Prime Endoscopy (Bristol) Limited

Quality Report

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

Ratings

Overall rating for this location	**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.

Overall summary

Prime Endoscopy (Bristol) Limited is part of the InHealth Group. The service has no inpatient beds and facilities consist of a reception and waiting area, two admission rooms, two pre-procedure rooms with ensuite facilities, two procedure rooms and a decontamination unit. In addition, a recovery area consists of four separate rooms and toilet facilities and a private non-clinical room used for consultation after the procedure. The service provides endoscopic procedures for patients who are over the age of 18 years.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 25 October 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this service was endoscopy procedures.

Services we rate

We rated it as **Good** overall.

- The service ensured there were enough staff who had the appropriate training, skills and experience to maintain patient safety.
- Staff mostly managed infection prevention and control risks well. They monitored equipment and staff complied with policies and best practice guidelines. Decontamination processes of endoscopic equipment were in line with national standards.
- Staff had access to information they needed to care for patients including policies and procedures and information about patients' current health needs.
- Staff were caring and kind to patients involving and explaining their care and protecting their privacy and dignity.
- The service used agreed pathways of care with NHS providers for patients who had a diagnosis of cancer.
- Patients could access the service at times that suited them, between Monday to Friday of each week and waiting times rarely exceeded six weeks.
- Staff felt respected and valued and were proud of working for this service.
- Suitably experienced and competent managers led the service.
- Staff used systems to report and manage risk. All concerns were investigated, reported and learning shared with staff.
- Comments from patients were taken seriously and used to improve the service. Staff actively encouraged feedback from patients to shape the service.
- Staff were sensitive to patients' needs and ensured they were supported appropriately.

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

- Staff were trained in basic life support and use of electronic defibrillator but not in the Resuscitation Council (UK) immediate life support.
- There was no formalised agreement between the service and the local NHS trust, for transferring an unwell patient.
- Not all staff followed infection control and prevention guidance in being bare below the elbow in clinical areas and wore jewellery beneath surgical gloves.
- Although staff had access to emergency equipment there was limited written guidance available for staff to use in the case of a major gastrointestinal haemorrhage.
- Policies were not always detailed enough to provide guidance for staff.
- There was a risk that in certain circumstances controlled medicines may not be in the custody of an appropriate professional.

Summary of findings

Nigel Acheson Deputy Chief Inspector of Hospitals (South West)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Endoscopy	Good 	The service provides diagnostic endoscopy for adults. We rated this service as good for caring, responsive and well-led, and requires improvement for safe. We do not rate the effective domain for this service

Summary of findings

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Background to Prime Endoscopy (Bristol) Limited

Prime Endoscopy (Bristol) Limited is part of the InHealth group. The service is a wholly owned subsidiary of the InHealth group. It opened in 2010 in Westbury-on-Trym (Bristol) and moved to its current premises, in the centre of Bristol, in February 2017. The regulated activities it is registered to provide are:

- diagnostics and screening procedures.

The service has had a registered manager in post since 2010. At the time of the inspection, the registered manager had been in post since 2014 and was also the unit manager.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in endoscopic procedures. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

Information about Prime Endoscopy (Bristol) Limited

Prime Endoscopy (Bristol) Limited is run from premises within a central location, in a mixed retail and residential area of Bristol. These premises were leased and had been designed for their purpose of endoscopy procedures within a community setting.

The service was incorporated into the InHealth group in 2014 and is run as a wholly owned subsidiary of the group.

Procedures offered by the service were colonoscopy, flexible sigmoidoscopy, Oesophagogastro duodenoscopy (OGD)-both transnasal and oral route, banding of haemorrhoids for patients 18 years of age and over. These are procedures which look at different parts of the gastric tract. The service used nurse, GP and consultant endoscopists to provide the endoscopic service and administration, with nursing staff providing care for the patients.

During the inspection, we visited all areas of the clinic including waiting areas, consultation rooms, procedure rooms and recovery areas. We spoke with 12 staff including; registered nurses, health care assistants, reception staff, medical staff, endoscopists and senior managers. We spoke with four patients, reviewed five sets of patient records and observed patient care provided by staff.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service has not previously been inspected by CQC.

Number of procedures performed from August 2017 to 10 August 2018:

- Oesophago gastro duodenoscopy (OGD) 2117
- Flexible Sigmoidoscopy 777
- Banding of haemorrhoids 37
- Colonoscopy 1530
- Clinic appointments 1099

Patients attended for their appointments and were discharged from the service on the same day. There were no overnight stays or facilities for this. The service operated between 9am and 6pm Monday to Friday of each week. All patients were NHS funded and were referred by their GPs.

Seven medical endoscopists and one nurse endoscopist worked at the service under practising privileges. Two nurse endoscopists were directly employed by the service. The service also employed a unit manager, a

Summary of this inspection

deputy sister, 10 registered nurses, eight health care support workers and four receptionists, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was provided by InHealth group.

Track record on safety 11 (August 2017 to 10 August 2018)

- There had been no never events
- There had been no serious incidents causing harm to patients reported.
- There had been 83 incidents reported on the service's incident reporting system.
- There had been no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli
- There had been four complaints of which, three had been partially upheld

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAG) accreditation was renewed in August 2018

Services provided at the clinic under service level agreement:

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

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

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

- Although risks were identified and managed, there was limited written guidance for staff to follow in the event of a major haemorrhage during an endoscopic procedure.
- There was no formalised agreement between the service and the local NHS trust, for transferring an unwell patient.
- Staff were trained in basic life support and use of electronic defibrillator but not in the Resuscitation Council (UK) immediate life support.
- Not all staff followed policy to be bare below the elbow during clinical procedures. A staff member wore jewellery beneath surgical gloves.
- There was a potential risk that management of controlled medicines would not be in safe custody of appropriate professionals in certain circumstances.

However, we also found the followingareas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff knew how to manage patient conditions in urgent situations which included calling the emergency services.
- Staff understood how to protect patients from most types of abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service mostly controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well. Any breakdowns were dealt with promptly.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- 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. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving and recording medicines. Patients received the right medication at the right dose at the right time.

Summary of this inspection

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Effective is not rated however we found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- 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.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. The service worked with NHS providers to support patient care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service's policy and procedures when a patient could not give consent.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic patient records system that they could all update.

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

- Staff who assessed whether patients had the capacity to make their own decisions about their care did not document their decision process using a recognised assessment tool.

Are services caring?

Good

We rated caring as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Summary of this inspection

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

Are services responsive?

