Droitwich Knee Clinic Ltd

The Bromsgrove Clinic

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risks and managed medicines and safety incidents well, learning lessons from them. Staff assessed risks to patients, acted on them and kept good care records.
- Staff provided good care and treatment. Staff assessed patients' pain levels and developed appropriate treatment plans to relieve pain. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff respected and valued patients as individuals. They treated patients with compassion and kindness, respected their privacy and dignity, and helped them understand their conditions. Staff empowered patients, families, and carers as partners in care, practically and emotionally, offering an exceptional and distinctive service.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Services for children & young people	Inspected but not rated 	The Bromsgrove Clinic provided outpatient services and diagnostic services to patients between the age of nine and 18 years of age. Children and young people's services was a very small part of the overall activity at the clinic with most patients being 18 years of age and above. During our inspection visit, we did not see any children or young people being treated, review any patient records of children or young people, and we did not speak to any children or young people, or their parents about their care and treatment. Therefore, we inspected services for children and young people but did not have enough evidence to give a rating. The main service was outpatient services. Where arrangements were the same, we have reported findings in the outpatient service section.
Outpatients	Good 	We rated outpatients as good because it was safe, caring, responsive and well-led. We currently do not have enough evidence to rate effectiveness of outpatient services. See the overall summary above for details.
Diagnostic imaging	Good 	We rated diagnostic imaging as good because it was safe, caring, responsive and well-led. We currently do not have enough evidence to rate effectiveness of diagnostic imaging services. See the overall summary above for details. Diagnostic imaging is a small proportion of the clinic activity. The main service was outpatient services. Where arrangements were the same, we have reported findings in the outpatient service section. Please refer to the overall summary above.

Summary of findings

Contents

Summary of this inspection

Background to The Bromsgrove Clinic

The Bromsgrove Clinic is run by The Droitwich Knee Clinic. The service has one registered location, and it has been registered since 2015 for treatment of disease, disorder or injury and diagnostic and screening procedures. The registered manager is a consultant surgeon and has been in post since 16 August 2019. They took on the role of the nominated individual on 24 June 2019.

The service is a small private clinic that provides specialist consultations for knee and shoulder complaints. It involves a one-stop service for patients with x-ray, ultrasound and magnetic resonance imagery (MRI) at the premises for further investigations. It also provides a physiotherapy service. There is no inpatient facility at this premises.

The clinic premises included a large reception and waiting area, two outpatient consultation rooms with an examination room to each, a physiotherapy room, an MRI room and an X-ray room. The ultrasound was portable and able to be used in the outpatient consultation areas. There were other rooms within the premises, but these were not leased by The Bromsgrove Clinic.

The registered manager occasionally rented their second consultation room to two other consultants working on practicing privileges. One of these consultants was a spinal consultant and the other was a foot and ankle consultant.

The Bromsgrove Clinic is consultant led and is open on reduced hours to work around the consultant's NHS commitments. The clinic is open on Monday evenings, all day Wednesdays and on Friday evenings.

The main service provided by The Bromsgrove Clinic was outpatient services. Where our findings on outpatients also apply to other services, for example, management arrangements we do not repeat the information but cross-refer to the outpatients' service.

From May 2021 to April 2022, The Bromsgrove Clinic had 1,491 outpatient attendances of which 903 were for outpatient consultations and 588 were for physiotherapy appointments. For the same period there were 683 diagnostic and screening attendances of which 374 were for MRI, 281 were for X-ray and 28 were for ultrasound.

Most patients at the clinic were adults. However, the service did see a small number of children between May 2021 and April 2022. Children accounted for 3.5% (52) of all outpatient attendances of which 28 were for outpatient consultations and 24 were for physiotherapy, and 1.5% (10) of all diagnostic attendances of which all were for MRI.

We have not inspected The Bromsgrove Clinic before.

How we carried out this inspection

The inspection team consisted of two CQC inspectors and a radiographer specialist advisor. In addition to carrying out observations of the premises, equipment, and staff interactions with patients, we reviewed governance documents such as policies, procedures, and audits. We spoke with four members of staff and three patients and reviewed five patient records and five staff profiles.

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.

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- Senior staff had completed burnout coaching to help support the wellbeing of their staff during the recovery of the health service after the COVID-19 pandemic.
- Staff were extremely passionate about their patients, promoting good health and ensuring people had access to tools, education, and support to make positive lifestyle changes. They ensured specialist information and education reached those people who would not ordinarily be able to afford it.

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 SHOULD take to improve:

- The service should ensure that Digital Video Discs (DVDs) containing Magnetic Resonance Imaging (MRI) images of patients are encrypted and stored in a lockable area.
- The service should ensure that they continue to work on reducing Diagnostic Reference Levels (DRLs) for x-ray exposures in line with The Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017.
- The service should consider developing the mandatory training matrix further to include due dates, level of safeguarding training and naming of modules in line with the staff training policy.
- The service should consider the use of an air cooler or portable air-conditioning unit in the MRI room, particularly during hot weather.
- The service should consider adopting 4.12.12 of the Medicines and Healthcare products Regulatory Agency (MHRA) Safety Guidelines for MRI Equipment in Clinical Use (February 2021) in relation to panic alarms.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for children & young people	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated
Outpatients	Good	Insufficient evidence to rate	☆ Outstanding	Good	Good	Good
Diagnostic imaging	Good	Insufficient evidence to rate	☆ Outstanding	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Inspected but not rated

Services for children & young people

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

Are Services for children & young people safe?

Inspected but not rated

For mandatory training, cleanliness, infection control and hygiene, assessing and responding to patient risk, staffing, records, medicines and incidents, please see outpatients. Only aspects of safeguarding and environment and equipment that are specific to children and young people's services are included in this part of the report, please see the outpatients' report for general aspects of safeguarding. Safeguarding

Safeguarding

Staff understood how to protect children, young people and their families 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. Training in children's safeguarding was based on the 2019 intercollegiate document *"Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff"* and staff were supported by a comprehensive safeguarding children's policy. All non-clinical staff were trained to Level 2, clinical staff to Level 3 and the safeguarding lead who was also the registered manager was trained to Level 5.

Staff initially completed children safeguarding training during induction and undertook refresher training annually. Training was provided by an external company.

