Didsbury MSK Ltd

The OrthTeam Centre - Manchester

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We have not previously rated this location. We rated it as good because

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff identified and quickly acted upon patients at risk of deterioration. The service used systems and processes to safely prescribe, administer, record and store medicines. The service managed patient safety incidents well.
- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983. Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. The service made sure staff were competent for their roles. Staff worked together as a team to benefit patients. Staff gave patients practical support and advice to lead healthier lives. Staff supported patients to make informed decisions about their care and treatment.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served. The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards. It was easy for people to give feedback and raise concerns about care received.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. The service had a vision for what it wanted to achieve and a strategy to turn it into action. Staff felt respected, supported and valued. Leaders operated effective governance processes, throughout the service and with partner organisations. Leaders actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. All staff were committed to continually learning and improving services.

However:

In Outpatients;

- Not all records had the required information saved.
- Staff did not always carry out daily safety checks of emergency resuscitation equipment.
- The service did not carry out audits to evaluate clinical effectiveness of treatment.

In Diagnostic Imaging;

- Staff did not always have the correct level of training on how to recognise and report abuse and not all staff in the diagnostic imaging department had completed safeguarding adults level three training.
- Staff did not always carry out daily safety checks of emergency resuscitation equipment.
- The number of radiographers and radiology assistants did not always match the planned numbers.
- The local rules for radiation were not always visible and had not been reviewed and signed by all staff who worked in the department.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Good 	We have not previously inspected The OrthTeam Centre Manchester. We rated this service as good because it was safe, caring, responsive and well-led. We inspect but do not rate effective for outpatients.
Diagnostic imaging	Good 	The main service provided by this hospital was outpatients. Where our findings on diagnostic imaging also apply to outpatients, we do not repeat the information but cross-refer to the outpatient service. We have not previously inspected The OrthTeam Centre Manchester. We rated this service as good because it was safe, caring, responsive and well-led. We inspect but do not rate effective for diagnostic imaging.

Summary of findings

Contents

Summary of this inspection

Background to The OrthTeam Centre - Manchester

The OrthTeam Centre Manchester is operated by Didsbury MSK Ltd and is a joint venture with Spire Healthcare. The service specialises in orthopaedic and musculoskeletal problems from sports injuries to degenerative and arthritic conditions.

The centre is located in Didsbury Manchester and is open Monday to Friday between 8am and 8pm for patients across Greater Manchester and beyond. The service occasionally operates on Saturdays to meet the needs of patients. Provision of care is for private and self-funding patients over the age of 12 years. Consultations are available for children under the age of 12 years.

The service provides outpatient consultations within the specialities of orthopaedics, neurosurgery, neurology, sport and exercise medicine, pain management and peripheral nerve injuries. They also offer diagnostic services for all of the above specialties including ultrasound, x-ray, digital x-ray and 3T MRI scanning. A range of image guided injections and treatment injections are also provided in the onsite fluoroscopy room. Other facilities include 7 consultation and examination rooms and a treatment and rehabilitation room.

Activity during the reporting period June 2022 to June 2023:

- There were 18,057 outpatient clinic appointments.
- There were 6072 MRI scans, 3341 x-ray scans, 2976 ultrasound scans and 654 image guided injection treatments.

The service has been registered with the Care Quality Commission (CQC) since 2019 and has been monitored through our engagement and transitional monitoring approach. The registered manager has been in post for 3 years.

The service is registered to provide treatment of disease, disorder or injury (TDDI), surgical procedures and diagnostic and screening procedures. The regulated activity of surgical procedures applies to the treatment injections they provide.

The main service provided by this hospital was outpatients. Where our findings on diagnostic imaging also apply to outpatients, we do not repeat the information but cross-refer to the outpatient service.

We have not previously inspected The OrthTeam Centre Manchester.

How we carried out this inspection

We carried out an unannounced inspection on 27 June with a follow up visit on 6 July 2023 to gather further information.

The team that inspected the service comprised of 2 CQC inspectors, a specialist advisor with expertise in diagnostic imaging and screening and an offsite CQC operations manager.

To get to the heart of patients' experiences of care and treatment, we ask the same 5 questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Summary of this inspection

Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

During our inspection we interviewed staff who were employed by the service, including the registered manager, health care assistants, registered nurses, consultants, radiographers and admin staff. We visited both clinical and non-clinical areas, spoke with patients and reviewed patient records. We also interviewed members of the leadership team.

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

Areas for improvement

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

Action the service MUST take to improve:

None.

Action the service SHOULD take to improve:

Outpatients:

- The service should save all information in patient records in line with the service requirements.
- The service should ensure that emergency resuscitation equipment trolley checks are completed daily.
- The service should carry out audits to evaluate clinical effectiveness of treatment.

Diagnostic Imaging:

- The service should take appropriate action to ensure all diagnostic imaging staff complete the required level of safeguarding training.
- The service should ensure that emergency resuscitation equipment trolley checks are completed daily.
- The service should ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of patients and demand on the service.
- The service should ensure all copies of the local rules throughout the diagnostic imaging department are visible and have been reviewed and signed by all staff who work in the department.
- The service should continue to monitor and record patients who did not attend (DNA) for diagnostic imaging procedures.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Inspected but not rated	Good	Good	Good	Good

Good

Outpatients

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Is the service safe?

Good

We have not previously rated safe. We rated it as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. Compliance targets were set throughout the year. For example, July 2023 25% compliant, September 2023 50% compliant, December 2023 75% compliant and March 2024 95% compliant. For the year 2022 to 2023 the outpatient department achieved 100% compliance for all modules apart from level 3 safeguarding adults training.

Data provided by the service showed that between April 2023 and July 2023 mandatory training compliance rate for staff in the outpatient department was 100% for most of the mandatory courses. Data showed that 90% of staff had completed training on data protection, 55% of staff had completed learning disability and autism training and 33% of staff had completed infection prevention and control (IPC) training. Remaining staff had until 31 March 2024 to complete their training as the new training year had started 1 April 2023.

Managers told us that the IPC training had been unavailable to staff between April and June 2023 due to updates being made to the module. However, 33% of staff had already completed the new IPC module in July 2023.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training courses included health and safety, equality and diversity and information governance as well as other key topics.

Consultants completed mandatory training with their substantive NHS employer and provided annual confirmation of completion of this training to the service in line with the practising privileges policy.

Managers had access to all training records for staff and would remind them to complete mandatory and additional training. Staff told us that they were given protected time allocated to completing training courses.

Good

Outpatients

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.

Staff received training specific for their role on how to recognise and report abuse. All staff were required to complete combined level 1 and level 2 safeguarding training for adults and children annually. Staff with a clinical registration were required to complete level 3 safeguarding adults and children training.

Data we requested showed that outpatient staff compliance was 100% for level 1 and 2 for both safeguarding adults and safeguarding children training. Records for the current training year showed 55% of outpatients staff had completed level 3 safeguarding adults and children training. Remaining staff had until March 2024 to complete this.

Safeguarding training compliance for 2022/2023 within the outpatient department was; level 1 and 2 safeguarding adults 100%, level 3 safeguarding adults 75%, level 1 and 2 safeguarding children 100% and level 3 safeguarding children 100%.

The safeguarding training also included female genital mutilation (FGM) and prevent (counter-terrorism strategy) training.

The service had a safeguarding lead for adults and children. There was a staff member with deputy responsibilities that staff could contact when the safeguarding lead was not on shift. The safeguarding lead role also covered support for FGM and prevent concerns.

The safeguarding lead, deputy lead, children and young person lead and outpatient manager had completed level 4 safeguarding training for both adults and children.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had safeguarding policies available to support staff and these could be accessed on the hospital's intranet. Staff we spoke with knew who the safeguarding leads were and described how to access the safeguarding policies. There was a white board in the staff office that displayed safeguarding information, contacts and a visual flow chart that clearly outlined the referral processes to follow.

There had been no safeguarding referrals made by staff between June 2022 and June 2023.

Staff followed safe procedures for children who were having procedures or visiting the service. There was a missing child procedure and visual flowchart for staff to follow in the event child should go missing during an appointment. There was a booking process specifically for children and young people in addition to a 'was not brought' flowchart and follow up record. Clinical staff would contact the carer or guardian to ensure there were no safeguarding concerns related to the non-attendance and record the outcome.

Staff followed a procedure for patients with domestic abuse concerns. There was an assessment and enquiry flowchart in addition to an assessment and referral form for staff to use. Safeguarding information related to domestic abuse was observed on posters in the patient toilets.

Good

Outpatients

Chaperones were offered to patients for any procedure. We observed posters in the reception area and on the television screen in the waiting area to inform patients that they could ask for a chaperone if they wanted one. We looked at policies for safeguarding adults and children and the chaperone policy. They were detailed and followed best practice and national guidance.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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.

Staff received mandatory training in infection prevention and control (IPC) and there were infection prevention and control policies and procedures in place which provided further guidance for staff.