Good

We rated responsive as **Good** because:

- The service planned and provided services in a way that met the needs of local people. The service worked with commissioners and GPs to ensure patients were referred to the service when appropriate.
- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- 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 issues the provider needs to improve:

- Where patient information is provided it should include detail of specific risks for patients undergoing procedures based on how often they occur.

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.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Summary of this inspection

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

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

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 and made sure staff completed it. The organisation provided mandatory training for staff in a range of subjects to ensure they were knowledgeable about systems and processes which protected patients from potential harm and abuse.** There were 15 modules which included information governance, basic life support, fire safety and equality and diversity. Staff received email reminders when modules were about to expire and needed refreshing and managers monitored attendance. On the 3 September, staff compliance was between 96% and 100% for each module. There was no formal target for compliance but the manager aimed for 100% staff training.

Safeguarding

- **Staff understood how to protect patients from abuse**. Staff had training on how to recognise and report abuse and they knew how to apply it.
- There was a safeguarding lead within the local service and within the wider InHealth organisation and staff knew how to contact these people for support. GPs had attended level three training in safeguarding children and there was always a GP in the clinic during procedures. Staff described situations that would cause concern and how they would take action to protect and support vulnerable people although they had not previously reported any concerns.
- Training was provided for all staff on safeguarding of children and adults and managers monitored attendance. The service did not see patients under the age of 18 years but staff were expected to complete safeguarding children training modules at level two. This was in line with national guidance. Figures for 3 September 2018 showed 100% of staff had completed safeguarding children level two and safeguarding adults training.
- The service ensured new employees underwent safety checks. These were undertaken by the InHealth corporate group who checked criteria outlined by the Disclosure and Barring Service before staff started working at the clinic.

Cleanliness, infection control and hygiene

- **The service mostly controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**
- The service undertook monthly hand hygiene audits to ensure staff were compliant with good practice. This included observation of staff decontaminating their hands before and after patient contact and before and after wearing gloves. The audit observed the way staff decontaminated their hands and included the solution used and process such as palm to palm, nail

cleaning and between fingers. These audits showed 100% compliance for five of seven months between January and July 2018. Staff were informed immediately of areas needing improvement.

- Staff were monitored on their use of personal protective equipment which included using eye shields when cleaning equipment to ensure they were not at risk of any cross contamination from used endoscopes.
- There was an infection control lead for the service and a named microbiological lead was provided by the InHealth group to support infection control.
- Staff screened patients for transmittable diseases and referred them to more appropriate services.
- Service staff had defined roles and responsibilities for areas of the patient pathway and for decontamination. Trained staff received additional training and were allocated to roles such as endoscopy care, recovery post procedure and equipment decontamination. We saw bedside cleaning take place immediately after the procedure. Linen was single use and disposed of after each patient. Endoscopes were cleaned immediately after use and in line with Health Technical Memorandum 01-06: Decontamination of flexible endoscopes. Used endoscopes were passed from the procedure room to the decontamination room through hatches for initial cleaning, testing and decontamination. Staff used personal protective equipment such as aprons, gloves, gowns and face visors in 'dirty' areas and removed this before moving to 'clean' areas of the room.
- Decontaminated equipment was transported in covered trays through doors to the two procedure rooms. One of the doors was faulty at the time of our visit and had been reported for repair. Staff were using an alternative route to this procedure room through the recovery area and equipment did not return through the 'dirty' area of the room.
- Drying cabinets held 20 endoscopes and monitored the time each item was in the cabinet for. Equipment was dated so that staff knew when equipment needed to be reprocessed if they were in the cabinet for long periods of time.
- Equipment was tested weekly to ensure it was cleaning endoscopes adequately and test reports were validated by an independent authorising engineer in decontamination and six monthly deep cleans of procedure rooms were completed.
- An external cleaning agency was contracted to provide daily cleaning and all areas appeared visibly clean and uncluttered.
- Hand cleaning sinks in clinical areas had elbow taps and no overflow waste areas where bacteria could build up. Solutions were readily available for appropriate hand cleansing.
- Clinical waste was handled, stored and removed in a safe way. Staff used colour coded bags to segregate waste and ensure it was safely disposed of.
- Most staff we saw were bare below the elbow. However, one staff member was observed wearing rings containing stones, beneath gloves when undertaking procedures. This could create a risk of cross infection from the jewellery. We informed managers at the time of our inspection.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well. Any breakdowns were dealt with promptly.**
- **The environment met the needs of patients attending the service.** There was a one-way flow through the clinic from reception, waiting area, consultation, pre-procedure room, procedure room and recovery area. Patients entered a reception area where hot and cold drinks were freely available. Chairs were placed outside of consultation rooms for patients to wait and magazines were available. Another seating area was available for relatives to wait if they preferred. Toilets were available for patient/visitor use and included a larger toilet which was suitable for people who had limited mobility or were using a wheelchair.
- Consultation rooms were adjacent to the waiting area and provided privacy for patients during assessments. Pre-procedure rooms were away from the waiting area, equipped with changing areas and toilet facilities for their use only. Patients moved to the procedure

room which was separate from public waiting areas. Recovery areas were individual cubicles and patients were easily observed by nursing staff. A small waiting area was available for patients to use with drinks facilities if they needed to wait for transport.