Staff followed safe procedures for children visiting the ward. There was a comprehensive policy titled *"Treating Children and Young People at DKC,"* (Droitwich Knee Clinic) which clearly outlined the provider's responsibilities for ensuring children were safe at the clinic. The policy included steps for clinicians to take when discussing treatment options and gaining consent. Children under the age of nine years old were not treated at the clinic and all children were to be accompanied by an adult. Children between the age of nine and 18 years did not receive any form of invasive treatment at the clinic, specifically diagnostic and therapeutic injections. They were referred to the NHS or private hospitals if these treatments were required where there were appropriate paediatric trained nursing staff available.

Inspected but not rated

Services for children & young people

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff knew the registered manager was the safeguarding lead for children. The children's safeguarding policy clearly outlined the name and contact details for the safeguarding lead for staff to contact. They also included the contact details for the local safeguarding boards and a flowchart on the action staff should take.

Environment and equipment

The service had suitable facilities to meet the needs of patients' families. There were drinks available in the waiting area. Pre-pandemic there were toys available for children attending the clinic. However, these had been removed because of the pandemic. We saw children's toys were documented in policies with instructions on how to clean these effectively and when they should be removed from the clinic i.e., during a pandemic.

Are Services for children & young people effective?

Inspected but not rated

For evidence-based care and treatment, pain relief, patient outcomes, competent staff, multidisciplinary working, seven-day services, and health promotion, please see outpatients. Only aspects of consent, Mental Capacity Act and Deprivation of Liberty Safeguards that are specific to children and young people's services are included in this part of the report, please see the outpatients' report for general aspects of consent, Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment.

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. They understood Gillick Competence and Fraser guidelines and supported children who wished to make decisions about their treatment. Staff understood the difference between Gillick Competence and Fraser guidelines and knew what was required to support children under the age of 16 years old in making decisions about their care and treatment. They were further supported by a comprehensive and detailed consent policy that included consenting children. Fraser guidelines were not applicable to the service provision, as these are specific to providing contraceptive and sexual health advice to a child under 16 years of age.

Are Services for children & young people caring?

Inspected but not rated

Please see outpatients.

Are Services for children & young people responsive?

Inspected but not rated

Please see outpatients.

Inspected but not rated

Services for children & young people

Are Services for children & young people well-led?

Inspected but not rated

Please see outpatients.

Good

Outpatients

Safe	Good
Effective	Insufficient evidence to rate
Caring	Outstanding
Responsive	Good
Well-led	Good

Are Outpatients safe?

Good

We rated safe 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. There were six members of staff including the registered manager and clinic manager that worked at the clinic across outpatients and diagnostic imaging. Mandatory training compliance was 100%.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included 12 core modules that clinical and non-clinical staff had to complete. Subjects included safeguarding, health and safety, and infection prevention and control.

There were additional training requirements for some staff dependent on their role within the organisation. Mandatory training was delivered through a mixture of electronic learning and internal or external training events.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The consultants working at the clinic carried out their mandatory training at the NHS trusts at which they were employed. This included the registered manager.

Managers monitored mandatory training and alerted staff when they needed to update their training. The mandatory training matrix was graded on level of skill and identified staff who were skilled enough to train others, as well as modules that certain staff did not need to complete. However, the matrix did not include dates of when staff were due their training and the clinic manager had to look through the individual staff profiles to obtain this information. The modules listed on the matrix were not named the same as in the staff training policy, which could cause confusion.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Training in adult safeguarding was based on the 2018 intercollegiate document *"Adult Safeguarding: Roles and Competencies for Health Care Staff"* and staff were supported by a comprehensive safeguarding adults' policy. All non-clinical staff were trained to Level 2, clinical staff to Level 3 and the safeguarding lead was trained to Level 4.

Staff initially completed adult safeguarding training during induction and undertook refresher training annually. Training was provided by an external company.

Staff could give examples of how to protect patients from harassment and discrimination and knew how to identify adults and children at risk of, or suffering, significant harm. They had not had to raise any safeguarding concerns but were able to explain what would trigger a safeguarding concern. The two policies in place to support staff clearly outlined types of abuse and the process for staff to follow should they have concerns. Female genital mutilation, child sexual exploitation, trafficking, modern slavery and prevent were all included in the training and policies.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff knew the registered manager was the safeguarding lead for adults. The adult safeguarding policy clearly outlined the name and contact details for the safeguarding lead for staff to contact. They also included the contact details for the local safeguarding boards and a flowchart on the action staff should take.

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. Comprehensive guidance was available for staff in the form of an infection prevention and control policy. The policy detailed all protocols required to maintain a good level of cleanliness, infection control and hygiene.

Staff cleaned work surfaces and floors daily and storage drawers and cupboards weekly. In addition, staff used disinfectant bombs in the clinic once a week on a Sunday when the clinic was not in use.

There were hand washing basins available in all clinical spaces and plenty of alcohol hand gel throughout the clinic. There was hand gel at the entrance and staff encouraged patients and visitors to gel their hands on arrival and on exiting the clinic. Staff displayed posters on how to wash your hands effectively in the waiting area, toilets and above the sinks in the clinical areas. This guidance was in line with national best practice guidelines.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff documented cleaning of equipment and premises on cleaning logs, which confirmed staff were cleaning regularly and in line with policy. Staff were allocated to clean on a rota and there were systems in place to ensure cover during sickness and annual leave.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had completed training on infection prevention and control as part of their mandatory training. The consultant was also the infection prevention and control champion in their NHS role and bought learning from that role into the clinic.

The service continued to use the increased infection control measures implemented during the coronavirus pandemic. This included staff always wearing masks and maintaining social distancing. Appointment times were staggered to reduce the number of patients waiting in the reception area. The clinic had display posters on the entrance asking patients to wear masks in the clinic.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. They cleaned reusable medical devices with alcohol wipes at the start of the day and end of each treatment. Staff utilised green “I am clean” stickers when cleaning was completed. We saw equipment had been cleaned at the start of the day on the day of our inspection.

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.

The design of the environment followed national guidance. Clinic spaces were compliant with Health Building Note 00-10 Part A Flooring. All flooring was laminated and included coving to ensure effective cleaning. There were hand washing basins in each clinical observation area and dedicated foot pedal operated clinical waste and domestic waste bins.

Staff carried out daily safety checks of specialist equipment. Staff checked resuscitation equipment daily when the clinic was open. We saw staff recorded when these checks had been carried out and all checks had been done in line with policy.

The service had suitable facilities to meet the needs of patients' families. There was tea, coffee, hot chocolate and water available in the waiting area free of charge.

The service had enough suitable equipment to help them to safely care for patients. The clinic was a specialist knee and shoulder clinic for consultation and minor procedures, such as local anaesthetic and steroid injections. There was suitable equipment for clinicians to review and treat patients safely, which was well maintained in line with manufacturer’s guidelines. All electrical equipment had been safety tested within the last 12 months.