The service had an IPC lead who oversaw infection control processes and provided support for staff. They conveyed any infection incidents, oversaw audits, training and changes to policies and national guidance.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Rooms had a daily clinical cleaning schedule on the wall. This was used to instruct staff on what cleaning products to use and to record cleaning activities. The list of items cleaned daily included the couch, work surfaces, dressing trolley, stethoscope and the sharps bins were also checked. There was an additional monthly clean also recorded and staff checked that consumables such as gloves, dressings and tubings were in date. Toilet cleaning logs were observed in the toilets and had been completed daily for the previous two weeks.

We requested hand hygiene and cleaning audit data for the previous 3 months. Data provided showed that hand hygiene and hospital cleanliness was 100%.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff following hand hygiene and 'bare below the elbow' guidance appropriately. Visitors were encouraged to wash their hands at reception and areas throughout the hospital. Toilets had signs to remind patients and staff to use ‘bare below the elbow’ when washing their hands. The service had a hand sanitising station at the entrance and more throughout patient waiting areas.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Disposable curtains in clinical rooms had been replaced in June 2023 and clearly recorded on the curtain.

The outpatient department had reported 5 superficial wound infections and 1 deep infection since registration with CQC in 2019. There had been no service acquired healthcare associated infections across the service for this period.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, staff did not always carry out daily safety checks of emergency resuscitation equipment.

Good

Outpatients

The centre was purpose built in 2019 and the design of the environment was modern with new facilities and equipment that was suitable and met the needs of patients.

The design of the environment allowed a good flow between the diagnostic imaging department and outpatient department situated on the ground floor. Admin staff, meeting rooms and other staff facilities were located on the first floor.

The main waiting area for outpatients was near to the hospital entrance and reception and close to the consultation and examination rooms. We saw that patient privacy was maintained at all times. There was also a treatment and rehabilitation room and patients we spoke with were complimentary of the facilities and the rooms.

The service had enough suitable equipment to help them to safely care for patients and carried out safety checks for specialist equipment. Staff could access the medical devices policy for guidance. There were medical devices and equipment leads who monitored when safety checks were due and shared information with the management committee.

We saw the equipment database with all medical devices and equipment listed. There were alerts recorded for any equipment with service dates due within a few weeks and for any that were overdue. At the time of inspection there were 2 devices that were overdue their service date. Managers told us that this was due to the external company not having availability. The 2 devices had risk assessments and the service were undertaking their own internal safety checks until the external company was available.

We completed a random sample of specialist equipment and found that each machine had a label showing the last and next service due date. The labels showed servicing was in date for all the pieces of equipment we checked. We also saw that examination couches, wheelchairs and the day surgery trolley were in date.

Staff disposed of clinical waste safely. Each clinical area had a foot operated clinical waste bin, sharps bins were present which were clean, not over filled and secure. Sharp bins were wall mounted and not accessible to children. The service had a standard operating procedure in place with the partnering hospital site for disposal of waste. The waste disposal procedure was monitored through regular audits and spot checks by the infection control lead nurse and health, safety and risk manager. Audit results were displayed on a performance, quality and safety board. Data showed that between January and March 2023 the sharps audit overall score was 97.2% and 99% in June 2023.

The service undertook assessments, reviews and audits of their activities under the Control of Substances Hazardous to Health Regulations 2002 (COSHH) and had a COSHH lead. The department had a lockable COSHH cupboard to store hazardous substances. Staff we spoke with were aware of COSHH and told us that documentation and manuals were easily accessible both electronically and in the COSHH file. We saw that the COSHH file included a list of hazardous materials with a safety data sheet with assessments and reviews in date.

The resuscitation trolleys were correctly stocked, oxygen cylinders were full, suction machines and defibrillators were in working order. All emergency equipment was secured with a seal tag. However, staff did not always carry out daily safety checks of emergency resuscitation equipment. For example, from February 2023 to June 2023, we saw 6 gaps in the daily resuscitation trolley checks. For the same reporting period, we saw 4 gaps in the daily paediatric emergency care system bag checks.

There were fire extinguishers throughout the premises, and these had been tested appropriately. Fire safety training was also included as part of mandatory training and staff had completed this.

The department was secure, all doors to clinical areas had a digital door lock and only staff with a swipe card could access the rooms.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. Staff could access a deteriorating patient and severe patient injury flowchart to establish when a patient needed an emergency transfer to an NHS hospital. Staff used a transfer checklist that included tasks such as documenting the reason for transfer and that allergies, medication and medical history were recorded in patient notes. Staff also used situation, background, assessment, recommendation (SBAR), a nationally recognised communication tool, to handover care between staff.

Staff completed risk assessments for each patient during the booking process, on admission and prior to discharge. This was reviewed regularly, including after any incident. The service had an exclusion criteria and a criteria for putting referrals on hold.

When a referral was accepted, staff used a procedure care pathway for risk assessment after admission which included allergies, medical history, and medication. The service had a booking procedure for children and young people that ensured that a paediatric nurse was always present at procedures for patients under 16 years of age.

Outpatient department staff received patients' records from the medical records team on the day of their appointments. For new patients, the booking team recorded any relevant risk information they had identified during the booking process. Consultants then recorded patient risks during their first consultation and made staff in the department aware. The service used a red patient alert form to keep at the front of records when required. Alerts included whether the patient had allergies, adverse drug reactions or was diabetic.

Staff knew about and dealt with any specific risk issues. Staff used risk assessments for venous thromboembolism (VTE – blood clots), risk of falls and infection control risks. Staff also screened patients for suspected sepsis and utilised both adult and paediatric sepsis six care pathways if required.

The service had mental health first aiders and could be utilised by staff if they needed support with patients with mental health difficulties.

Staff shared key information to keep patients safe when handing over their care to others. This was done through the morning staff huddle, shift changes, multidisciplinary team meetings and handovers included all necessary key information to keep patients safe.

The service had first aid kits and emergency anaphylaxis kits for both adults and children. There was a flow chart attached to the kit for staff to follow if a patient had suspected serious allergic reaction. The kits were tagged to show that they were complete, and the expiry date was displayed on the front of each kit. Most staff in the outpatient department had completed anaphylaxis scenario training in the past 12 months.

The service compiled resuscitation training data for all hospital staff, it was not broken down separately for diagnostic imaging and outpatient departments. Data we requested showed 94% of staff had completed basic life support (BLS) training at level one and 69% had completed BLS level two. Compliance for immediate life support (ILS) training was 80% and 75% for paediatric immediate life support (PILS) training.

Good

Outpatients

Consultants with practising privileges were trained in life support training at a level relevant to their role. They completed advanced life support training (ALS) with their substantive NHS employer.

Compliance with mandatory training was a requirement of the approval of their annual appraisal. Relevant consultants for children and young people were required to complete European Paediatric Advanced Life Support (EPLS) training.

Staffing

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

The service had enough nursing and support staff to keep patients safe. The outpatient department included a clinical head of department, 3 registered nurses, 1 nurse associate and 3 health care assistants. The clinical head of department and registered manager had management oversight of the department.

Managers used a safe staffing tool to determine the number and skill mix of staff required each day depending on the types of procedures taking place. We looked at required and actual staffing levels from April 2023 to June 2023 and found that actual staffing levels were safe and mostly above the level of staff required. Shifts during the day were mainly covered by 2 or 3 registered nurses and 1 or 2 healthcare assistants. Evening shifts were mainly covered by 1 registered nurse.

The service also held weekly planning meetings to identify any shortfalls in staffing and used a red flag system to escalate unsafe staffing levels. Red flags included insufficient skilled staff to cover booked procedures or safe staffing levels not meeting minimum requirements.

The service had a low turnover of staff. The service had 2 vacancies for registered nurses and 1 vacancy for a health care assistant. The sickness rate was not broken down by department and at the time of our inspection was 2% for clinical staff and 8.4% for non-clinical staff.

The service could use bank staff when required. All bank staff were current employees which meant they had already had a full induction and understood the service. The outpatient department had not used any bank staff between April and June 2023.

The service had enough medical staff to keep patients safe. There were 39 consultants including orthopaedic surgeons, neurologists, radiologists, neurosurgeons and sport and exercise medicine consultants. Most of the consultants worked under practicing privileges and had substantive NHS consultant posts. Other consultants were employed directly by the service.

The senior management team had an on-call rota outside the normal working hours of 8am to 8pm to support staff with any issues being escalated.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. However not all records had the required information saved.

The outpatient department used electronic and paper systems for patient records. We reviewed 13 outpatient records; all were clearly recorded with most of the required information. This included referral records, consent forms,

consultation summaries and discharge letters. However, 6 records we looked at did not have registration forms which was a service requirement. We raised this during the inspection and staff explained that all new patients completed a registration form that was saved electronically. They were also given a paper copy to take to their initial consultation. Staff told us that patients might accidently take the paper copy home. Managers told us they would take action to keep two copies of the registration form so that the patient could keep a copy and the other could be permanently saved to their file.