- An independent organisation provided services to maintain equipment. We saw records of planned maintenance visits and when they had last taken place. Electrical equipment was labelled to indicate when it had last been checked as safe to use and when it was due again. They provided same day visits for repairs if the need was urgent.
- Water quality sampling was carried out weekly. This measured levels of bacteria in the final rinse water and if levels were outside of acceptable parameters, the equipment would not be used. Tests we saw showed bacteria levels had been within acceptable ranges. There had been some breakdowns of decontamination equipment due to high levels of limescale in the water. This had been happening over a period of months and was resolved after discussions between the registered manager and suppliers of the equipment identifying the fault.
- Staff worked in such a way that ensured clean and contaminated equipment was kept separately. Staff used a system to track and trace equipment at each stage of the decontamination process. Printed information was produced and staff signed and dated the printout at the time of the decontamination. The design of the decontamination premises prevented contaminated equipment coming into contact with clean equipment. There was a one-way system from dirty to clean areas. Although the area was small and did not have a door separating the clean and dirty areas, there was demarcation between clean and dirty areas. Drying cabinets were located in the clean area. We saw staff were familiar with the process, wore protective clothing and removed it when moving to clean areas. This was in line with advice in Health Technical Memorandum -1-06: Decontamination of flexible endoscopes.
- Equipment used for emergency resuscitation was available in the recovery area and was easily accessible to staff in the procedure rooms. We saw signed records by staff who had checked the equipment each day the service was open. The recovery area was always staffed and patients were never left alone in this area.
- Cleaning solutions subject to COSHH (Control of Substances Hazardous to Health) Regulations 2002 were kept in a metal cabinet which was not locked. However, the cabinet was in the dirty decontamination area which was not accessed by patients.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. However, training in responding to risk did not meet national guidelines for patients undergoing conscious sedation.**
  - Comprehensive risk assessments were carried out for people who used Prime Endoscopy (Bristol) services. The service ensured patients were suitable to be cared for and treated in the community clinic environment. A set of criteria was provided for referring GPs and patients which screened their health status. Any patients whose health presented a risk, such as unstable heart condition, patient weight over 220kg and dementia causing complicated consent processes, were referred to the referring GP for ongoing care and alternative treatment. All patients were screened for risks of being positive to variant Creutzfeldt-Jakob Disease on their admission and directed back to the referring GP. This was to prevent any risk of cross infection from equipment.
  - Other health conditions were assessed and plans put in place to support the patient. For example, when an appointment was arranged, staff asked questions about a patient's health. If they were diabetic the appointment would be arranged for a morning to reduce the impact on control of their diabetes and length of time patients needed to not eat in preparation for their procedure.
  - The clinic staff completed the World Health Organisation (WHO) checklist at the beginning of each procedure and all staff were involved in the process and read from the checklist to ensure no step was missed. The WHO checklist is an initiative designed to strengthen the processes for staff to recognise and

address safety issues in relation to invasive procedures. Although we observed the process being used there was no assurance it was always followed. Senior staff monitored the use of this checklist but did not record it formally as an internal audit. Information from the informal checking was shared at staff meetings. We saw minutes of meetings reminding staff to ensure they were taking a full part in the process.

- Staff used an early warning system for deteriorating patient condition. This involved measuring a patient's vital signs such as temperature, blood pressure, heart rate, and consciousness which provided a numerical score. Patients were monitored during their procedure. The score determined the actions staff should take in relation to a deteriorating patient, and guidance was available to support staff with this. Following their procedure staff monitored their condition until they were well enough to be discharged.
- Staff were able to support a patient whose condition deteriorated and basic life support was needed. Staff were trained in basic life support which was in line with InHealth training policy. Registered nursing staff and clinicians were trained to use the defibrillator to further support patients who suffered a cardiac arrest. However, there were no clinicians operating from the site who were trained in more advanced life support such as the Resuscitation Council (UK) Immediate Life Support. This was not in line with guidance from the Academy of Medical Royal Colleges – Safe Sedation Practice for Healthcare Procedures October 2013.
- If patients needed further urgent treatment staff followed a flow chart advising them to call an ambulance to transport the patient to the nearest emergency department. There was no official agreement in place with the local NHS trust for transfer to their services. Urgent transfers had occurred three times in 12 months.
- The policy for providing conscious sedation (sedation where patients remain awake) was in line with national standards. Staff had been trained in assessing patient's suitability for receiving conscious sedation. Patients received information before their procedure regarding conscious sedation and if it might be likely. Information provided them with advice on not driving a vehicle and to remain with another adult for 24 hours after leaving the clinic. were assessed for suitability and provided with information about conscious sedation before their procedure and what they could expect. The clinic held equipment and medicines to manage any issues of patient oversensitivity to sedation and could reverse the effects if needed.
- Clinic staff met each morning to assess risks for the clinic and patients for that day. These huddles included sharing information about health risks of patients attending for procedures and planned activities such as water testing. There was also a huddle at the end of the day to allow staff to raise any concerns about the procedures during the day.
- Staff had access to equipment to deal with an unexpected major haemorrhage during an endoscopy procedure. Equipment for lower gastro intestinal bleeding was kept in different draws of an emergency cabinet. Permanent staff knew where to find clips and iced water to control any bleeding. Managers told us patients were carefully screened for any risk of bleeding and iced water was available as an emergency measure to stop bleeding. However, protocol for staff to use as guidance was limited to calling emergency services and did not include specific actions and where to find the clips and iced water. There was a potential risk that staff who were unfamiliar with the environment may not be able to easily find the equipment. We discussed this with senior staff who planned to review their processes and provide more specific guidance for staff.
- Patients were provided with written information advising them of when to seek further support after their discharge. This was followed up by a call from clinic staff a few days after their procedure.

Staffing

- **The service had enough medical and nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- Staffing numbers followed recommendations from British Society of Gastroenterology. Weekly capacity meetings looked forward to demand over the coming

months and planned staffing levels and skill mix needed for each day they were operating. These were attended by senior administration staff, clinical lead and service manager where workload and staffing levels were planned for eight weeks in advance. There were enough registered nurses to oversee care of patients from initial assessment to discharge from the service. Two members of staff including registered nurse was always present in the procedure room with the endoscopist and in the recovery area. Administration and health care support workers provided care to patients which was within their level of expertise.

- The service had a small bank of two nursing staff which they called on if there was an unexpected shortage of staff. These staff worked for another endoscopy service within the area. They were offered the same training as regular staff and competencies were monitored.
- The service reported a low level of sickness and low turnover rate of staff. Most staff had been with the service since it had moved to its new premises in 2017. There was one vacancy for administration staff and none for nursing staff.
- Recruitment followed processes which were led by the InHealth group. The regional manager and service leads took part in the employment process and the corporate human resources department followed up with ensuring new recruits met the standards for the role including disclosure and barring system checks and agreed levels of qualifications and experience.

Medical staffing

- There was a clinical lead who oversaw performance for medical endosopists and there were enough medical staff with the right mix of skills and experience to provide the right care and treatment. Seven endoscopists worked under a system of practising privileges. Practising privileges is a system which independent organisations use to allow a person to practice in their service. The organisation monitored the suitability of the practitioner annually, including their ongoing training, appraisals and competencies. These endoscopists also worked in other services within the InHealth group and the weekly capacity meetings included allocating endoscopists to activities in the clinic.
- Handover of patients as they moved between areas was provided verbally and using the electronic records.