Staff disposed of clinical waste safely. Sharps bins were available in consultation treatment rooms for disposing needles and other sharps. There was a contract in place for removal of clinical waste, which was collected regularly. We saw separate bins for clinical waste, such as items that contained bodily fluids and these were clearly labelled. Staff were supported with comprehensive guidance on how to safely dispose of clinical waste, which was clearly documented in the infection prevention and control policy.

Staff stored and handled COSHH items in line with national best practice guidelines. There was a comprehensive COSHH policy available for staff. The policy outlined procedures staff must adhere too when handling and storing COSHH items, a risk assessment template, and instructions on how and when to complete a risk assessment.

Assessing and responding to patient risk

Staff completed and updated risk assessments appropriate to the clinic setting for relevant patients 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 Bromsgrove Clinic was not an inpatient facility and did not see patients that were acutely unwell. Training, processes, and systems in place for deteriorating patients were suitable for the clinic environment and the level of treatment provided.

The emergency resuscitation trolley at the clinic contained correct equipment in line with the Resuscitation Council UK 2021 guidelines for both adults and children. Staff had training in basic life support for adults and children and were further supported by comprehensive guidance in the form of a management of the deteriorating patient policy. There were flow charts displayed around the clinic and staff we spoke with were aware of their responsibilities and the process to follow.

The consultant working at the clinic provided local anaesthetic and local steroid injections to treat patient's musculoskeletal complaints. There was a surgeon steroid injection policy that provided guidance to consultants carrying out this procedure and included risk assessments of the patient. The policy refers to the World Health Organisation surgical safety checklist that staff must follow before carrying out the procedure.

Staff knew about and dealt with any specific risk issues. Staff had completed training in sepsis and there was Sepsis UK trust guidance available for staff in addition to the management of the deteriorating patient policy.

Surgery was not performed at the clinic. All relevant risk assessments associated with any surgical procedures were carried out at the premises where the surgery was taking place and not at the clinic. Staff commenced clear communication with these organisations as soon as the decision for surgery was made, to ensure pre-operative assessments were booked in.

Staff shared key information to keep patients safe when handing over their care to others. Policies clearly outlined when and what information should be monitored and recorded in the event of a deteriorating patient. Staff completed a deteriorating patient pro forma to record assessments and communicated to the ambulance crew on handover using structured communication tools.

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 gave new staff a full induction.

The service had enough staff to keep patients safe. The clinic was very small and only ran services around the consultant's NHS and private hospital commitments. There were no nurses due to the nature of the service. Physiotherapy appointments were booked in according to the physiotherapists' availability. The physiotherapists worked on a zero-hour contract under practicing privileges. There were suitable arrangements to cover annual leave and sickness.

The service had low turnover rates. There were eight members of staff including the consultant registered manager. They had all been at the clinic for several years, most having been at the clinic since it was established.

Managers did not use bank or agency staff and made sure all new staff had a full induction and understood the service. The induction was comprehensive, and we saw evidence of completion within staff profiles. Tasks to be completed on induction included pre-employment checks, orientation of the premises, introduction to the organisation, roles, responsibilities, and training.

Managers did not use locum staff. There was one main knee and shoulder specialist consultant who worked at the clinic. Occasionally a foot and ankle specialist, and a spinal specialist consultant worked out of the clinic on practicing privileges.

Good

Outpatients

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.

Patient notes were comprehensive, and all staff could access them easily. The clinic used an electronic patient record system that allowed all relevant staff access. The system was easy to use and navigate. We reviewed five patient records and saw these were comprehensive and detailed. There was also an audit trail in each record that dated and timestamped when staff had accessed and updated the records.

When patients transferred to a new team, there were no delays in staff accessing their records. The record system was integrated between services at the clinic, which meant the physiotherapist and radiotherapists had immediate access to the consultant's notes and vice versa. Letters were addressed to patients and sent to them electronically with a copy sent to their general practitioner (GP).

Records were stored securely. The electronic system was password protected and only accessible to relevant staff.

There was a record retention policy that clearly outlined how long different types of records should be kept in line with The Data Protection Act 1998 and General Data Protection Regulations 2018.

Medicines

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

Staff followed systems and processes to administer medicines safely. The only medicines administered at the clinic were local anaesthetic or steroid injections to treat knee or shoulder complaints. These were only administered by the consultant and only to patients over the age of 18 years.

Staff stored and managed all medicines safely. Staff stored medicines securely and records kept by staff demonstrated medicines were stored within their recommended temperature ranges.

Staff learned from safety alerts and incidents to improve practice. A signing in and signing out process was implemented following an incident where medicines had not been stored securely. The new process was audited to ensure it was embedded. We reviewed the audits that confirmed staff were following the new process.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and knew how to report them. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff knew to apologise and give patients honest information and suitable support.

Staff knew what incidents to report and how to report them, which included concerns near misses and reportable incidents. There were no patient safety incidents or clinical incidents for outpatients in the last 12 months.

Staff understood the duty of candour. Staff were fully aware of the requirements to be open and transparent, offer a full explanation if, and when, things went wrong and to apologise.

Good

Outpatients

Staff received feedback from investigation of incidents, both internal and external to the service. The clinic manager worked full time in the NHS and shared learning from never events or serious incidents that were relevant with staff at the clinic during the monthly governance meetings.

Staff met to discuss the feedback and look at improvements to patient care. The monthly governance meetings looked at incidents, grumbles, and complaints together due to the low numbers of each. Time was allocated to improve practice when incidents, complaints or grumbles had been raised.

There was evidence that changes had been made because of feedback. Staff gave an example where senior staff had implemented a new process to ensure the security of medicines following an incident in February 2020.

Are Outpatients effective?

Insufficient evidence to rate

We do not currently rate the effectiveness of outpatient services. This is due to insufficient evidence attributable to the service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The registered manager worked predominately in the NHS and was the lead for patient outcomes. This role ensured they kept up to date with changing guidance relevant to their speciality, which they bought to their private clinic.

All policies and guidance for staff were based on recognised national best practice guidance such as, National Institute for Health and Care Excellence (NICE), British National Formulary (BNF), National Patient Safety Agency (NPSA). We saw evidence of staff updating policies and guidance regularly to reflect changes in national guidance.

Pain relief

Staff assessed patients' pain levels and developed appropriate treatment plans to relieve pain. They supported those with communication barriers using suitable assessment tools.

The service provided was not an inpatient facility and therefore, patients were only at the clinic for short periods of time. Injectable pain medicines were not available for patients under 18 years of age.