There was a medical records team at the partnering hospital site who prepared patient records in advance of patients' appointments. There was a secure record storage area in the medical records department and records were prepared the day before appointments. The service used an electronic tracking system to securely transport records to the clinics which meant that records could be located at all times. After each patient consultation, consultants would update the record and staff would return the records to a secure trolley once patients had booked their follow up appointments at reception. Records were returned to the medical records team the following day.

Patient records were audited monthly, and results showed an average of 97% compliance for the past 9 months. Learning and actions were taken from audit results which included the use of documentation stamps to improve standards. We saw evidence that documentation stamps were being used in the records we looked at.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff stored and managed medicines and prescribing documents in line with the partnering provider policy. Medicines used included local anaesthetic and contrast agents. The service did not use any controlled drugs. However, the service had applied for a controlled drugs domestic licence.

All medicines were stored safely in locked cupboards. A pharmacy team based at the partnering hospital site were responsible for completing weekly stock checks and medicines management audits. Data showed that 5 audits had been completed since September 2022 with 100% compliance. The pharmacy team was responsible for ordering medication and a member of staff from The OrthTeam Centre would collect once available.

We saw that medicines that required storage at temperatures between 2ºC and 8ºC were appropriately stored in medicine fridges. There was a system in place that alerted staff when the fridge temperature exceeded the maximum temperature range.

Staff completed medicines records accurately and kept them up to date. Each patient had a medication form that documented allergies, what medicines had been administered and what medicines were given on discharge. The form also documented the prescriber's name, professional registration number, signature, and date.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff reported incidents via the electronic incident reporting system. Staff could also report incidents using a paper copy of the incident report form.

Good

Outpatients

Staff raised concerns and reported incidents and near misses in line with the partnering provider policy.

Staff we spoke with understood the duty of candour process and gave examples of when this had been followed. The duty of candour is a regulatory duty that relates to openness and transparency with patients if their treatment causes or has the potential to cause harm or distress.

Managers investigated incidents thoroughly and patients and their families were involved in these investigations. We looked at an investigation report following an incident and found staff had followed the duty of candour process. The report outlined immediate learnings and appropriate actions had been taken. There was scenario-based training and a learning poster shared across the service and partner hospital site.

Managers debriefed and supported staff after any serious incident. The investigation report included details of the team debrief and staff reflections.

From July 2022 to June 2023 the service reported 61 incidents. Incidents were broken down by department and category. Around 16% of incidents were reported by the outpatient department. Three incidents related to 'treatment' and 2 incidents related to 'cancellation'. There had been no never events reported by the service in the previous 12 months.

The service held safety huddles every morning with managers and staff from outpatients and diagnostic imaging. They shared incidents at the safety huddles and also with the partner hospital site. There was an additional '48 hour flash report' which was used to discuss any serious incidents that had occurred both internally or at the other partner services within 48 hours. The report included information on contributory factors and preventative measures identified.

Is the service effective?

Inspected but not rated

We inspect but do not rate the effective domain for outpatient services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. We saw evidence that department processes reflected national guidance such as National Institute for Health and Care Excellence (NICE) guidelines and World Health Organisation (WHO).

Care pathways and clinical policies were developed through the partnering hospital provider. Updated policies and changes to practice were shared with outpatient staff during monthly team meetings. Changes to clinical practice and policies were also discussed at routine Medical Advisory Committee (MAC) and operational board meetings.

Outpatients staff used a modified care pathway for certain treatments (such as injections) based on the World Health Organisation (WHO) safety checklist.

Staff knew how to support patients with mental health issues and could access information to signpost patients who might need support with their mental health. Staff could access a folder with information specifically for mental health services. This could be shared with patients and included phone numbers for urgent mental health support and a link to support groups close to home.

Pain relief

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

Patients were assessed for pain symptoms during outpatient appointments using a recognised pain scale. Patients that underwent certain treatments (such as injections) were assessed and monitored by staff as part of their routine observations to identify and manage pain symptoms.

Patients were given a pain diary when appropriate. They could log their pain levels through the week and take it to their follow up consultation.

Patients were supported in managing pain through prescriptions with the appropriate pain-relief medicines.

Patients were prescribed pain relief medicines to take home and given advice on how to manage pain symptoms following discharge after certain procedures.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. However, staff carried out local audits. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff carried out a programme of repeated audits to monitor effectiveness of care and used the results to improve patients' outcomes. The outpatient department carried out local audits, such as quality assurance audits, point of care testing (POCT) audit, records and IPC audits. Between September 2022 and June 2023, the average score in the POCT audit for the outpatient department was 97%. In March 2023 the department scored 100% in the quality assurance audit and 97% in June 2023.

However, we did not see evidence that the service carried out audits specific to patient clinical outcomes of treatments.

The service monitored clinical activity including rates for appointments and scans provided. From June 2022 to June 2023 there had been 18,057 clinic appointments. Of those appointments, 17920 were for patients aged 12 and over, 137 were for patients under the age of 12 years old.

The service monitored patient outcomes and data showed positive results. For example, between December 2022 and June 2023, 602 patients responded to the outpatients ‘Friends and Family Test’ which is a feedback tool sent to every patient to review the service. Results showed that around 84.8% of patients reported to have a ‘Very Good’ experience and around 96.4% of patients reported to have a ‘Good’ or ‘Very Good’ experience in the department.

Competent staff

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

Good

Outpatients

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We reviewed four outpatients staff records during our inspection, and they all had evidence of professional registration, a valid disclosure and barring service certificate (DBS), qualifications and curriculum vitae's. Staff had access to mandatory training, additional training and continuous professional development.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff were required to attend a corporate induction followed by a local induction. Areas covered included health and safety, clinical governance and information technology. Induction was structured over twelve weeks and staff were assigned a 'buddy' for support with regular induction reviews. Staff were provided with a handbook, an induction checklist and learning logs to maximise the retention of learning.

Staff in the department completed core and clinical competency training during induction and optional training which was relevant to their role. Core competencies included dementia training, anaphylaxis reactions in adults and children, caring for adolescents and incident reporting. Clinical competencies included wound care, administration of oxygen and cannulation.

The service used a training matrix to monitor compliance with competency training. We observed the training matrix for outpatient staff and it showed that staff had completed all relevant training modules with a few in the process of completion. Outpatients staff had also completed optional training in other areas such as controlled drugs, duty of candour, human factors and national early warning scores (NEWS2).

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff we spoke with gave examples of their continual professional development. Staff could also access a clinical practice facilitator to support their learning and development.

Managers identified poor staff performance promptly and held performance improvement meetings to support staff if required. The service had a policy for managing poor performance which set out a clear process that was focused on fairness, confidentiality, and integrity.

Managers supported staff to develop through yearly, constructive appraisals of their work. The data provided showed that 80% of staff had received an appraisal in the last 12 months. We were told that 13% of staff were in their probation period and 7% of staff were on maternity leave.

Consultants working under practicing privileges were required to submit evidence of their clinical appraisal annually from their main employer which was usually an NHS trust. This was reviewed as part of the practicing privileges process and compliance was 100%.

Staff attended team meetings and had access to full notes when they could not attend. If staff members were not able to attend a team meeting the meeting minutes were shared through group email, to allow staff the opportunity to keep up to date with any changes or learning which had been highlighted. We requested minutes of any outpatient team meetings from the previous 6 months. However, the service did not provide any other meeting minutes to show they had met as a team since January 2023.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Good

Outpatients

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. This included morning safety huddle meetings for staff to discuss staffing, patients and procedures for that day. Consultants from various specialities shared their knowledge and expertise and discussed patients anonymously in multidisciplinary meetings. They told us that this benefited patients because they were referred to the most relevant specialist in a more timely manner. The multidisciplinary meetings also reduced the financial cost of multiple appointments for patients.

The service also had representation at the partnering hospital site daily safety huddle to share planned activity and discuss any current risks.

Although consultants did not attend outpatient team meetings, all staff we spoke with told us that there was a positive working relationship between the consultants, administration workers, nurses and healthcare assistants. Nurses and health care assistants worked closely with consultants during appointments to support patients and give department oversight of patient's care.

Consultants worked closely with administration staff to share patient and GP letters that included information on clinical history and consultation outcomes. Letters were sent via encrypted email or by post. They would also share relevant information with the patient's NHS acute hospital where necessary.

Seven-day services

Key services were available to support timely patient care.

The outpatient department was open 5 days a week, Monday to Friday from 8am until 8pm.

Managers were available on call out of hours for any urgent enquiries.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. There was a health promotion noticeboard in the waiting area that contained information about smoking and alcohol cessation, cancer care, falls, weight management and caring for dementia. Patients could request copies of the information leaflets at the reception desk. There was also a folder with various health information leaflets with electronic codes. Patients could scan the code with their phones to access the relevant website.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care. Posters were displayed in the staff office that described the mental capacity act (MCA), lasting power of attorney and deprivation of liberty safeguards (DoLS).