Records

- **Staff kept detailed records of patients' care and treatment**. Records were clear, up-to-date and easily available to all staff providing care.
- Individual patient records were managed in a way that ensured staff had access to up-to-date and accurate information about patient needs. Referral letters from GPs provided an overview of health needs and administrators obtained information at the time of making the appointment. Patient records were electronic and any paper information was scanned to the patient record. Each patient was assessed by a registered nurse before their procedure and relevant health information was recorded on the electronic system. This system could be viewed by all clinic staff after using a password and included medical history, medication and reason for the referral.
- Each patient was provided with a written report of the investigation before they left the clinic on the day of their procedure. A paper copy was posted to their GP with the same information. This included any samples sent for testing and when results would be expected. The service undertook audits of patient records each month to ensure scanned copies of records were held within the patient record. The electronic record consisted of fields that had to be completed by staff before they could move on.We reviewed five individual patient records and found them to be accurately and fully completed providing information on care provided and individual needs for the patient.

Medicines

- **The service followed best practice when prescribing, giving and recording medicines**. **Storage of controlled medicines did not always follow best practice**. Patients received the right medication at the right dose at the right time.

- Medicines management kept patients safe from harm. Pharmacy support was provided by a pharmacist for the InHealth group. Medical endoscopists could prescribe medicines for pain relief, sedation and to numb the throat before the procedure. A medical endoscopist was always present in the clinic when procedures were planned. There was one non-medical prescriber who could prescribe from a defined list of medicines and could request advice as necessary.
- Controlled medicines (medicines controlled under the misuse of drugs legislation) were administered in line with national recommendations. They were within their use by dates and stored at appropriate temperatures. Single use medicines were disposed of after use.
- There was a potential risk that controlled medicines may not always be safely managed. The Misuse of Drugs Act - Safe Custody,1973 requires controlled medicines to be under the control of a staff member at all times. We saw staff in the procedure room, checking the stock of controlled drugs before patient administration and the remaining stock being left in the procedure room but not in a locked cupboard for the remainder of the list. At the time we were visiting these medicines were under the control of a staff member because there was always a registered professional in the procedure room. Stock was checked and stored securely at the end of the list. However, should an urgent situation need staff to leave the procedure room at these times, there would be a risk of the controlled medicines being left out and accessible to patients. This would contravene the Misuse of Drugs Act - Safe Custody,1973.
- Registered nurses worked to patient group directions (PGDs) to provide nitrous oxide and oxygen, enemas, and paracetamol. Staff received training and were authorised to administer these items by the Inhealth Group pharmacist. All the PGDs we saw were up to date and the registered manager monitored when they were due for renewal.
- Registered nursing staff checked any bowel preparations and patient instructions before they were posted to patients. This enabled the patient to administer their own bowel preparation before their procedure. No medicines were prescribed for patients to take home from the clinic after their procedure. Patients were able to take their own regular medication when it was due.
- Oxygen cylinders were mostly stored safely. However, one was stored on the floor and not in a designated crate as recommended by Health and Safety Executive, 2013. Nitrous oxide gas was stored appropriately, in a designated store room.
- Clinic staff undertook audits to measure how well prescription charts were completed. Each month,10 prescription charts were audited for completeness and results were fed back to staff at team meetings and on daily safety briefings. Since February 2018 compliance had improved from 40% to 80%. Missing information included NHS numbers, allergies and date the bowel preparation had been taken by patient prior to admission. We saw meeting notes highlighting these issues to staff.

Incidents

- **The service managed patient safety incidents well**. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- There was a process for staff to report incidents and near misses. This was set out in the Adverse Event (incident) reporting and Management Policy October 2017, which was provided by InHealth group and was within its review date.
- There had been no never events reported by the service between 8 October 2017 and 8 October 2018. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- All incidents were reported electronically and reviewed by the registered manager. They were discussed at governance meetings and information shared at monthly endoscopy user group meetings and six monthly quality meetings.
- The service was working with commissioning bodies to develop a system of informing the service about any patients who were admitted to hospital following their endoscopic procedure and the outcomes. Any admissions the service was made aware of were discussed at monthly unit meetings. Between January and June 2018 there had been no patients who had been admitted to hospital within eight days of their endoscopy or died 30 days after the procedure. Any patients who had attended the local emergency department but without hospital admission, following their procedure were also discussed at these meetings. We saw records of incidents reporting these attendances and actions taken by the service. Two of these had been identified using a post procedure telephone call to the patient and their progress was followed up by clinic staff.
- Staff described an open culture and how they would always keep patients informed if a mistake had been made. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Incident records we reviewed had included patient communication where it was relevant.
- There had been 83 incidents reported between 11 August 2017 and 10 August 2018. Records we reviewed showed these had been rated in terms of risk to safety and resolved. Trends and themes were discussed at Quality meetings held six monthly and learning shared with staff at team meetings and daily briefings. The greatest number of issues for this period were for IT issues. We saw these documented as discussed with staff at monthly meetings and alternative actions to take in the event of IT malfunction.

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

We do not rate the effective domain for independent endoscopy services

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness**. Managers checked to make sure staff followed guidance. Prime Endoscopy, Bristol followed guidelines from the National Institute for Care and Excellence (NICE): QS 124 Direct access to diagnostic tests and NICE guideline (NG12) July 2017 suspected cancer: recognition and referral. GPs were able to refer patients directly to the endoscopy service.
- The service had been awarded Joint Advisory Group (JAG) accreditation on 13 august 2018. This is a national organisation which assesses details of how endoscopy services are delivered and monitored. Endoscopy services provide evidence to JAG and once the required standards are achieved, receive an accreditation to practice. They were contributing to the audits carried out by JAG. This included inputting data electronically to the JAG database daily. There were standard activities endoscopists needed to undertake to provide assurance they were following best practice guidelines. This included taking images of parts of the bowel and the time they took to withdraw the scope. These results were compared nationally and individual endoscopists could gain feedback from the audit to identify where they needed to improve. At the time of our visit all results for endoscopists in the service had been above national standards. For example, withdrawal times for colonoscopy should be controlled and take more than six minutes. The service met this standard in 100% of cases.
- Patients were assessed for their risk of bleeding at the point of booking. Advice was provided for patients who were on anticoagulant medicines (anti-clotting), to have their clotting levels checked before their appointment.
- We observed patients being treated equally and provision made for patients who needed to use a

wheelchair. Patients needed to be able to transfer themselves onto the beds and trolleys without the use of lifting equipment. Mobility issues were documented ont the referral form.

- Patients with dementia or learning difficulties could be treated at the clinic if they were supported by a carer. We saw records detailing how a patient's mental capacity was assessed by clinicians. This provided information on whether the patient could provide valid consent for the procedure. However, staff did not use a recognised assessment tool to document their assessment.
- Electronic information systems were used which allowed endoscopists and nursing staff to view up to date patient conditions. This included information from referral, assessment and recovering from the procedure.
- Patients were supported to be independent following their treatment by receiving information on when they could next eat and drink and in what circumstances they should seek further medical advice.