Staff assessed patients' pain using a recognised tool and developed appropriate treatment plans in line with individual needs and best practice. Staff assessed and monitored patients' pain levels to establish effectiveness of treatment provided. Physiotherapy staff also assessed pain levels to stop or amend treatment as required.

Staff prescribed, administered and recorded pain relief accurately. The only pain medication prescribed and administered was local anaesthetic or steroid injections, and only by the consultant. Staff were supported by a comprehensive policy, which was based on the BNF guidance for treatment of inflammatory disorders with corticosteroid injections and the NPSA promoting the safer use of injectable medicines guidance.

Good

Outpatients

Staff recorded treatment plans in patients' records that included any pain medication administered along with the dose and plan for repeat injections. Staff gave a summary of the appointment in writing to the patient and sent a copy to the patients' general practitioner (GP).

Patient outcomes

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

Outcomes for patients were positive, consistent, and met expectations, such as national standards. Consultants individually maintained their outcomes on the National Joint Register and used the information to improve care and treatment. This involved all surgical procedures they carried out at all the health care organisations in which they performed surgery.

There were no surgical procedures carried out at The Bromsgrove Clinic. However, the patient outcomes reported also covered those patients who shared a patient journey via The Bromsgrove Clinic. Not all patient cases reported attended The Bromsgrove Clinic.

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.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There was a comprehensive and detailed recruitment policy and process to ensure the right staff with the right skills, knowledge and qualifications were appointed at the clinic. This included a full employment history check, referees, professional body checks for clinical staff and Disclosure and Barring System checks.

Managers gave all new staff a full induction tailored to their role before they started work. The induction process lasted four weeks. It included supervision and a staff competency checklist. Competencies were specific to job role and were documented in staff profiles. Two signatures were required on completion of competencies, one from the manager and another from the staff member. We reviewed five staff profiles and saw completed induction and competency checklists in all five records.

Staff had the opportunity to discuss training needs and managers supported staff to develop their skills and knowledge through yearly, constructive appraisals of their work. Clinic managers appraised non-clinical staff and the registered manager appraised clinical staff. Appraisals included staff self-assessments, objective and goal setting and personal development plans. We saw all staff had an appraisal within the last 12 months.

Clinical staff working under practising privileges had checks on their mandatory training, safeguarding of children and adults, and life-support training status. The registered manager liaised with the responsible officer at the staff member's place of employment regularly that included discussions around appraisals.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Senior staff held team meetings regularly and all meeting minutes were uploaded on the electronic governance system that all staff had access to.

Managers identified poor staff performance promptly and supported staff to improve. They had not had to implement performance management or disciplinary processes. However, the systems were in place should it be required. There was a staff disciplinary policy that clearly outlined what would constitute disciplinary procedures and performance management.

Multidisciplinary working

Doctors and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff met regularly to discuss individual patients as and when needed due to the small size of the clinic team in addition to scheduled monthly multidisciplinary team (MDT) meetings.

The service had an informal local MDT that included consultants in the local area external to the clinic. This arrangement allowed the registered manager to bring more consultants in to the MDT free of charge to discuss more complex cases and get the best outcome for the patient. The registered manager was in the process of formalising a local MDT moving forward.

The registered manager also attended other external quarterly meetings at the other health care organisations in which they worked. Patients that had part of their patient journey at the respective organisations were discussed at these meetings.

Patients could see all the health professionals involved in their care at one-stop clinics. The clinic operated as a one-stop clinic and had consulting outpatient facilities, physiotherapy and diagnostic facilities on site. This allowed patients to have an initial consultation and any required testing on the same day.

The consultant often attended the start of patients' physiotherapy appointments. This allowed patients to raise any concerns and for treatment plan adjustments to be discussed in real time with the physiotherapist.

Staff referred patients for mental health assessments when they showed signs of mental ill health. Staff had received training in mental health, mental capacity and deprivation of liberty safeguards. They were further supported with comprehensive guidance and policies. Staff referred patients identified as requiring further treatment for a mental health condition unrelated to their presenting physical complaint to the patients' GP.

Seven-day services

The clinic ran a service on a Monday evening, all day on a Wednesday and alternate Friday mornings and evenings. Staff were able to accommodate patients on request if they could not attend the clinic in normal opening hours. Patients were able to access support and advice remotely from staff via telephone during clinic opening times.

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 were several leaflets in the waiting area around lifestyle changes to facilitate positive outcomes in relation to the conditions being treated at the clinic. These were available in multiple languages.

Good

Outpatients

One of the practice values was to work with local practices in improving the health of patients and the local population. The clinic held an annual free health promotion evening every year. They had an evening scheduled for September 2022, which was a joint clinic for over 80-year-old people in the community with knee pain that could not afford private healthcare.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Senior staff had attended a weight management coaching course and aspired to appointing a dietitian in December 2022. They invested in this course due to joint pain conditions worsening with weight gain, to help drive a more holistic approach in treating patients. Staff were already assessing weight and diet habits at the time of our inspection but were looking to expand this service to include a plan for weight loss by managing calorific expenses with dietitian input.

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 clearly recorded consent in the patients' records. Consent was implied for physiotherapy and diagnostic procedures. There was an electronic link sent to patients when appointments were booked that included a tick box consent form for the appointment and for relevant General Data Protection Regulations and privacy laws.

Staff also gained verbal and implied consent throughout appointments, particularly when carrying out physiotherapy, observations and diagnostic treatment. Staff obtained written consent from patients when carrying out injections at the clinic, or if surgery was the be scheduled at another premises.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff gained consent for surgical procedures whilst patients attended the clinic after providing the patients with treatment choices, pathway options and risks involved. Staff used the consent form from the hospital (NHS or private) where surgical procedures were to be carried out.

Managers based the consent from and practices for injections on cosmetic surgery guidelines giving the patients a 14-day cooling off period to enable them time to digest the information given to them, and to make an informed decision free from pressure.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. The consent policy clearly outlined these requirements and was easily accessible for staff should they require further support or guidance. The nature of the clinic meant the patients that required extra support for poor mental health were seen by the consultant in the NHS or one of the private hospitals they work at. This ensured these patients had appropriate support from suitably qualified staff.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The nature of the clinic and the exclusion criteria meant Mental Capacity Act and Deprivation of Liberty Safeguards was not directly relevant to staff roles. However, clinical staff had completed this training at their place of employment, usually the NHS.

Good

Outpatients

Are Outpatients caring?

Outstanding ☆

We rated caring as outstanding.