Good

Outpatients

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff we spoke with said if they had concerns regarding a patient's capacity, they would seek support from their senior members of staff or the safeguarding leads.

Staff made sure patients consented to treatment based on all the information available. Parents were required to complete an agreement to investigation or treatment form for any child or young person who accessed the service.

Staff clearly recorded consent in the patients' records. We reviewed 10 sets of patient notes and saw that these all had consent signed by the patient.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The service had an up to date policy which staff followed regarding consent to treatment for competent adults, children and young people. It provided guidance on mental capacity, consent and the processes involved. The policy outlined Gillick competence guidelines specifically for patients under the age of 16.

For patients who could not speak English there was an interpreting service available that could be used to help with the consent process.

Is the service caring?

Good

We have not previously rated caring. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw that staff asked patients if they wanted help making a drink and took time to talk with them in the waiting room. We also observed a staff member telling a consultant that their patient had arrived early and they brought their appointment forward.

Information on privacy and dignity was displayed on the television screen in the waiting area. It informed patients that they could speak to staff privately and outlined ways that staff would respect their dignity.

Staff shared an example of when they had altered their working shifts last minute to accommodate an urgent procedure so that the patient could receive treatment and results within 48 hours.

Patients said staff treated them well and with kindness. We spoke with six patients during the inspection and they told us that staff had been "lovely" and "friendly" towards them. Comments included "it's a lovely place" "staff know us well; we have come here a few times and staff know us by name and are really friendly". "staff explain everything to me about my appointment and why I need it, they explain the results so I can understand" "staff are great and come over to speak to us while we wait".

Good

Outpatients

The department collected patient satisfaction feedback each month and results between December 2022 and June 2023 were consistently positive. Results from the June 2023 patient satisfaction survey showed that 94% of patients either 'Agreed' or 'Strongly Agreed' that the reception staff were attentive and efficient. Feedback also showed that 99% of patients either 'Agreed' or 'Strongly Agreed' that they had received excellent care.

Staff followed policy to keep patient care and treatment confidential. Side room doors were closed when providing care and treatment and we saw staff spoke with patients in private to maintain confidentiality.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There was a quiet room available that patients could use for prayer or wait if they were distressed and wanted privacy. The quiet room had a resource folder with leaflets that included information on emotional support, wellbeing and dementia.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff could access mental health first aiders who acted as a point of contact for issues related to mental health or emotional distress. A poster on a noticeboard informed staff who the first aiders were and how they could help.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients gave positive feedback about how information was explained before and during their appointments. Results from the June 2023 patient satisfaction survey showed that 100% of patients either 'Agreed' or 'Strongly Agreed' that their treatment was explained to them in a way that was easy to understand. Feedback also showed that 89% of patients either 'Agreed' or 'Strongly Agreed' that information they received prior to their appointment was clear and easy to understand.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff used pictures when necessary to help children and young people understand information on procedures and feedback forms.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patient information packs and leaflets in the waiting areas had electronic codes that patients could scan and leave feedback. Patients could also leave feedback using the feedback form provided on the day of their appointment for patients who didn't want to use electronic forms. The service used specially adapted child friendly feedback forms to support children and young people to share their views.

Good

Outpatients

Staff supported patients to make informed decisions about their care. Patient information packs included detailed and clear information on treatment and procedure prices, chaperones and what to expect before, during and after their appointment. Patent information also included an electronic link to the consultants on the service website.

Is the service responsive?

Good

We have not previously rated responsive. We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. The outpatient department offered a range of joint injections to both self-paying and privately insured patients. A variety of joint injections were available and included corticosteroid, hyaluronic acid and platelet rich protein.

The service minimised the number of times patients needed to attend the service, by ensuring patients had access to the required staff and tests on one occasion. Facilities and premises were appropriate for the services being delivered. There were baby changing facilities and disabled toilets available. The centre had free car parking including parking spaces for people with disabilities and wheelchairs were available on request. The centre was easily accessible by public transport. The waiting area was on the ground floor and accessible to wheelchair users.

Televisions were observed in the waiting area and displayed information such as on-site facilities, fees, staff uniforms and contacts for local support groups.

The department offered late evening appointments to accommodate for patients who needed it.

Meeting people's individual needs

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

Administration staff enquired about additional needs at the first point of contact using a red flag system. Alert stickers were then kept at the front of records when required. Alerts included visual and hearing impairments, dementia and leaning difficulties. Staff contacted families prior to their appointments where invisible disability had been identified and worked collaboratively to make the necessary adjustments for their care and treatment.

The service displayed information about accessible information standards and advised patients or carers to speak to a member of staff about this. The sign stated that this was "to make sure that people who have a disability, impairment or sensory loss are given information they can easily read or understand". Information was available to patients in large print; sign language; easy read; text to speech; via a hearing loop; by SMS; braille or via email.

Staff could access a lead for neurodiversity and used a picture exchange communication system for children and young people diagnosed with autism or communication difficulties.

The service had a sensory box for patients who were anxious about their scan or treatment. The sensory box was filled with sensory toys which use light, sound and texture to keep minds and hands distracted. In addition, activity packs were available for children and young people who accessed the service.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had an autism lead that staff could contact for support and advice. There was a quiet room available for patients that needed or preferred a quieter environment to wait in. The service had hospital passports and specific feedback forms available in adult and child formats for patients with an invisible disability. Patients with complex needs were provided with increased appointment times to allow staff time to provide additional support and these could be at the beginning or end of a clinic.

The service offered dementia awareness training and 'The Oliver McGowan Mandatory Training on Learning Disability and Autism'.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Interpreter and translation services were available. Posters were displayed in languages other than English.

Information was displayed in the waiting area which explained the different types of scans the service offered and why they are used. Staff had access to communication aids to help patients become partners in their care and treatment and translation services and hearing loops were available.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure patients could access services when needed. The service completed quarterly audits to gain an overview of waiting times from arrival on site to treatment. Managers reviewed this data to identify any themes when clinics overrun and took appropriate action to prevent future occurrences. Data from 207 appointments between November 2022 and January 2023 showed that 86% of patients were seen within the target of 15 minutes.

Patient appointments were booked by the administrative team, who assessed patients' individual needs and scheduled an appointment with adequate time.

Patients were told to inform staff if they had been waiting longer than 15 minutes. This information was displayed on the television screen in the waiting area to prompt patients.

The department reported zero cancelled appointments in the past six months.

Data provided by the service showed that between July 2022 and June 2023 there were 19,286 outpatient appointments and 0.59% (113) of patients did not attend.

Learning from complaints and concerns

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

Good

Outpatients

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a complaint in patient areas.

The service had received 8 complaints in the past 12 months and 2 of these related to outpatient department.

Managers investigated complaints and identified themes. The clinical services lead told us that the service took complaints seriously and tried to resolve complaints at the point of care. They told us that patients were always offered a chance to report their complaints formally if they remained unhappy.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints was a standing agenda item at the operational board meetings. The outcomes from complaints were shared at the staff team meetings so that staff could learn and improve patient safety and experience.

Staff understood the policy on complaints and knew how to handle them.

Staff could give examples of how they used patient feedback to improve daily practice. We saw 'You said, we did' posters in patient areas which included examples of action the service had taken in response to patient feedback.

Is the service well-led?

Good

We have not previously rated well-led. We rated it as good.

Leadership

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

Leaders at the service had the right skills and abilities to run the service. There was a clear management and leadership structure with defined lines of reporting and accountability.

The provider leadership team comprised of a hospital director who was primarily based at the partnering hospital site, the registered manager, a clinical services lead, diagnostic imaging lead and administration team lead. The registered manager had a close day to day working relationship with staff in the service and met regularly with the hospital director to discuss the service.

Staff knew the management arrangements and their specific roles and responsibilities, and the service had a clear staff organisational chart. Staff told us the managers were visible and approachable. All the staff were positive about the management of the service and said that they were supported to develop both personally and professionally. The managers and staff were passionate about the service and providing patients with a safe, quality experience.

The clinical services lead told us they had undertaken a course in quality improvement.

We saw examples of staff development. For example, the registered manager, clinical services lead and diagnostic imaging lead had been promoted into these roles from other roles within the provider.

Staff we spoke with told us managers and leaders, were visible, approachable, and supportive. Consultants were fully engaged and committed to deliver the best possible services for their patients. Consultants reported feeling supported and any issues they highlighted were dealt with quickly.

The service had effective systems in place to monitor compliance with the Fit and Proper Person Requirement (FPPR) Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that staff are fit and proper to carry out their roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

The service had embedded values with the objective of delivering the highest quality patient experience. We saw staff and leaders demonstrating these values during our inspection; 'team', 'excellence', 'commitment' and 'legacy'.