Nutrition and hydration

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

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 assessed patient's pain using a number score between one and ten with ten being the most pain. Staff described how they observed facial expression and body language to recognise when a patient was experiencing discomfort. We saw patients being asked about their pain or discomfort throughout the procedure and provided with pain relief when necessary. Spray was used to numb the throat before gastroscopy procedures which reduced the gag reflex making the procedure more comfortable.
- Patient survey results for July 2018 indicated comfort levels patients had experienced. Of 40 responses four had experienced severe pain, 13 moderate pain,17 mild pain and six patients experienced no pain. Service managers had reviewed the procedures where the discomfort was greatest and changed to using smaller type of scope for this type of procedure on future patients. They were continuing to monitor comfort levels for patients to assess how successful the change was.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.** They compared local results with those of other services to learn from them.
- The service collected data on endoscopy outcomes to benchmark their performance. They contributed to audits on a quarterly basis using the Global Rating Scale (GRS) as outlined by JAG. The Clinical Lead, and individual endoscopists had access to real time outcome data using the recently developed National Endoscopy Database (NED). This could be downloaded daily for individual endoscopists All endoscopists figures were above the expected standard. For example: the adenoma (a benign tumour) detection rate of 15.5% was above the national standard of 15%. This allowed patients to receive appropriate treatment based on their diagnosis. Results were reviewed by clinical leads who provided clinical support to endoscopists if results fell below national benchmarks.
- The service used a system to monitor and act upon outcomes from mortality and readmissions resulting from procedures. These were monitored to provide learning. Commissioners were working towards providing information about readmissions to another hospital. There had been a low number of attendances at the local emergency department but these had not resulted in admissions to hospital following procedures. Practitioners reviewed the detail

to identify any learning. We reviewed records of three of these attendances and reasons for the patient attending the emergency department had not been a direct result of their procedure.

- Managers monitored the time patients were waiting for their procedures after they were referred to the service. Their target was for 99% of patients to be seen no later than six weeks after their referral. From August 2017 to July 2018, there had been four months when 98% of patients had been seen within six weeks of their referral. This was just under the 99% target and reasons given were of patients choosing other dates as a preference.

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. Staff had the right skills and knowledge to assess patient needs and provide care for patients undergoing endoscopy procedures at the clinic.
- Staff received annual appraisals, had learning needs identified and were supported to revalidate their registration when required. The registered manager monitored attendance at training and ensured staff were up to date with competencies they needed to complete. All new staff received an induction, were allocated a mentor and attended training in skills required to care for patients undergoing endoscopy procedures. Staff attended training in their area of work such as decontamination, administration nursing and endoscopy.
- Staff with specific skills were given the opportunity to provide learning materials for the clinic staff. A member of staff who had experience with patients with a learning disability presented information on mental capacity, consent and communication techniques. As a result, some easy read information was being developed to use at the clinic and delivery was expected shortly.
- Endoscopists working under practising privileges had their performance monitored and number of procedures performed over a year to ensure they had enough experience to continue practising effectively. They worked across other clinics within the InHealth group of endoscopy services. The clinical lead and medical director reviewed training attended and performance before renewing practising privileges.
- Poor or variable staff performance was identified and managed by leads of the service. We saw meeting notes of staff expressing their thoughts about staff behaviours. This had resulted in endoscopists being reminded to visit their patients who were in the recovery room to discuss their procedure.

Multidisciplinary working

- **All staff worked together as a team to benefit patients.** Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Service staff worked together to provide effective care and support for patients. There were agreed care pathways for patients who had a diagnosis of cancer. They worked with specialist nursing staff from the local NHS trusts to provide care in a seamless way. Liaison with specialist cancer nurses had changed the way clinic staff managed patients with a new cancer diagnosis. This meant patients were receiving care from the specialist nurses earlier in their pathway.
- GPs received written information about a patient's procedure and what advice the patient had received for their ongoing care.
- The service worked with a laboratory in a nearby NHS trust for the processing of samples taken during endoscopy procedures. Test results were returned to the service within a maximum of five weeks but usually within two to three weeks. The responsible endoscopist reviewed the test results and sent a letter to both the patient's GP to inform them of the findings. Prime Endoscopy(Bristol limited was open from Monday to Friday between 8am and 6pm and did not operate at weekends. There was no on-call service at weekends and patients were advised on actions to take if there were any concerns.
- Endoscopists and nursing staff provided information for patients on life style choices which might relieve their symptoms when it was appropriate. We saw this was provided in written format for patients to take away.

Good

Endoscopy

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 InHealth procedures when a patient could not give consent.
- Staff followed InHealth group policies and were clear about their responsibilities when gaining consent from patients before their procedure. Nursing staff had received training on obtaining consent from patients. Information was provided for patients to read and sign at home before attending for their appointment. This information included details of how data from their procedure would be used and stored nationally and how they could withdraw consent for this. The information was discussed again with the admitting nurse, when they attended the clinic for their procedure. The endoscopist checked consent was given by the patient when they were in the procedure room. This also gave the patient to withdraw consent at any stage. We observed staff explaining procedures using diagrams and informing patients what they could expect to occur and any risks of the procedure. Explanations were provided at each stage of the procedure in language patients could understand and time was given for patients to ask questions. Patients told us they were fully aware of what to expect and were clear about any risks. Patients who needed support with understanding the English language were able to use translation services. The consent form had space for an interpreter to sign they believed the patient understood the information provided.
- Information about complications of the procedure were provided on the information sent to patients before their procedure. In some cases, the information provided was in general terms and did not refer to specific figures. For example: information provided for gastroscopy (using a flexible tube to look inside the oesophagus (gullet), stomach and first part of the small intestine) patients included rare complications of perforating the gullet if there was a narrowing, but did not specify the percentage rate of this occurring. However, information provided to patients undergoing colonoscopy contained specific risks such as, risk of bowel perforation being less than one in 1500 procedures. Patient satisfaction surveys from June 2018 demonstrated 37 out of 39 patients were informed of the risks and complications associated with their procedure.
- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. However, there was no clear documentation about how the decision was made.** The referral documentation requested information from the GP about the patient's ability to consent to procedures. Any patients who did not have the capacity to do this were not treated by the service. Clinicians assessed a patient's ability to make decisions using their clinical knowledge but did not use an assessment tool to document the information. This meant there was a lack of assurance of how the final decision about mental capacity was made if the assessment was needed. Staff described how they could accept consent from carers on behalf of a patient, if they had the appropriate legal status to do this.