Compassionate care

Staff were highly motivated and inspired to offer care that was compassionate and kind and promoted privacy and dignity. Staff recognised and respected the totality of patients' needs, finding innovative ways to meet them.

Staff and leaders highly valued and promoted strong, caring, respectful and supportive relationships with their patients. Staff were compassionate about ensuring there was a strong and positive patient-centred culture at the clinic. They focused on patients feeling valued, important and cared for every time they entered the clinic. Feedback from patients was continually positive with patients expressing their care and support exceeded their expectations. The consultant made time in their schedule to ensure they were present at the start of other therapy appointments to see how patients were when they accessed different services within the clinic, for example physiotherapy or diagnostic imaging. They used these opportunities to say hello and ask how the patient had been coping since they were last seen by the consultant.

Staff always treated patients well and with kindness. We saw staff interact with patients on arrival and throughout their time at the clinic with compassion and kindness. The clinic manager welcomed patients in the clinic and was the first point of contact for all appointments and follow-ups. Staff told us "Patients come first" and this was important to all staff within the clinic. We saw senior staff with a fantastic attitude towards patients and students who were training during appointments.

Consideration of patient's privacy and dignity was consistently embedded in everything staff did. Staff always followed policy to keep patient care and treatment confidential. The registered manager and staff kept all information stored securely with password protection on electronic patient records and used computer privacy screens to ensure patients' confidentiality was always maintained. Staff ensured conversations with patients about care and treatment were held in areas of the clinic that were private and not overheard.

Staff recognised, understood and respected the totality of patient's needs and always considered the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff always showed a non-judgmental attitude when caring for or discussing patients with mental health needs. The clinic appointed a diverse workforce, which helped understanding different religious needs and cultural backgrounds of the diverse population the clinic served. Staff were focused on a holistic approach ensuring religious and cultural practices were considered to support therapeutic process. This included seeking advice and support from an appropriate religious or community leader when required with the patient's consent.

Staff understood the needs of the wider community and told us about equality and diversity training and understood the human rights of patients. This was important within the team and the culture was professionally embedded across the clinic. Staff were further supported by policies, such as the body dysmorphia policy and protocol, to help understand mental health needs and offer more tailored care packages for those patients requiring extra support.

Good

Outpatients

Emotional support

Staff saw patient's emotional and social needs as important as their physical needs. There was a strong, visible person-centred culture that was inclusive and understanding of patients' personal, cultural and religious needs.

Staff always gave patients and those close to them help, emotional support and advice when they needed it. They supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We witnessed a patient become distressed in the diagnostic room. Staff were attentive and quickly provided support in a caring and compassionate manner. They moved the patient to a private space and helped to calm the patient and reduce their anxiety. The registered manager was trained as a burnout coach (mental health support), who supported the team and patients visiting the clinic. They were passionate about making a difference by putting patients first and encouraged staff to achieve better care outcomes for patients who used the service.

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. They recognised that patients needed access to, and links with advocacy and support networks in the community and they supported people to do this. The registered manager set up a group they called the Droitwich Knee Clinic (DKC) University in June 2021, with sessions running monthly. The DKC University involved patients who had been with the clinic for a long time as experts by experience to help newer patients cope with their conditions emotionally and socially. Patients could meet with people who had similar conditions to learn from and share their experiences of the positive impact from their treatment. It enabled patients to manage their own health and care when they could and to maintain independence as much as possible. Feedback had been positive to date and there were further meetings planned for July and August 2022.

Staff empowered patients to have a voice and showed determination, passion, and creativity to overcome obstacles to delivering care. Staff encouraged patients to be part of the patient forum to help shape the culture and services provided at the clinic.

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. Staff communicated with patients effectively during appointments and provided patients with a hard copy of their treatment plan, which included a summary of their appointment, treatment options and any physiotherapy exercises.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Staff ensured patients understood their care and treatment plans by providing translation services for appointments and writing to patients in their first language. The consultant also visited patients in the clinic during physiotherapy appointments to give patients an opportunity to raise any questions or concerns.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients had access to a patient survey in the reception area and were able share their views of the services provided. Staff had told us patients were able provide feedback through the website, social media, and questionnaires. Staff were passionate about encouraging patients to provide feedback to improve care.

Good

Outpatients

Staff supported patients to make advanced and informed decisions about their care. We observed staff explaining care and treatment plans very clearly, involving patients and giving them time to ask questions. One patient told us they had lots of information given to them about their procedure and plenty of time to make an informed decision before consenting. They said staff encouraged them to ask questions and were given plenty of time to do so. Patients were able to contact the clinic for further advice and support.

Feedback from patients was continually positive about the way staff treated them. Patients felt staff went the extra mile. Patients told us their experience of their treatment at the clinic was excellent. One patient said they were very happy with the exercises they were given. Another patient said their experience at the clinic exceeded their expectations and they were looking forward to using the service again.

Senior staff shared patient feedback with staff members individually. We saw an example of this in a staff member's annual appraisal. The patient was very complimentary about how understanding and caring the staff member was in dealing with their query. The clinic received lots of thank you cards from patients, which drove a caring and positive attitude within the clinic across the whole team. The staff told us everyone worked together to put patients first and this was reflected in the feedback received from patients.

Are Outpatients responsive?

Good

We rated responsive 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. There was a biannual patient forum with topics of discussion to help tailor services to the patients they served.

The service held free evenings once a year for the local community. These sessions were run by the consultant and a physiotherapist to help educate the community about joint conditions and complaints. This year's evening was scheduled for September 2022 and was open to people over the age of 80 years old with knee pain that could not afford private healthcare. The service advertised this event in local supermarkets and GP practices.

The service minimised the number of times patients needed to attend the clinic, by ensuring patients had access to the required staff and diagnostic tests on one occasion. Patients were able to have their first consultation and diagnostic testing on one day. There were also physiotherapy services available.

Facilities and premises were appropriate for the services being delivered. The clinic had a car park with ample parking and two designated disabled parking spaces. The clinic was easily accessible for patients with mobility issues or wheelchair users' access with ease.

Managers monitored and took action to minimise missed appointments. They contacted patients who did not attend appointments. Patients booked appointments electronically and received electronic confirmation of bookings via email, which included reminders before their appointments. The service did not see many missed appointments.

Good

Outpatients

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.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The premises had a hearing loop to assist patients who had hearing aids. Hearing loop systems send sound directly to the telecoil receiver in a user's hearing device. The system eliminates most background noise and improves understanding of speech.