The service had a vision that involved putting patients at the heart of everything they do and to use patient feedback to shape services to better meet the patients' needs. Good patient experience was a central outcome for the service alongside clinical effectiveness and safety.

The service had a comprehensive clinical strategy for 2023 which was clearly displayed on a staff notice board. It included regulatory, clinical and commercial objectives and was focused on six key priorities:

- To grow sports, exercise and medicines (SEM) services. To provide a diverse SEM service for more patients delivered by more consultants.
- Innovate through the introduction of new services such as a new type of treatment for knee osteoarthritis and intravenous therapy.
- Be inspection ready and deliver safe and effective healthcare.
- Increase utilisation of facilities including fluoroscopy and MRI.
- Gather and measure outcome data to demonstrate the health gain of patients and the positive impact on their lives.
- Develop a business case for expansion and growth which enables to grow services and expertise and to treat more patients from 2024 onwards.

The strategic objectives were underpinned by key performance goals and measurable targets. The senior management team attended operational board meetings to discuss and monitor the progress of the objectives.

The service values and strategy were covered in the induction programme for new staff and objectives were incorporated into individual staff appraisals. Staff we spoke with were aware of the service values and strategy and these were on display throughout the service.

The service had implemented a joint Inclusivity Strategy for 2022-2023 with the partnering hospital site. The purpose was to "make a positive difference to people's lives, through outstanding personalised care". The service had goal specific objectives and projects to help deliver the strategy which were managed by the children and young person's staff nurse and autism lead and the children and young person's lead nurse.

Good

Outpatients

Culture

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

Staff we spoke with were highly motivated, patient focussed and spoke positively about working at the service. They told us there was a friendly and open culture and felt supported and valued by managers. All staff we spoke with told us they felt respected by colleagues regardless of their job role and that consultants were welcoming and approachable.

Staff that needed 'reasonable adjustments' under the Equality Act 2010 were fully supported to help them in the workplace.

Results from the most recent staff survey showed that 92% of both clinical and non-clinical staff were proud to work for the organisation, 90.5% of staff felt supported by their manager and 96% of staff said they respected their manager.

The service promoted events such as 'pizza Friday' and other social events to bring staff together. Staff could attend regular colleague and senior management forums and use staff suggestion boxes. The partnering hospital site also held a chief executive forum that staff could attend without any senior management present. The service had 'inspiring people awards' to recognise staff contribution and show appreciation.

Staff told us they received regular feedback to aid future learning and that they were supported with their training needs by the managers. Staff told us they received good training and learning opportunities. Staff felt confident to raise issues with managers and felt managers responded positively when concerns were shared.

Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. Staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardians if needed. They could attend regular drop-in sessions with the freedom to speak up guardians and the freedom to speak up process was covered in the induction programme.

Staff had worked for the service for considerable periods of time which reflected their views that they felt respected, supported and valued. They spoke very passionately about providing the highest quality of care and treatment and told us they felt privileged to be part of this.

The service was open in its communications with patients and had a system to provide patients with clear information regarding terms and conditions, including the amount and method of payment of fees.

Governance

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

The service had a clear governance structure that outlined key lines of accountability and responsibility. The meeting and committee structure ensured information flowed from service level through to the board of directors and back down to the service.

The governance structure in place provided assurance of oversight and performance against safety measures. There were several groups and committees in place that held meetings either monthly or quarterly and reported to the senior management team. These included operational board meetings and partnering provider committees such as clinical governance committee, infection prevention and control committee, clinical audit and effectiveness committee.

The medical advisory committee (MAC) held quarterly meetings led by the MAC chair. The MAC meetings were attended by the hospital director and director of clinical services from the partnering hospital site, 17 consultants and the regional medical director. Meeting minutes for March and June 2023 showed the MAC undertook reviews of new clinical services and research, regulatory compliance, practicing privileges and medical compliance standards.

The service used the partnering hospital site policies in addition to their own service specific policies such as cleaning schedules and procedure pathways. The service monitored service level agreements, policies, audits, patient safety and reported key performance indicators at the monthly operational board meetings. Finance and business updates were also discussed.

The service had processes in place to ensure clinical staff had up to date professional membership registration, indemnity insurance, evidence of qualifications and up to date disclosure and barring service (DBS) checks. They also had an effective system to monitor and review practising privileges for consultants. This included all appropriate evidence such as references, appraisals, qualifications, health declaration form and DBS checks.

Management of risk, issues and performance

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

The service was embedded into the partnering hospital site governance processes and had service level agreements in place. The service had its own board of directors who reviewed incidents, complaints and lessons learnt. Any trends, themes and group wide learning was shared at the partners safety quality risk committee. The service also had meetings with the partnering hospital site to discuss patient feedback and performance.

The service had a risk register which was monitored and updated by the registered manager. The risk register was shared with the board and discussed at monthly operational board meetings. All risks had a score, review date, controls and risk owner assigned. Risks aligned with what staff and managers told us was on their worry list. The top 3 risks were ‘not enough available clinical and admin space to accommodate expanding activity’ ‘failure to meet the annual operating plan (AOP) due to a delay in the expansion phase’ and ‘staff wellbeing due to increased incidents of confrontational behaviour from patients and their companions’.

The service held monthly finance reviews of performance including revenue, operating profit and margin. The board of directors met regularly to explore growth opportunities and operational board meetings to identify short-term measures and assess financial reports.

The service had a business continuity process to manage unexpected events. This clearly outlined actions to take in case of an emergency, key contacts and lines of responsibility.

Good

Outpatients

The service had processes and procedures in place to discuss learning from incidents. This included daily safety huddles, team meetings, operational board meetings and escalated through the partnering hospital quality meetings. Leaders told us they had a good reporting culture and empowered staff to discuss concerns and be involved in investigative reports where possible. The service participated in campaigns to raise awareness of incidents such as a 'near miss'.

The service had a sustainability model and sustainability actions for any new ways of working. This was based on the NHS sustainability model and included staff training, encouraging staff to share their ideas, demonstrating the benefits of change and a 'can do' culture.

Information on performance, quality and safety was displayed on the staff notice board and updated regularly with up to date results of audits and surveys.

The service conducted their own audits and used an electronic system for most audits undertaken. Any audit scoring less than 95% compliance had an action plan to improve compliance. The outpatient department completed an assurance audit, data showed the department scored 100% in March 2023 and 97% in June 2023.

The service used new procedure pathways based on national guidance and clinical research when implementing a new procedure to ensure safety.

Information Management

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

The service had systems in place for the safe storage, circulation and management of electronic and paper-based documents. Electronic patient records and information technology systems were integrated and secure. Electronic systems (such as to store scan and manage patient appointments) required password access.

Service specific policies and guidelines were available for all staff to access in a folder or online. The policies we looked at were version-controlled, up to date and had periodic review dates.

There were systems in place to ensure data and statutory notifications were submitted to external bodies. The registered manager was responsible for submitting notifications to the Care Quality Commission. There had been no incidents that had been reportable over the previous 12 months.

Staff completed information governance training as part of their annual mandatory training. Records showed all administration and outpatient staff had completed this training.

The service had no data breaches that were reportable to the Information Commissioner's Office (ICO).

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The partner hospital site conducted patient surveys and they shared results with the service through monthly meetings. The service had its own specific patient satisfaction feedback forms and strived to improve patient response rates through various engagement methods. Patient feedback was sent to staff including consultants via email each month with the identified trends. Trends were discussed at monthly operational board meetings and patient experience committee meetings. Action plans were implemented, and success was reviewed against future feedback.

The service carried out an annual staff survey to gain feedback from staff about their experiences. The staff survey (2022) had a response rate of 64% for clinical staff and 75% for non-clinical staff. For clinical staff, 84% said they were proud to work for the provider. For non-clinical staff this figure was 100%. The results also showed that 92% of clinical staff and 89% of non-clinical staff said that they would be happy with the standard of care if a friend or family member needed treatment. The staff survey showed the lowest score for clinical staff was 'I believe meaningful action has been taken in my team as a result of the last survey' (39%). For non-clinical staff the lowest score was 'I feel as connected and in-touch with my colleagues as I'd like to be' (55%). The service had implemented an action plan for low scores to focus on any areas for improvement.

The service had an inclusion working group that met quarterly to review and monitor inclusivity and equality priorities. Meetings were chaired by the autism lead and outcomes were shared with senior managers at governance led meetings. They also had a patient experience lead that held regular patient forums and had been involved in lesbian, gay, bisexual, and transgender (LGBT) events.

Staff had also performed patient educational awareness events on the subject of joint pain.

The service engaged with stakeholders through charity events and continuous professional development events. Staff had undertaken numerous educational events with GP's, football clubs, podiatrists, physiotherapists in addition to pain management events for educational sessions with consultants. Consultants also engaged with national bodies and relevant sports clubs.