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. We saw staff caring for patients with compassion. Staff introduced themselves to patients and asked how the patient would like to be addressed by staff during their stay and documented on patient records for colleagues to be aware. All interactions we saw were kind and caring to patients and colleagues. The patient experience was a high priority for all clinic staff and discussed at team and unit meetings.
- Reception staff greeted patients as they entered the clinic and checked personal identity without being overheard by other patients or visitors. Identity bands were provided at this stage and patients were asked to check the details were correctly documented.

- Patients were provided with private space to discuss their condition with nursing and endoscopy staff before their procedure. The clinical area was inaccessible to the public and there was space for patients to change in private and have access to private toilet facilities. Dignity shorts were provided for patients undergoing lower gastro-intestinal procedures. Baskets were provided to hold personal belongings, which stayed with the patient during their time at the clinic.
- During the procedure we observed how care was provided with sensitivity. Staff monitored the patient and made sure they understood any explanations as well as monitoring their comfort at each stage.
- This continued in the recovery area which was segregated into cubicles to provide privacy but was still easily observed. Patient survey results for June 2018 reported 100% of responses had their privacy and dignity respected during the procedure.
- Staff told us of incidences when they had reported any staff behaviours they witnessed if they were not in line with the values of the service.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.** Staff understood the impact the procedures and potential diagnosis could have on patients. There was a room which was accessible from both the clinical area and the waiting room. This room was used to provide private space to discuss results and suspected cancer diagnoses. We saw staff managing a situation with extreme sensitivity by ensuring family support was available for the patient and providing relevant information for ongoing care with empathy. The process for suspected cancer diagnoses was to refer patients to specialist cancer nurses at the local NHS trust and this was explained to patients and their relatives.
- Time was given to patients and they were not rushed through any part of the process. Staff discussed what patients needed to do when they left the clinic depending upon their procedure and provided written leaflets for patients to take home.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.** Staff communicated with patients in a way they could understand. We observed staff describing procedures in plain language. Patients were offered the opportunity to view their procedure on a screen but there was no pressure to do this and the patient decision was respected.
- Endoscopists ensured patients were able to understand the outcomes of their procedure and provided feedback about findings directly after the procedure. Staff could contact translation services for patient's whose first language was not English. Information was provided on discharge. Leaflets provided for patients contained links to other sources of support if patients felt they needed further support. Staff also provided follow up phone calls to patients after colonoscopy and answered any further queries.
- Patient feedback was actively sought and reviewed by staff. Annual patient surveys were undertaken and included how patients felt they were treated, information they received and discomfort experienced. Some comments from this feedback included "[the staff] made an unpleasant experience more bearable". Comments and survey results were discussed at team and unit meetings. Negative comments were also highlighted to identify where processes could be changed to improve the patient experience. Clinic staff actively encouraged patients to complete the NHS Friends and Family survey by providing patient feedback forms before they left the service. Response rates we reviewed had been above the target of 40%. This was fed back to staff who followed process to encourage patients to feed back their views. Patients could return forms in a number of ways. They could return them to staff, place in a box within the clinic or contribute on the internet after leaving the clinic. Results for July and August 2018 showed 100% of patients who responded were 'extremely likely' or 'likely' to recommend the service to their friends and family if they needed endoscopic treatment.

Are endoscopy services responsive to people's needs?

Good

Endoscopy

(for example, to feedback?)

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- **The service was planned and provided in a way that met the needs of local people. The service worked under a contract with the local clinical commissioning group and with a local NHS trust.** There were agreed referral criteria for patients attending for procedures, which had been agreed with commissioning stakeholders. Patients were able to attend the clinic for their procedure, between Monday and Friday of each week, instead of attending their local hospital. GPs and the local NHS trust referred suitable patients to the service, which reduced the demand on NHS services for the same procedure.
- Service managers reviewed attendance rates and trends in demands for the service. There had been an increase from 451 GP referrals in October 2017 to 530 referrals for September 2018. The majority of patient feedback was positive and managers believed more patients could benefit from their services and the shorter waiting times they could offer. To support this belief, service managers were contacting local NHS hospitals and GP surgeries to ensure they were aware of the choice available.

Meeting people's individual needs

- **The service took account of individual patient needs and advised referrers of health conditions that would not be suitable for treatment at the clinic.** This was to ensure patient safety was maintained. Patients needed to be mobile enough to transfer to a trolley for their procedure without the need for lifting and to have stable health conditions.
- Some adjustments were made so that patients with a disability could access the clinic on an equal basis to others. The admission criteria identified that patients needed to have enough mobility to transfer to the procedure trolley. Patient areas in the clinic were all on one level with wide doorways which allowed wheelchair access to all areas
- Services could be provided for patients with communication needs such as the need for large print or braille information, interpreter services and patients with learning difficulties.
- Patients received clear instructions before their appointment. This included information about how long they should remain nil by mouth prior to their procedure. Specific information about taking medicines for diabetes and patients on anticoagulants (blood thinning medicines). This was written in simple language. Information in easy read format was in the process of being produced to support patients who had learning difficulties.
- Patients were assessed by registered nurses before their procedures and time was allowed for patients to ask questions. Patients with communication difficulties were identified at the point of booking and additional time was allowed for the appointment to accommodate the additional support needed.
- Patients were provided with verbal and written information about their procedure before they left the clinic and when they would expect to receive the results of any tests undertaken. In the patient survey all respondents had received explanations and a written information but two out of 23 respondents were not clear about how they would get their results. Letters we reviewed at our visit had the waiting time for histology results included in the information.

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.
- Patients could access care and treatment at the clinic when they needed within clinic opening times. The service had a system of seeing patients in order of date referred and could override the system if there was clinical urgency.
- The service could provide additional clinics if demand increased. The service held capacity and demand meetings weekly to assess the demand and allocate staff to clinics. Most patients were seen within six weeks of referral. The target was to see 99% of referred patients within six weeks. The service was just below

this target for four months from August 2017 to July 2018. Managers reviewed reasons for each delay and found most reasons were due to patient availability and choice.