Clinical staff had attended specialist training for patients who required additional support due to living with a disability at their place of employment (the NHS). Patients who required a high level of support were seen by the consultant in the NHS or at one of the private hospitals in which they worked.

The service had information leaflets available in languages spoken by the patients and local community. The consultant was also able to speak several languages and wrote summaries of appointments in the first language of their patients where they could.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had easy access to translation services, which were organised and booked in advance of the patient's appointment.

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. Patients requesting urgent appointments were seen within one week of the request. Non-urgent appointment requests were booked in within two weeks.

The clinic ran a purely elective service that GPs and other health professionals could refer patients to, patients could also self-refer.

Patients could be seen in the clinic during part of their patient pathway with aspects of their care and treatment provided at other healthcare organisations. They were able to choose a day and time that suited them from the clinic opening times.

If a patient required a slightly later appointment on the day a clinic was scheduled, the staff were able to accommodate this. If patients were not able to make any of the days or times available at the clinic, they would be seen in one of the other health organisations the consultant worked from.

Managers worked to keep the number of cancelled appointments to a minimum. If an appointment was cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Cancellation of appointments or treatments were very rare. Senior staff had contingencies in the form of a rota should a member of staff call in sick on the day. Clinic's usually ran during the afternoons, which meant senior staff had time in the morning of a clinic day to fill the staff absence with a suitable replacement, limiting the impact on patients.

Staff supported patients when they were referred or transferred between services. The consultant ensured they were available to attend the start of their patient's physiotherapy or diagnostic appointment to offer support.

Good

Outpatients

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. Patients we spoke to said they had no reason to complain but were aware of how they could, should they need to in the future.

The service clearly displayed information about how to raise a concern in patient areas. There were posters and leaflets available explaining how to make a complaint and these were displayed in the waiting area and consultation rooms. Patients were also provided with an electronic patient satisfaction survey after their appointment where they could raise any concerns.

Staff understood the policy on complaints and knew how to handle them. There were two policies on complaints, one for patients eligible for ombudsman support and another for when the ombudsman was not applicable. Both complaint protocols were clearly laid out and understood by staff. Staff were able to refer patients to other organisations that could further advise, such as The Citizens Advice Service and the Patients Association and the contact details for these organisations were in the policies.

Managers investigated concerns and identified themes. The service had not received any formal complaints for several years. In response, they developed a database called complaints, grumbles, and incidents. Although still very low numbers, senior staff were able to analyse the complaints, grumbles, and incidents regularly to identify any themes or trends.

Staff knew how to acknowledge concerns and patients received feedback from managers after the investigation into their complaint. The service had implemented the “you said, we did” ethos at the clinic. This was a topic for one of the scheduled patient forum meetings. Staff were developing posters to display in patient areas for those patients not part of the patient forum.

Managers shared feedback from concerns with staff and learning was used to improve the service. Complaints, grumbles and incidents were discussed during governance meetings and multidisciplinary team meetings. The meetings from these minutes were saved on the electronic system with easy access for staff who were unable to attend.

Staff could give examples of how they used patient feedback to improve daily practice. Some grumbles raised by patients were around the length of time it took for staff to respond to the online chat function through the clinic’s website. In response, the service had implemented a new flagging system to notify staff when a message had been received.

Are Outpatients well-led?

Good

We rated well-led as good.

Good

Outpatients

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 had the skills, knowledge, experience, and integrity that they needed to run the service. Senior staff had been at the clinic since it was first established in 1988 and moved with the service when it opened the location in 2015. The registered manager had been in post since 2019.

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. The registered manager was a specialist consultant surgeon in knee surgery and orthopaedics and understood what was required to ensure patients received the best care and treatment.

Leaders were visible and approachable to staff and patients. The registered manager or the clinic manager were always on site when the clinic was open. Staff had informal catch ups at the start and end of each clinic session. Leaders ensured they greeted patients on arrival.

Leaders had clear priorities for ensuring sustainable, compassionate, inclusive, and effective leadership. Staff were supported to develop their skills and take on more senior roles and we saw many senior staff had been promoted from more junior positions.

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 and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a clear vision and set of values, with quality and sustainability as the top priorities. This was “as an evidence-based organisation we will be a leading one-stop provider facility in the UK.” The mission was to “provide a bespoke one stop clinic experience in a safe, evidence-based and effective way.

The service had three sets of values, one set for the patients, one set for the practice and locality and one set for the practice team. All three sets of values had people at the centre ensuring all patients and staff members felt important, supported and valued.

The vision, mission, values, and strategy had been developed using a structured planning process in collaboration with staff, people who use services and external partners.

Staff knew and understood the visions, values and strategy, and their role in achieving them. Staff demonstrated the values and should passion towards the vision and mission throughout our inspection.

The strategy aligned to local plans in the wider health and social care community. The strategic plan was spread over five years and was to expand the service by implementing a further two locations, as well as improving the health of the local community. It was a realistic strategy for achieving priorities and delivering good quality care.

Senior staff continually monitored progress against delivery of the strategy and local plans through regular audit and discussions with staff, patients, and external partners.

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 felt supported, respected, and valued. Staff worked together as a team to identify and address concerns to continually improve.

Staff felt positive and proud to work at the organisation. The culture was centred on the needs and experience of patients and staff consistently demonstrated passion towards putting patients first.

The culture encouraged openness and honesty at all levels within the organisation. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. There was appropriate learning and action taken because of concerns raised.

There were mechanisms for providing all staff with the development they needed, such as high-quality appraisals and career development conversations. We saw this had taken place to a high standard in staff profiles and staff told us they were supported to develop. There was a comprehensive staff training policy that outlined training available to staff and this included training programmes external to the practice and in addition to mandatory training.

There was a strong emphasis on the safety and well-being of staff. The registered manager had completed a course to become a burnout coach and provided this service to staff free of charge. Senior staff held regular “fish and chip” social evenings for all staff to attend. This was also an opportunity for staff to raise any concerns they had about the practice in a comfortable and informal environment.

There was a lone worker policy in place that demonstrated the organisation was actively committed to protecting staff from violence and assault. Staff were given appropriate information, instruction, and training around lone working during induction, which was refreshed when necessary.

Equality and diversity were promoted within and beyond the organisation. The team were diverse and worked together well. All members of staff were treated equally and given equal say and value.

Cooperative, supportive, and appreciative relationships among staff were present. Staff worked collaboratively as a team, they shared responsibility and resolved conflict quickly and constructively.

The service had comprehensive policies on bullying and harassment and whistleblowing. Staff knew where to find and access these for guidance.

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.