Learning, continuous improvement and innovation

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

Managers encouraged staff to progress and enhance their skills. Staff we spoke with gave examples of their continual professional development such as progression from a health care assistant to nurse associate with the goal of becoming a registered nurse. Other staff had progressed into team leader roles and one administration staff member had completed the relevant training to become a health care assistant.

The service benchmarked their performance against the partnering hospital site. The service scored better than the partners on patient satisfaction measures and wait times for MRI scans.

The service used patient feedback to improve services for patients. The service had set up a patient feedback committee in January 2023 to look closely at patient feedback and take action for areas of improvement. These were now held quarterly meeting with senior directors, team leaders and patient experience leads.

Consultants had used patient feedback to expand into sport and exercise medicine (SEM). The service employed a SEM consultant who was the first of its kind employed across the partnering hospital site or other provider hospitals. This meant that patients could be referred onto the right specialist quicker after a holistic assessment.

Good

Outpatients

Managers told us they were proud of meeting their 5 year business targets within 2 years and had achieved accreditation with independent provider British United Provident Association (BUPA). They were the first group of consultants in the North West to meet the high standards of the Bupa accreditation Scheme. The service was scored on key areas such as clinical measures, patient satisfaction, level of specialist cover, clinical governance processes and complaints management.

The service was committed to growing the service whilst retaining a high positive patient experience. Patient activity had grown 9.2% from 2021 to 2022 and the service had an average of 2000 patient appointments per month. Results from the June 2023 patient satisfaction survey showed that 99% of patients either 'Agreed' or 'Strongly Agreed' that they had received excellent care.

Since May 2022 the service had implemented new procedures such as a non-surgical treatment for knee osteoarthritis and infusions for the treatment of iron deficiency. The new procedures were implemented as effective alternatives to the currently available therapies and can increase recovery time.

The service had recently set up an inclusion working group which involved staff from all departments and chaired by the autism lead. The inclusion working group met quarterly to review current equality priorities and objectives and looked at patient experiences. Staff told us that it improved oversight of inclusivity and ensured emerging issues were responded to. Information and updates from the group was shared quarterly with the senior management team and at governance led meetings.

Good

Diagnostic imaging

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Is the service safe?

Good

This was the first inspection of this core service. We rated it as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. Mandatory training was delivered through e-learning modules with some face to face training modules.

Mandatory training compliance was monitored throughout the year and the training year began in April and ended in March. Compliance targets were set throughout the year. For example, quarter 1 25% compliant, quarter 2 50% compliant, quarter 3 75% compliant and quarter 4 95% compliant.

For the year 2022 to 2023 the diagnostic imaging department achieved 93.75% compliance. At the time of our inspection, the compliance rate for the department was around 73%.

The mandatory training was comprehensive and met the needs of patients and staff. The mandatory training requirements included courses covering infection prevention and control, safeguarding children and adults, fire safety, health and safety, manual handling and equality and diversity.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff did not always have the correct level of training on how to recognise and report abuse. However, staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Managers told us that all staff were required to complete level 2 safeguarding adults and children training. Clinical staff and the registered manager were required to complete level 3 safeguarding adults and children training. The service had a safeguarding lead for adults and children who was based at the partnering hospital site.

Good

Diagnostic imaging

Safeguarding training compliance for 2022/2023 within the diagnostic imaging department was: level 1 and 2 safeguarding adults 85%, level 3 safeguarding adults 15%, level 1 and 2 safeguarding children 100% and level 3 safeguarding children 100%.

At the time of our inspection, safeguarding training compliance within the department was: level 1 and 2 safeguarding adults 62%, level 3 safeguarding adults 25%, level 1 and 2 safeguarding children 75% and level 3 safeguarding children 75%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had up to date safeguarding policies for both adults and children.

Staff we spoke with told us that they had not had to make a safeguarding referral whilst working at the service however, they were able to verbally describe the steps they would take if they identified a safeguarding concern.

Staff followed safe procedures for children visiting the service. Staff completed a safeguarding children admission checklist for each child and young person who accessed the service.

All appointments were offered a chaperone for support. Information about chaperones was displayed throughout the service. The service had an up to date chaperone policy.

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.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The waiting area, examination and treatment rooms, diagnostic areas and changing rooms were all visibly clean and cleaning records were up to date.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff wearing uniform that was 'bare below the elbow' and they adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting clinical areas. We witnessed staff using PPE effectively.

There were sufficient hand washing facilities and hand gel dispensers throughout the service. Handwashing posters were displayed above all wash basins.

We were told that the infection prevention and control (IPC) mandatory training module was not available in quarter 1 for 2023/2024 due to an update. However, 25% of staff in the diagnostic imaging department had completed the training in July 2023.

The service carried out monthly hand hygiene audits and quarterly service cleanliness audits. Hand hygiene audit results showed 100% compliance for the 3 months before our inspection. Quarterly service cleanliness audit results showed 100% compliance for the same reporting period.

Good

Diagnostic imaging

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used green 'I am clean' stickers to indicate equipment that had been cleaned and was ready for use.

Ultrasound probes were cleaned in line with best practice, the cleaning process was documented and audited.

The department had not reported any healthcare associated infections since the service had registered with CQC.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, staff did not always carry out daily safety checks of emergency resuscitation equipment.

The service had enough suitable equipment to help them to safely care for patients. The diagnostic imaging department was located on the ground floor of the building, this included an ultrasound scanning room, x-ray room, fluoroscopy room, recovery room and a magnetic resonance imaging (MRI) scanner.

The design of the environment followed national guidance. There was clear signage and warning lights outside controlled areas where radiation was being used, which told both staff and patients not to enter when the sign was illuminated. In addition, names and contact details for the Radiation Protection Supervisor (RPS) and Radiation Protection Advisor (RPA) were displayed on the scanning room doors.

The department was secure, all doors to clinical areas had a digital door lock and only staff with a swipe card could access the scanning rooms.

The department had suitable facilities to meet the needs of patients. The waiting area was spacious and had adequate seating, however some staff told us that this area could get overcrowded on occasions. Patients had accessible toilets and a changing area which consisted of a locker, wipeable chair, gowns, a linen bin and call bell. Water and hot drinks were available to patients and their families in the waiting areas and staff offered refreshments.

We saw evidence that staff had received the appropriate training, instructions and information for equipment used including the MRI scanner. The service carried out quarterly quality assurance checks of specialist equipment and we saw evidence of these being completed for the past 12 months.

Lead aprons were used when staff were carrying out fluoroscopy scans, these aprons were used to protect against radiation exposure. Staff used body and thyroid shield lead aprons. The aprons were well maintained and in good condition.

Patients could reach call bells and staff responded quickly when called. Patients had access to an emergency call buzzer and could communicate with staff through an intercom system during their scan.

The service completed control of substances hazardous to health (COSHH) risk assessment documents for individual substances which were used in the department. All COSHH chemicals were stored securely and appropriately in locked cupboards with restricted access.

There were fire extinguishers throughout the premises, and these had been tested appropriately. Fire safety training was also included as part of mandatory training and staff had completed this.

Staff disposed of clinical waste safely. Sharps bins were wall mounted, dated and labelled correctly.

Equipment in the department was clean and well maintained and servicing contracts were in place. We saw that most equipment had been serviced, however records showed that an ultrasound machine was due for servicing in April 2023. We saw evidence of a completed risk assessment which included actions to ensure it was safe to use.

Staff did not always carry out daily safety checks of emergency resuscitation equipment. For example, from February 2023 to June 2023, we saw 6 gaps in the daily resuscitation trolley checks. For the same reporting period, we saw 4 gaps in the daily paediatric emergency care system bag checks. The resuscitation trolleys were correctly stocked, oxygen cylinders were full, suction machines and defibrillators were in working order. All emergency equipment was secured with a seal tag.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. The service had a flow chart which directed staff to the escalation action they needed to take in response to patient risk.

Staff completed risk assessments for each patient on arrival. We observed reception staff confirming patient identity when they arrived at the service, this was then checked again by radiographers before patients were scanned. Safety questionnaires were completed prior to imaging procedures taking place and patient allergies were noted on their record.

Comprehensive safety questionnaires included details of any magnetic devices or implants, details of any other metal in the body, allergies, and risk of pregnancy. Posters were displayed in the service reminding staff and patients about the need to discuss the possibility of pregnancy or risks if they already had a confirmed pregnancy.

The service had a process in place for children and young people who had been referred for an interventional procedure. The paediatric team who was based at the partnering hospital site would assess the referral prior to the procedure. A paediatric nurse would be present for any procedures involving patients aged up to 16.

Patients who received image guided injection treatments were admitted to the service for a short period. Staff used the nationally recognised national early warning scores (NEWS2) tool to ensure any changes to the patients' medical condition could be promptly identified. We checked patients' NEWS2 charts and found them to be filled in correctly.