- Referral pathways had been agreed with commissioners and secondary care. All referrals were vetted by a clinician to provide assurance they were in line with agreed criteria. Onward referrals were made in accordance with agreed protocols, these were generally suspected cancers.
- Procedures cancelled by the service were monitored and from February to July 2018, there were from 0.5% to 1.9%. From 8 October 2017 to 8 October 2018, there had been 260 procedures cancelled due to non-clinical reasons. 44 of these were due to a machine breakdown. There had been instances of limescale in the water causing washer breakdowns. This issue had been resolved and since March 2018 there had been no further breakdowns of this equipment. Reduced demand during this period of time had led to reorganising services based on number of patients waiting, length of time waiting and best use of resources. This had led to cancelling93 patients due to attend sessions. All of the cancelled patients were informed ahead of their appointments new appointments were offered which were within the six week target time frame for referral to treatment. Staff recognised these cancellations as a concern and discussed capacity and demand weekly to ensure endoscopists time was used effectively and patients were not cancelled.
- Patients were provided with appointment times close to the time of their procedure to reduce the amount of time they waited in the clinic. Waiting time could vary due to some procedures taking longer than anticipated. This information was communicated to patients at their assessment and using a white board in the waiting area which was updated by staff.
- To reduce risks of patients not attending appointments they received text messages as a reminder of their appointment. Patients who did not attend for appointments without informing the service varied from seven to 14 patients a month for the period from May to October 2018. There was no pattern identified and clinic staff managed the patients who did not attend by informing their GP of their non attendance and advising them to re-refer should the patient wish to rebook for the procedure.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.** From October 2017 to October 2018, the service had received 730 compliments and four complaints. Complaints were reviewed for validity and three of these complaints had been partially upheld. One complaint had prompted a change in type of scope used for a specific procedure, to improve patients' comfort. Learning was shared at team meetings daily huddles and quality meetings. Other learning had been shared with staff regarding staff being more rigorous when reviewing referrals and information received from GPs to ensure it is detailed enough.
- There were processes to ensure patients and their relatives could make a complaint or raise a concerned if required. There were leaflets on display on the reception desk and a poster in the waiting area. The complaints we reviewed followed the InHealth group complaints process/policy. This provided guidance for staff of how to resolve concerns raised by patients and the process for handling a formal complaint. Service managers also reviewed and responded to comments made by patients which were not formal complaints. These were responded to by contacting the patient to apologise and discuss their experience. All outcomes were discussed at unit meetings to share learning points.

Are 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.** Service leads had the skills, knowledge, experience and integrity they

needed to lead the service, which was in line with guidance from the British Society of Gastroenterology (2007). There was local leadership at the service who received leadership, management, governance and support from the InHealth group. The unit manager was a registered nurse with endoscopy experience and was the registered manager for the service. The clinical lead was GP who had undertaken additional training to become an endoscopist. The clinical lead was relatively new to the role having filled a post left vacant following the retirement of the previous lead. A regional manager for InHealth formed part of the service leadership team. This role was being fulfilled by the regional operations manager because ahead of gastroenterology for the region had just been appointed to the role but had not taken up the post at the time of our visit.

- The three leads for the service were aware of their responsibilities and supported and challenged each other with leadership actions. We were told of how leaders prompted each other to take action to ensure staff behaviour was in line with the service' values. They were aware of challenges to quality and sustainability and had processes in place to review and manage them. The regional manager fed up to the InHealth group at monthly performance meetings and attended the clinic at least weekly. Meetings at the clinic were held to forward plan their activity. This included ensuring suitable staff were available to cope with demand. Capacity and demand meetings were also attended remotely by another member of the InHealth team using electronic communication. They were able to share information from other locations about workloads for other clinics and staff availability. Team meetings were held to update staff and gather their views.
- Leaders were visible and approachable to all staff in the service. Staff knew who their line managers were and said they felt they could approach any of the service leadership team for support if they needed it.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff and patients**. The service had a clear statement of purpose to provide safe, effective and timely community endoscopy services for adults. Quality and sustainability were top priorities. There was a business plan for 2018 – 2019, which set out how they planned to sustain the quality of the service, expand service provision and use effective procedures. Some of these plans were to provide training for GPs and use more transnasal gastroscopy procedure without the need for sedation. They worked closely with commissioners to streamline referral systems and were in the process of designing new processes.
- Part of the business plan included a clinical workshop to consult with staff about new models of care. This was to address sustainability and further development of the service.

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 told us they felt supported, respected and valued. Managers encouraged a culture of openness and engagement and we saw minutes of team meetings. which included staff comments and how managers had dealt with their comments. These were sometimes about staff attitudes and behaviours. We observed staff interactions as comfortable and inclusive between all levels of staff. There was a freedom to speak up guardian assigned to the service. This was provided by named staff in the InHealth group. A freedom to speak up guardian is a requirement for organisations which provide NHS funded care and should provide an avenue for staff to raise concerns if they are uncomfortable to do so with their manager. Staff were aware of this but stated they could raise any concerns without fear of retribution even if this was about more senior staff and were confident appropriate action would be taken.
- There was a strong emphasis on staff safety and well-being. Equipment was provided to prevent staff injury during the course of their work. The decontamination area had a sink which would adjust to different heights of staff to prevent back injuries. Equipment that may cause a risk to staff was secured and staff were informed of alternative actions to take. A door which connected the procedure rook to the

clean decontamination area, had become unsafe for staff to use and was put out of action until it was repaired. An area was available for staff to use away from patient areas. This included a spacious kitchen area, seating, shower, toilets and lockers. Information was provided for staff in this area about upcoming events. These could be mandatory training events in lifting and handling, staff meetings and staff social events.

- A system of staff appraisal was followed and updated appropriately with training needs identified. Staff were trained in each area of the clinic which allowed them to support each other. We saw staff working together and communicating the needs of the patients to provide a smooth pathway for the patient. All staff we spoke with were focussed on the needs of the patient and improving the experience for them.