There were effective structures, processes, and systems of accountability to support the delivery of the strategy and good quality, sustainable services. Senior staff regularly reviewed these and made improvements when needed.

There were comprehensive and detailed policies and procedures to help guide staff. These were kept up-to-to date with relevant legislation and national best practice guidance and were aligned to the Health and Social Care Act (Regulated Activities) Regulations 2014. They were document controlled, contained dates of approval and next review dates, clearly outlined, and contained relevant information. All polices and guidance were saved on the electronic governance system and were easily accessible. All staff knew where to find them.

All levels of governance and management functioned effectively and interacted with each other appropriately. There were weekly governance meetings held between the registered manager and the clinic manager of which discussions were recorded and saved on the electronic governance system for all staff to access.

All staff met monthly for multidisciplinary team meetings, which gave staff the opportunity to discuss individual patient cases, concerns, and areas of improvement for the practice. Monthly meetings had a topic to discuss for example, human error reduction was scheduled for August 2022.

The team was very small, and the leaders of the service worked closely with staff on the ground. This enabled effective two-way communication channels for raising concerns and providing feedback.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

The service had service level agreements (SLAs) with the local specialist NHS trust and some local private hospitals at which the registered manager also worked from. The SLAs were set up to ensure patients could be referred into either setting should concerns about the patients' health be identified during diagnostic testing or their recovery from treatment is more complex requiring specialist input.

Patient pathways were shared across organisations with some patients receiving their pre- and post-surgery care and treatment at The Bromsgrove Clinic and surgical procedures at the other health care organisations.

The registered manager attended external monthly consultant and separate organisational meetings at the partner organisations.

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.

There were comprehensive assurance systems that allowed performance issues to be escalated appropriately through clear structures and processes. These systems were regularly reviewed and improved.

Senior staff monitored staff performance through appraisals, one-to-one meetings, and a comprehensive audit programme. There was a staff performance appraisal policy and a staff disciplinary policy and procedure to guide staff through performance reviews. Staff were reminded to focus on actual events, behaviour and results when reviewing someone's performance.

Staff working under a regulatory body were required to demonstrate an up-to-date knowledge of their clinical practice and its implementation in their annual learning portfolio. This portfolio also contained recognised training undertaken and commitment, compassion and caring for patients evidenced from patient feedback. Staff were aware of the need to report staff to relevant professional bodies for serious breaches of their code of conduct and knew how to do this.

Senior staff used a recognised behavioural tool for coaching performance that worked based on self-awareness.

The tool enabled senior staff to improve their understanding of their staff to facilitate more tailored support and encouragement in their role.

The registered manager NHS role as outcomes lead ensured they were familiar and experienced with healthcare data and how to analyse it, identifying when clinical practice required investigation or improvement.

There was a systemic programme of clinical and internal audit to monitor quality, operational and financial processes. The service carried out a suite of internal audits to monitor staff performance in areas such as, infection prevention and control and record keeping.

Staff carried out audits six monthly and, in some cases, every three months due to low numbers of activity and to obtain a representable sample. Staff would re-audit sooner if an issue were identified. Results for recent audits showed the service was performing well and policies and procedures were embedded.

There were robust arrangements for identifying, recording, and managing risks, issues, and mitigating actions. The service had an incident reporting system that captured incidents, grumbles, and complaints. It included an action to take, an action owner, completion date and any learning.

The risk register and accompanying business continuity plan took account of potential risks when planning services, such as unexpected fluctuations in demand, disruption to staffing and facilities because of Information Technology (IT) failures for example.

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.

Staff had a holistic understanding of performance, which covered and integrated people's views and information on quality, operations, and finances. There were multiple avenues for the service to gain information from a vast and diverse group of people. This included regular team meetings, patient forums, external party engagement and patient feedback. Senior staff used the information from these meetings for improvement and not just for assurance.

Quality and sustainability both received sufficient coverage in relevant team meetings. Staff were able to easily access information and had opportunities to challenge when appropriate.

The service had clear and robust service performance measures, which were reported and monitored regularly, with action taken to improve when issues were highlighted. The arrangements ensured information was accurate, valid, reliable, timely and relevant.

The service used IT systems effectively to monitor and improve the quality of care. All audits, governance meetings, policies, procedures, and guidance were stored centrally on the electronic governance system. The system was password protected, secure and easy to navigate and use.

Staff were aware of and understood what data and notifications required submission to external bodies. Staff were aware of the need to report to the Information Commissioner's Office for data breaches, CQC in relation to incidents in line Care Quality Commission Registration Regulations 2009, and Public Health England. Senior staff regularly submitted data to external audit databases.

The service was Cyber-essentials certified and took data security seriously. They had detailed and comprehensive policies to guide staff in access to clinical records, information governance and data protection, and data breaches. The registered manager was the appointed data protection officer and knew when, how and who to report a data breach. The policies were in line with relevant legislation such as, Freedom of Information Act 2000, General Data Protection Regulations 2018, and The Data Protection Act 1998.

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 service gathered and acted on people's views and experiences to shape and improve the services and culture. This included people in a range of equality groups. There were multiple avenues for patients to submit feedback that included anonymous feedback.

Staff routinely monitored feedback to analyse trends and themes in both positive and negative feedback and we saw staff had implemented changes when areas of improvement were highlighted.

The service routinely and regularly invited patients to engage with them and gave them opportunities to shape services delivered. They held an annual patient forum group in June that included a range of topics of discussion relevant to the clinic and wider local health economy.

Staff were passionate about ensuring the culture was open and inclusive, to enable a positive patient experience. They actively engaged in meetings so that their views were reflected in the planning and delivery of services.

The service had positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population.

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.

Staff participated in appropriate research projects to strive for continuous learning, improvement, and innovation. The registered manager was a founding member of UK Computer Assisted Orthopaedic Surgery charitable organisation. This organisation was dedicated to supporting health care professionals applying, developing, and using modern technology for orthopaedic surgery. The charity was an affiliated specialist society of the British Orthopaedic Association.

Good

Outpatients

The registered manager had also developed a new instrument to use during knee surgery that helped to balance the knee and resulted in better recovery post-surgery. The registered manager had a specialist interest in robotic and virtual reality knee replacement and was conducting research into this during their role in the NHS. They were also working with an organisation that was researching joint replacement digital cards to help with patients travelling via air post-implant surgery.

Good

Diagnostic imaging

Safe	Good
Effective	Insufficient evidence to rate
Caring	Outstanding
Responsive	Good
Well-led	Good

Are Diagnostic imaging safe?