The use of the World Health Organisation (WHO) surgical safety checklist for radiological interventions not requiring general anaesthetic was embedded in practice and we saw that staff used this. WHO checklist audit results showed 100% compliance for the past 12 months.

There were pause and check signs in the control areas of each diagnostic room which reminded staff to check patient identity, correct area for scan, radiation dose and clinical justification. Pause and check compliance was audited monthly, and results showed 100% compliance for the past 12 months.

Staff knew about and dealt with any specific risk issues and shared key information to keep patients safe. If the radiographer noted any unexpected or significant findings from image reports these would be escalated to the treating consultant.

Good

Diagnostic imaging

The service had mental health first aiders and could be utilised by staff if they needed support with patients with mental health difficulties.

All clinical staff were required to complete resuscitation quality improvement (RQI) training. Some staff had undertaken immediate life support (ILS) and paediatric life support (PILS) training. One staff member in the outpatients department had advanced life support training. Data provided was not broken down by department and showed overall compliance of 94% for RQI level 1 and 69% for RQI level 2. Compliance for ILS was 80% and PILS 75%.

Resuscitation action cards were allocated to staff members in the event of a patient emergency. The action cards included roles and responsibilities for the team leader and clinicians.

The service had a first aid kit and anaphylaxis kit for both adults and children. Most staff in the diagnostic imaging department had completed anaphylaxis scenario training in the past 12 months.

Information about diagnostic imaging safety and radiation exposure was displayed throughout the service.

Staffing

The number of radiographers and radiology assistants did not always match the planned numbers. However, managers regularly reviewed and adjusted staffing levels and skill mix to keep patients safe from avoidable harm and to provide the right care and treatments.

The department included a diagnostic imaging lead, 4 radiographers and 3 radiology assistants. The clinical lead and registered manager had management oversight of the department.

The number of radiographers and radiology assistants did not always match the planned numbers. Managers used a safe staffing tool to calculate and review the number of radiographers and radiology assistants needed for each shift in accordance with scheduled activity. We were told that staffing requirements were calculated in hours. We reviewed staffing rotas from April 2023 to June 2023 and found that the department only achieved the required staffing hours for 24 shifts out of a total of 73. This meant the department did not achieve the required staffing hours for 49 shifts.

Managers told us that any deficit in actual hours versus planned included actions to maintain patient safety. For example, the diagnostic imaging lead was not included in the actual staffing hours however they would become part of the numbers. Bank staff were also used to cover additional shifts and completed 1024 hours from April 2023 to June 2023.

All bank staff were current employees which meant they had already had a full induction and understood the service. The induction programme included training on how to use the diagnostic imaging equipment.

The service had a low turnover of staff. The department had one vacancy which was a diagnostic imaging lead post. The sickness rate was not broken down by department and at the time of our inspection was 2% for clinical staff and 8.4% for non-clinical staff.

There were 5 radiologists who worked at the service under practising privileges. Processes for managing staff employed under practising privileges was carried out by the partnering provider.

Good

Diagnostic imaging

Records

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

The diagnostic imaging department used electronic and paper systems for patient records. A daily log of scans was kept by staff and recorded on the radiology information system (RIS).

Staff used a password protected picture archiving and communication system (PACS) to store records and images. Images could be sent securely to other hospital sites if the clinician responsible for the patients' care needed to review the image.

We reviewed 10 patient records, all were clearly recorded with the required information for example, radiation doses, personal details, consent, prescription, and safety checklist.

Patient records were audited monthly, and results showed an average of 97% compliance for the past 9 months.

The electronic imaging systems used were password protected and all diagnostic imaging staff had personal log in details.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff stored and managed medicines and prescribing documents in line with the partnering provider policy. Medicines used included local anaesthetic and contrast agents. The service did not use any controlled drugs. However, the service had applied for a controlled drugs domestic licence.

All medicines were stored safely in locked cupboards. A pharmacy team based at the partnering hospital site were responsible for completing weekly stock checks and medicines management audits. Data showed that 5 audits had been completed since September 2022 and showed 100% compliance. The pharmacy team was responsible for ordering medication and a member of staff from The OrthTeam Centre would collect once available.

We saw that medicines that required storage at temperatures between 2ºC and 8ºC were appropriately stored in medicine fridges. There was an electronic system in place for monitoring fridge temperatures that alerted staff when the fridge temperate exceeded the maximum temperature range.

Staff completed medicines records accurately and kept them up to date.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff reported incidents via the electronic incident reporting system.

Staff raised concerns and reported incidents and near misses in line with the partnering provider policy.

Good

Diagnostic imaging

From July 2022 to June 2023 the service reported 61 incidents. Incidents were broken down by department and category. Around 30% of incidents were reported by the diagnostic imaging department and related to 'equipment', 'documentation', 'cancellation' and 'staffing'. There had been no never events reported by the service in the previous 12 months.

The service had an incident flowchart which highlighted actions for staff to take if the incident caused disruption to services.

Managers told us that learning from never events and serious incidents in other partnering hospital sites were shared at staff meetings and safety huddles. We saw evidence that incidents were discussed at team meetings and quarterly clinical governance meetings (medical advisory committee). Incident information was also displayed in the staff areas.

Staff understood the duty of candour which was covered in a mandatory training module for staff to complete. Staff could explain its principles and would give patients and families a full explanation if things went wrong.

There was evidence that changes had been made as a result of feedback. For example, the magnetic resonance screening and consent form had been updated following a patient safety incident in the MRI scanner.

Is the service effective?

Inspected but not rated

We inspected the effective domain, but we do not rate this for diagnostic imaging services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Diagnostic imaging staff adhered to national provider policies in accordance with the RPA and Ionising Radiation (Medical Exposure) Regulations IR(ME)R guidance and requirements.

The Ionising Radiation Regulations 2017 are regulations concerned with the protection against exposure to ionising radiation as a result of work activities. The radiation safety policy was up to date and had been signed by the registered manager, diagnostic imaging lead, RPS and RPA.

However, during our inspection we found that copies of the local rules which summarised instructions to restrict exposure in radiation areas were not always visible for staff. In addition, local rules in the MRI scanning room had only been signed by the diagnostic imaging lead.

A radiation protection compliance audit was undertaken in July 2023 by the provider RPA to assess the level of compliance against requirements of the Ionising Radiations Regulations 2017 and Ionising Medical Exposure Regulations 2017. Audit results showed that the diagnostic imaging department was fully compliant in 17 areas, partially compliant in 3 areas and not compliant in 1 area. Recommendations and actions were implemented following the audit.

Good

Diagnostic imaging

The department had local and national diagnostic reference levels in place. Diagnostic reference levels are specified radiation doses that are not expected to be exceeded.

The partnering provider held a national steering group for radiographers, which allowed for best practice to be shared across the service and gave an opportunity to make recommendations on new guidance.

We saw evidence of updates to policies and standard operating procedures being discussed at team meetings.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients having scans do not routinely require pain relief. Staff did monitor and check patients pain verbally throughout their scan or appointment and could seek support from medical staff if needed.

Staff were aware of how to escalate concerns with senior colleagues if they had concerns regarding a patient's ability to communicate pain to them.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and used the results to improve patients' outcomes. The service had a clinical audit system. The department carried out local audits, such as safety checklist audits, imaging documentation audits and post-examination documentation audits.

The service monitored clinical activity including rates for appointments, scans and image guided injections provided. From June 2022 to June 2023 there had been 7491 appointments, 12,389 scans and 654 image guided injection treatments carried out in the diagnostic imaging department. Of those scans, 6072 were MRI scans, 3341 were x-ray scans and 2976 were ultrasound scans.

Outcomes for patients were positive, consistent and met expectations. Between December 2022 and May 2023, 154 patients responded to the diagnostic imaging 'Friends and Family Test' which is a feedback tool sent to every patient to review the service. Results showed that around 91% of patients reported to have a 'Good' or 'Very Good' experience in the department.

The service was accredited by the Bupa Group Accreditation Scheme.

Competent staff

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

Good

Diagnostic imaging

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We reviewed 3 diagnostic imaging staff records during our inspection, and they all had evidence of professional registration, a valid disclosure and barring service certificate (DBS), qualifications and curriculum vitae's. Staff had access to mandatory training, additional training and continuous professional development.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff were required to attend a corporate induction followed by a local induction. Areas covered included health and safety, clinical governance and information technology. Staff were provided with a handbook, an induction checklist and learning logs to maximise the retention of learning.

Diagnostic imaging staff completed radiation protection training and competency assessments in areas such as MRI and x-ray however there was no evidence of completed refresher training.

Managers supported staff to develop through yearly, constructive appraisals of their work. The data provided showed that 80% of staff had received an appraisal in the past 12 months. We were told that 13% of staff were in their probation period and 7% of staff were on maternity leave.

Consultants working under practicing privileges were required to submit evidence of their clinical appraisal annually from their main employer which was usually an NHS trust. This was reviewed as part of the practicing privileges process and compliance was 100%.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us there were opportunities for continual professional development.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, during our inspection some staff were training to use and interpret all service diagnostic imaging modalities.