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for good clinical care to flourish** There was a defined structure to support delivery of the service. Managers had oversight of service performance using the InHealth audit processes. These were reported to the InHealth group monthly and discussed with the team at 'user group' meetings. The 'user group' was made up of all staff who worked at the clinic. We saw documented discussions from these meetings, which involved performance of the service such as audit results and any risks for the smooth operation of the service.
- There was an audit programme set out by InHealth which was completed by clinic staff. Areas of audit included decontamination, water quality, hand hygiene, vetting of referrals and resuscitation trolley checks. The unit manager reviewed the completion of these audits monthly to ensure they were completed and returned to InHealth. Results were fed back to staff at team meetings and issues where improvements could be made were highlighted. This had included cleaning admission rooms having been missed because it was in use at the time of cleaning activity. A solution to prevent the room remaining uncleaned was to write this on the checklist for the next shift of staff to be aware and ensure the cleaning was completed as soon as was practicable.
- The service used audit to drive improvement. Audits of the time it took for final reports to be sent to GPs after receipt of histology results resulted in a change of process. These reports had been found to be taking a long time for the endoscopist to dictate a letter and administrators to produce a typed document. A recent change in process was being trialled to make the process quicker. Endoscopists had started typing their own reports once they had received histology results. This would reduce the number of steps in the process and the time taken for GP to receive patient results.
- The service manager monitored training compliance and appraisals and encouraged staff to complete these within the required timeframe.
- Staff had specific responsibilities and knew what they were. There was a decontamination lead, infection control lead and health and safety lead. Any issues regarding these subjects were discussed with the individual leads.
- The service followed policies which were provided by InHealth group who reviewed them at agreed dates. Policies we saw were within their review dates.
- Endoscopists had started contributing to the global rating scale (GRS) for the Joint Advisory Group for Gastroenterology. The clinical lead would review these results and raise issues if they were outside of what was considered to be normal parameters. Audits were also undertaken on how long endoscopists took to provide final reports. These were reports produced once the histology results had been received. Processes had been changed to reduce the time taken for this activity.
- Processes to ensure endoscopists holding practising privileges had appropriate professional indemnity insurance was undertaken by InHealth Group corporate services. They would liaise with the service if there was a problem and endoscopists would not be given lists until it was resolved.

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- Risks were identified and mitigating actions developed to manage them. The service had a

comprehensive risk register, which included business specific risk, health and safety and environmental risks. Staff were confident to report any risks and the registered manager monitored and fed back on actions needed. Risks which were felt to be significant to the wider organisation were fed into the InHealth risk register.

- Risks placed on the local risk register were scored for level of risk and actions taken to reduce the risk were documented. They were assessed for how often they should be reviewed and we saw, were updated accordingly. Items on the risk register were consistent with what managers had raised as issues for the service. We saw action plans had been reviewed to reduce these risks. Risks and performance were standing items at the monthly user group meetings and we saw notes of the discussions.
- Staff performance was monitored and if it fell below the level expected by the service, this was managed to protect patients. There had been no occasions when patient safety had been identified as at risk but an issue had been raised about staff attitudes. This had been managed in a way that gave practitioners the option to discuss the concerns raised with managers, before working at the service again.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- Information was mainly stored electronically. Data Security involved staff inputting passwords to access the information. Some letters were sent to GPs and patients after their procedure and these were sealed in envelopes in an office, which was inaccessible to patients and the public.
- The service was compliant with the General Data Protection Regulations (2018). All patients received, signed and returned an information sheet setting out how information about them was collected and shared with other relevant healthcare providers.
- InHealth group collected, reported and published information in line with legislation regarding Workforce Race Equality Standards. The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This became a requirement for independent health providers in 2017 when the providers NHS contract exceeds £250K per annum. InHealth group had been reporting this data since October 2017 and had actions identified around improving self-reporting of ethnicity. The data was across the organisations in their group and included but was not specific to the Bristol service. The action plan based on the most recent report for 2018 was available on their website.

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 invited feedback from patients who used their services. We reviewed patient satisfaction surveys for the year ending July 2018. In total, 100 questionnaires had been distributed and 41 patients had returned a questionnaire. Feedback was mostly positive and included comments such as “I was very nervous and all staff were friendly, helpful and kind and put me at ease. So big thank you” and “the way the doctor and the nurses work as a team was really effective”. Some patients (10 responses) offered suggestions of improvements which included parking facilities near the clinic. There was no service owned car park and patients needed to park in a pubic car park to attend. As a result, InHealth were considering purchasing some car parking space.
- A patient experience network (PEN) were invited to assess the service. They visited in May 2018 and provided a report from a patient perspective. An action plan was created in response to the report and included providing more detail about car parks, and making the waiting area more interesting for patients. We saw a range of up to date magazines provided and art work from a local artist displayed in all patient waiting areas.
- Staff in the clinic encouraged patients to provide feedback about their experience in the service. Staff

gave the Friends and Family test (FFT) feedback form to patients before they left the clinic. Results were fed back to staff once they had been collated by InHealth group. Of the responses we saw a high percentage 99.5% to 100% of patients would recommend the service if patients needed to use the service. Annual patient surveys were undertaken in June of each year. There was a set of 23 standard questions for patients about their experience. Managers produced an action plan based on these results and shared the information at staff meetings. Some changes which had been actioned included displaying information for patients about delays to lists. Survey results and patient feedback was displayed in the clinic for patients to view.

- All staff were invited to attend monthly user group meetings. We reviewed minutes of meetings, which demonstrated most staff attended and were involved in decisions made about service improvement. Staff also received feedback on incidents, audits and other quality measures as applicable.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.**
- Managers of the service were exploring how they could extend their service. They were offering procedures to neighbouring clinical commissioning groups and NHS trusts. The clinical lead had enrolled in a train the trainer programme of study. This was to enable training to be offered at the clinic. The clinic had virtual endoscopy training equipment. This gave trainees the opportunity to practice skills without fear of any patient harm. There were plans to offer trainees from outside the service, opportunities to hire the equipment for training purposes.
- The service manager encouraged staff to produce learning tools for their colleagues and placed this on a board adjacent to the staff room. The subject matter was refreshed every couple of months and was focussed on a variety of subjects such as mental capacity of patients with learning difficulties.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Ensure staff are trained in life support which follows national standards

Action the provider SHOULD take to improve

- Ensure staff follow clinic policies of being bare below the elbow to reduce cross infection risks.
- Ensure clear guidance is accessible for all staff on the procedure for dealing with a major gastrointestinal haemorrhage.
- Consider having formal agreements with the local NHS trust for patients who may be transferred for more urgent care at the trust.
- Consider procedures to mitigate the risk of controlled medicines not being under the control of staff if urgent situations lead to staff leaving the procedure room.
- Ensure that when mental capacity assessments are made, patient records reflect how the decision was made.
- Consider arrangements for storing all oxygen cylinders safely to prevent their risk of falling.
- Consider ensuring all patient information includes specific risk of complications occurring when procedures are undertaken.
- Consider ensuring policies include all relevant details to provide effective staff guidance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment regulation 12 (b) doing all that is reasonably practicable to mitigate risks There were no clinicians operating from the site who were trained in Resuscitation Council (UK) Immediate Life Support. This was not in line with guidance from the Academy of Medical Royal Colleges – Safe Sedation Practice for Healthcare Procedures October 2013.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.