate risks referred to those from across the specialised services directorate and functional risks referred to risks that involved multiple units in the network.
- At the time of our inspection there were 17 on-going risks related specifically to this location, each of which

had a risk rating and information on mitigation. The manager used risk assessment criteria to identify likelihood and severity and documented mitigating strategies. The clinical quality team maintained oversight of risks at location and provider level and ensured those that applied to all clinics were managed consistently. For example, the team added a risk relating to the safe use of oxygen cylinders following a national safety alert.

- Staff used an electronic risk management system to record and store the risk register, incidents, complaints and related data. This included guidance on the use of the duty of candour, which all staff demonstrated understanding of. Risks with a high score, which measured severity and probability, were added to the regional risk register and the risk and governance committee reviewed these quarterly.
- An up to date risk management policy was in place and staff had access to this in hard copy and on the intranet. The risk policy clearly explained the responsibilities of staff based on their role and established how staff used intelligence to make decisions about clinical risk. Risk management had a specific governance structure and the provider embedded a risk 'appetite' in the service that meant staff had the ability to develop the service without taking risks in patient health. The risk management policy was based on national evidence of best practice and it demonstrably underpinned practice.
- A risk and governance lead was in post in the provider and worked with a health and safety advisor to monitor risks reported by the clinic. They worked with the registered manager to ensure risk assessments were fit for purpose and accurately reflected the risk.
- The clinic team held a weekly demand and capacity meeting to review the number and types of referral and to review the efficiency of used appointment slots.
- The service followed the provider's strategy of using the international 'Six Sigma' techniques to improve processes and achieve a continual process of quality improvement.
- The service had an emergency reduced staffing procedure, which provided the manager with guidance on risk management and service delivery in the event of unexpected or sustained staffing shortages.
- The provider monitored NHS Friends and Family Test results in all their clinics and shared results with each individual service as part of a performance and quality benchmarking process. Staff analysed narrative comments from the FFT as part of on-going work to achieve patient satisfaction.
- The clinic team monitored RTTs, report turnaround times and reporting audits as key indicators of performance and service quality.
- The registered manager carried out an annual healthcare quality audit as part of the service quality plan led by the clinical governance lead.
- There was a lack of robust assurance around the delivery of staff development and competencies. We found multiple examples of missing information and discrepancies in staff development documentation. For example, we found a non-clinical member of staff had completed training in the technical operation of clinical equipment. We asked the manager about this who said they had taken it in error and the senior team had not noticed until afterwards. One agency nurse who had worked in the clinic had not signed a mandatory confidentiality statement. There was an unsigned, undated note in their file stating that this needed to be completed. There was no system in place to ensure this was tracked and resolved. Although there were significant gaps in documentation, all of the staff we spoke with said they were happy with the appraisal system and opportunities for progression.
- The provider maintained a corporate business continuity plan that would enable staff to coordinate care and communication remotely with patients and to arrange alternative care in the event the premises were uninhabitable.
- The provider used a monthly clinical governance report to monitor risks, safety and performance. We reviewed the reports from April 2018 to July 2018 and found reports clearly scrutinised areas of performance such as risks, incidents, significant events, compliments and complaints. The executive team used this process to monitor engagement with patients and referrers and acted on positive and negative comments to continually improve the service.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- Systems were in place to ensure the secure handling, storage and destruction of confidential records. The service managed this in line with the European General Data Protection Regulation (GDPR) 2016/679.
- Staff adhered to the Information Governance Alliance Records Management Code of Practice for Health and Social Care (2016), which ensured disclosure of patient information was restricted to clinical purposes and retention and disposal methods were in line with national guidance. In addition, staff worked within a confidentiality policy that was based on national legislation to ensure they protected data and private information in line with national requirements.
- Staff accessed an intranet system to maintain up to date awareness of care and treatment standards across the organisation. This included an average of 10,000 patient feedback and data items per month, which the team used to standardise and improve care.
- All staff completed information governance and GDPR training as part of their mandatory modules.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

- The service acted on feedback from patients and visitors. For example, an independent external organisation analysed feedback on patient comment cards and advised the local team on themes and trends to help them improve the service. The manager used a 'you said, we did' display to demonstrate to patients how they acted on feedback. For example, they listed the names of staff on duty and the status of each clinic following feedback. During our inspection staff regularly updated the status of each clinic by listing delay times and including a clear, simple reason for this.
- Staff contributed to an annual survey that the provider used to develop service improvement plans in the local service and across the organisation.
- The team facilitated a monthly endoscopy user group meeting to maintain continual engagement with staff as part of a quality and service plan.
- The service worked closely with other clinics in the provider's network and new staff were encouraged to spend time working at another site as part of their induction and continuous development. This helped to build relationships between clinic teams and meant staff were prepared to provide cover in other clinics when colleagues were on holiday or unwell.
- The provider had carried out a staff survey and released the results in December 2017. This demonstrated overall better engagement between staff and senior colleagues than the provider's average. For example, this location's engagement score was 79% compared with the provider average of 71%. However, specific results in the survey indicated staff felt variably about working there. For example, 86% of staff said they were be happy for a friend or relative to have treatment in the service and 100% said they knew what was expected of them at work. However, only 67% felt poor performance was well-managed and only 69% said they had received praise or thanks for their work in the previous week. In addition, only 50% of staff said someone regularly spoke with them about progress and development and 68% felt their opinion counted. Both results reflected lower performance than the provider overall. There was limited local evidence of action taken to address the results of the survey, all the staff we spoke with said they were happy with working conditions and support.
- The provider had involved staff, stakeholders and patients in the development of the five-year clinical quality strategy and in the priorities for improvement in 2018/19. This included more consistent engagement through surveys and easier access to feedback processes.
- Staff meetings were held monthly. We looked at the minutes for two meetings that had taken place in the previous 12 months and saw they had been well-attended by staff from a range of different roles. The unit manager had documented actions to suggestions and challenges and it was evident meetings led to improved practice and staff understanding.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

- The provider encouraged staff to enrol on a leadership and development programme that enabled them to

develop and progress in the organisation. This included the opportunity to spend time shadowing existing senior staff and gaining experience in other clinics in the provider's network.

- The service had actively engaged with local primary care services and held two events for GPs as a strategy to build awareness and service growth.
- The provider was an early adopter of transnasal gastroscopy services, which provided a more comfortable experience for patients and reduced the need for sedation. Staff received positive feedback from patients about this procedure who appreciated being able to talk and breathe normally during the procedure.
- The local business plan projected growth in patient numbers until September 2019, which staff worked towards as part of clinical quality improvement and service development work. The senior team planned to achieve this through an improved programme of educational sessions for GPs and other medical referrers.

Outstanding practice and areas for improvement

Outstanding practice

The provider was an early adopter of transnasal gastroscopy services, which provided a more comfortable experience for patients and reduced the need for sedation. This clinic had adopted the practice and provided the service as an option for appropriate patients.

Areas for improvement

Action the provider SHOULD take to improve

- Implement consistent standards of practice in relation to the safe management of Controlled Drugs (CDs). This should include effective audit processes.
- Provide staff with the tools to monitor patients for deterioration and to respond to urgent clinical needs.
- Implement robust, consistent safety and maintenance processes for emergency equipment.
- Minimise infection control risks through effective, consistent audits and practice.
- Review safety monitoring and training to manage risks associated with major haemorrhages and sepsis.
- Store sufficient quantities of oxygen stored on site to meet patient need, including during unplanned emergencies.
- Actively embed learning from incidents and other safety issues elsewhere in the organisation.
- Require all staff, including agency staff, to fully complete induction and orientation processes and document this.