Managers identified poor staff performance promptly and supported staff to improve.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. If staff members were not able to attend a team meeting the meeting minutes were shared through group email, to allow staff the opportunity to keep up to date with any changes or learning which had been highlighted. However, the last diagnostic imaging team meeting was held in April 2023.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Staff held daily safety huddle meetings to discuss patients and improve their care. Good teamwork and communication were evident during our observation of clinical practice. Staff told us they had a good working relationship with consultants and the outpatient department.

The service included the input of radiologists, consultants and clinical assistants. Staff told us they worked well together, and this was supported by an effective and approachable manager.

The diagnostic imaging department had representatives who attended the daily huddle. Staff stated this was well attended and helped to keep them informed. Issues discussed in the daily huddle were communicated to staff by email.

Good

Diagnostic imaging

The service also had representation at the partnering hospital site daily safety huddle to share planned activity and discuss any current risks.

Seven-day services

Key services were available to support timely patient care.

The diagnostic imaging department was open five days a week from 8am until 8pm. The service occasionally operated on Saturdays to meet the needs of patients.

Managers were available on call out of hours for any urgent enquiries.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. There was a health promotion noticeboard in the waiting area that contained information about smoking cessation, cancer care, weight management and caring for dementia. Patients could request copies of the information leaflets at the reception desk.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The service had an up to date policy which staff followed regarding consent to treatment for competent adults, children and young people. It provided guidance on mental capacity, consent and the processes involved. The policy outlined Gillick Competence for patients under the age of 16.

Staff made sure patients consented to treatment based on all the information available. We observed staff obtaining verbal consent from patients before carrying out a scan.

Patients attending for an MRI scan were required to complete a safety checklist and give written consent prior to entering the scanning area.

Parents were required to complete an agreement to investigation or treatment form for any child or young person who accessed the service.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff said if they had concerns regarding a patient's capacity, they would seek support from their senior members of staff or the safeguarding leads.

Good

Diagnostic imaging

Staff clearly recorded consent in the patients' records. We reviewed 10 sets of patient notes and saw that these all had consent signed by the patient.

Information was displayed relating to the benefits and risks associated with the radiation dose from the exposure.

For patients who could not speak English there was an interpreting service available that could be used to help with the consent process.

Is the service caring?

Good

This was the first inspection of this core service. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients spoke positively about the quality of care they had received and how they were treated during their appointment, they said staff were respectful of their time, and they were given enough time to ask questions at any stage.

During our inspection we observed staff introduce themselves, explained their roles, provided details of the scan and welcomed any questions.

Results from the June 2023 patient satisfaction survey showed that 91% of patients either 'Agreed' or 'Strongly Agreed' that they felt welcomed when they arrived at reception and staff were friendly.

Staff followed policy to keep patient care and treatment confidential. Side room doors were closed when providing care and treatment and we saw staff spoke with patients in private to maintain confidentiality.

Chaperones were available to support patients during procedures if needed.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There was a quiet room available that patients could use for prayer or wait if they were distressed and wanted privacy.

Good

Diagnostic imaging

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff maintained constant interaction with patients throughout their scans, they talked patients through the procedure and went at a pace that suited the patient. Patients who may need more time for scans due to complexities such as mobility issues or pain were highlighted during the booking process so that additional time could be added to their appointment.

Patients gave positive feedback about the service. Results from the June 2023 patient satisfaction survey showed that 92% of patients either 'Agreed' or 'Strongly Agreed' that their treatment was explained to them in a way that was easy to understand, and they were informed how to get their results following treatment.

Understanding and involvement of patients and those close to them

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

Staff provided patients with information prior to their scan. Patients told us that this information was informative.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Staff supported patients to make informed decisions about their care.

There was a range of imaging and diagnostic information on the services website which was available to patients. This information explained why someone might need a scan or image guided injection and the procedure.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information on how to provide feedback was displayed on noticeboards. Comments and survey results were discussed with the aim of improving the patient's experience.

Is the service responsive?

Good

This was the first inspection of this core service. We rated it as good.

Service delivery to meet the needs of local people

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

Good

Diagnostic imaging

Managers planned and organised services, so they met the changing needs of the local population. The department offered a range of diagnostic services to both self-paying and privately insured patients.

The service minimised the number of times patients needed to attend the service, by ensuring patients had access to the required staff and tests on one occasion.

Facilities and premises were appropriate for the services being delivered. There were baby changing facilities and accessible toilets available. The centre had free car parking including parking spaces for people with disabilities. The centre was easily accessible by public transport. The waiting area was on the ground floor and accessible to wheelchair users.

Televisions were observed in the waiting area and displayed information such as on-site facilities, fees, staff uniforms and contacts for local support groups.

The department offered late evening and weekend appointments to accommodate for patients who could not make weekday appointments, for patients who needed an urgent scan the best effort was made to give the patient a scan on the day they were referred.

Meeting people's individual needs

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

The service displayed information about accessible information standards and advised patients or carers to speak to a member of staff about this. The sign stated that this was "to make sure that people who have a disability, impairment or sensory loss are given information they can easily read or understand". Information was available to patients in large print; sign language; easy read; text to speech; via a hearing loop; by SMS; braille or via email.

The service had a sensory box for patients who were anxious about their scan or treatment. The sensory box was filled with sensory toys which use light, sound and texture to keep minds and hands distracted. In addition, activity packs were available for children and young people who accessed the service.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients with complex needs were provided with increased appointment times to allow staff time to provide additional support and these could be at the beginning or end of a clinic.

The service offered dementia awareness training and 'The Oliver McGowan Mandatory Training on Learning Disability and Autism' to staff.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Interpreter and translation services were available. Posters were displayed in languages other than English.

Information was displayed in the waiting area which explained the different types of scans the service offered and why they are used.

Access and flow

People could access the service when they needed it and received the right care promptly.

Good

Diagnostic imaging

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. Patient appointments were booked by the administrative team, who assessed patients' individual needs and scheduled an appointment with adequate time.

The average waiting times for referral to scan from January 2023 to June 2023 was 10 days for MRI and 3.5 days for x-ray. The service did not provide data for ultrasound and fluoroscopy procedures.

The diagnostic imaging department had targets for reporting times for images. The target was to produce a report within 5 working days. The average report turnaround time from January 2023 to June 2023 was 2 days for MRI and 3 days for x-ray.

Data was collected to gain an overview of waiting times from arrival on site to treatment. Managers reviewed this data to identify any themes when clinics overrun and took appropriate action to prevent future occurrences.

The department reported 0 cancelled appointments in the past 6 months.

There had been 47 appointments in which patients did not attend (DNA). The department had only recently implemented a patient DNA procedure therefore data was only available for May and June 2023. MRI patients made up around 30% of those that DNA. However, the service had not recorded the modality for 51% of patients who DNA.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a complaint in patient areas.

The service had received 8 complaints in the past 12 months and 2 of these related to diagnostic imaging.

Managers investigated complaints and identified themes. The clinical services lead told us that the service took complaints seriously and tried to resolve complaints at the point of care. They told us that patients were always offered a chance to report their complaints formally if they remained unhappy.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints was a standing agenda item at the operational board meetings. The outcomes from complaints were shared at the staff team meetings so that staff could learn and improve patient safety and experience.

Staff understood the policy on complaints and knew how to handle them.

Staff could give examples of how they used patient feedback to improve daily practice. We saw 'You said, we did' posters in patient areas which included examples of action the service had taken in response to patient feedback.

Is the service well-led?

Good

Diagnostic imaging

Good

This was the first inspection of this core service. We rated it as good.

Leadership

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

See information under this sub heading in the outpatients section.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

See information under this sub heading in the outpatients section.

Culture

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

See information under this sub heading in the outpatients section.

Governance

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

See information under this sub heading in the outpatients section.

Management of risk, issues and performance

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

Annual Radiation Protection Committee meetings were established and attended by the radiation protection advisor, partnering hospital director, diagnostic imaging lead as the radiation protection supervisor, and registered manager. The last meeting had been held in August 2022 and an annual action plan had been developed.

See information under this sub heading in the outpatient section.

Good

Diagnostic imaging

Information Management

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

There were systems in place for the safe storage, circulation and management of electronic and paper-based records such as patient records, performance reports, audit records and meeting minutes.

Diagnostic imaging staff completed information governance training as part of their mandatory training and compliance was 100% at the time of our inspection.

Electronic systems (such as to store records and manage patient appointments) required password access. Diagnostic scan results, reports and images were stored electronically and could be accessed by staff in other parts of the hospital, such as during routine outpatient consultations.

See information under this sub heading in the outpatient section.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

See information under this sub heading in the outpatient section.

Learning, continuous improvement and innovation

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

See information under this sub heading in the outpatient section.