Good

We rated safe as good.

For mandatory training, safeguarding, records, and medicines, please see outpatients. The generic aspects of cleanliness, infection control and hygiene, environment and equipment, assessing and responding to patient risk, staffing, and incidents are in the outpatients' section of this report. Only aspects of these areas that are specific to diagnostic imaging are included in this part of the report.

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 cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The service had separate cleaning protocols and policies for the diagnostic equipment. All protocols included cleaning after patient use and at the end of the working day. In addition, the ultrasound equipment had to be cleaned at the start of the day and before patient use. The service did not carry out invasive ultrasound. There were decontamination processes outlined in each policy should an infectious patient use the machine.

Adequate time was given between patients to enable cleaning. All cleaning equipment and solutions were suitable and adequate. Staff recorded cleaning on cleaning logs, and we saw this was being done regularly.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment. There were checklists for staff to complete at the start of each day. Staff had to record checks and we saw this was being done regularly in line with policy.

Good

Diagnostic imaging

Instruments and equipment were mostly compliant with Medicines & Healthcare products Regulatory Agency (MHRA) requirements. However, there was no panic alarm provided to patients in the MRI in line with section 4.12.12 of the MHRA Safety Guidelines for Magnetic Resonance Imaging (MRI) Equipment in Clinical Use (February 2021). This meant patients were not easily able to alert staff when they became distressed in the scanner. We did witness a patient become distressed and staff attended quickly and appropriately.

All relevant MRI equipment was labelled in line with MHRA recommendations. Items that were MRI safe and those that were not easily identifiable.

The service ensured they had arrangements to control areas where non-ionising and ionising radiation occurred and restrict access. This included clear signage where ionising radiation exposures occurred, which alerted people to stay out of the controlled area whilst the exposures were taking place. The room in which x-rays took place was compliant with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017. There were lead partitions in the door and walls.

The service monitored staff for radiation exposure and ensured staff had access to specialist personal protective equipment. Staff wore specialist personal protective equipment, which included lead vests and radiation badges whilst performing x-rays to protect them from and monitor radiation exposure.

Staff had carried out risk assessments for x-ray and MRI equipment. The risk assessments addressed occupational safety as well as considering risks to patients. They included actions to take in the event of a fire or information technology failures.

The service had appropriate contracts in place for servicing and maintaining diagnostic equipment and we saw this was being done in line with manufacturers guidelines and the clinic's policies. This included a clear process for reporting of any faults. Maintenance of diagnostic equipment was also on the service risk register. The MRI and x-ray machines both had a full service in April 2022.

The service had a clear business continuity plan that included replacement of aging equipment. All diagnostic equipment is currently in good working order albeit quite old. The MRI and X-ray scanning equipment is due to be replaced in later 2022, early 2023. There is also a planned replacement on the ultrasound equipment for late 2022. However, this is not used as often and will only be replaced at this time if demand requires.

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 completed risk assessments for each patient on arrival and reviewed this regularly, including after any incident. There were processes in place to ensure the right person had the right radiological scan at the right time. This included clear protocols for referral and a three-point checking policy for identification.

The service was compliant with Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). They had appointed a suitably qualified radiation protection supervisor at the clinic, who was regularly in contact with the external radiation protection advisor (RPA).

Good

Diagnostic imaging

Local rules and employers' procedures had been implemented, clearly displayed (local rules) and easily accessible for all diagnostic staff to follow. The local rules contained relevant information as required by IR(ME)R, including the name and contact details for the RPA. Both the local rules and employers' procedures protected staff and patients from ionising radiation.

The service ensured that the requesting of x-ray, MRI and ultrasound services by GPs or others was made in accordance with IR(ME)R, which included a referral criterion.

The imaging department employers' procedures outlined the requirements for requests, which included that the referrer must be a registered healthcare professional, such as a surgeon, general practitioner, or a medically qualified doctor. The referring practitioner must also include justification for the exposures they were requesting.

Staff were further supported with a referral guidance and policy for diagnostic imaging, which outlined whether diagnostic tests were indicated dependent on different conditions.

The service had an annual quality assurance survey carried out by the RPA that covered compliance with IR(ME)R. We saw a copy of the latest survey from May 2021, which had highlighted areas for improvement. We saw staff had addressed the areas of improvement identified by the time of our inspection.

One outstanding action was in relation to diagnostic reference levels (DRLs) for x-ray, which staff had been monitoring closely and we saw evidence of this improving. The survey highlighted those exposures were slightly higher than expected for several different regional imaging.

DRL means the expected dose levels required to produce a diagnostic quality medical image. They are required for each piece of x-ray equipment and if levels are exceeded without a known cause, a technical performance issue with the equipment is indicated.

Staff had managed to reduce the DRLs to an acceptable range for all knee exposures and were continuing to trial ways to reduce DRLs for the remaining areas (cervical spine, lumbar spine, and pelvis).

Staff regularly sought advice and support from the RPA during this period and continued to do so during the three-month trial for the remaining areas. The clinic carried out limited numbers of cervical spine, lumbar spine, and pelvis exposures. It was agreed with the RPA the trial would last three months for the numbers to be of use.

Staff knew about and dealt with any specific risk issues. Staff ensured that women (including patients and staff) who were or may have been pregnant always informed a member of staff before they were exposed to any radiation in accordance with IR(ME)R.

The routine safety screening that staff carried out before starting an exposure included the question, *"Are you, or could you be, pregnant?"* Staff were supported by a detailed pregnancy policy and procedure that reminded staff to ask this question to all female patients between the ages of 12 and 60 years old. Staff made sure they asked this question in a confidential environment and if there was any uncertainty, scans were postponed.

The safety screening also included questions around foreign body implants, such as pacemakers and other metallic implants.

Good

Diagnostic imaging

The service had clear processes to escalate unexpected or significant findings both at the examination and upon reporting. These included clear pathways if people required admission to an NHS hospital. Guidance on reporting diagnostic imaging highlighted "red flags" that indicated serious underlying pathology and a requirement for referral to other services. There was a service level agreement in place with the local specialist NHS trust and local private hospitals.

Staff had carried out risk assessments for x-ray and MRI equipment. The risk assessments addressed risks to patients as well as considering occupational safety. Included in the risk assessments was the use of injectable contrast agents and exposure to foetuses.

Staff were further supported with guidance in the form of a contrast administration policy. This included protocols and risk assessments to prevent contrast-induced nephropathy. Protocols included blood tests to confirm kidney function within four weeks of the scan for higher risk patients, contra-indications with contrast and the presence of a consultant radiologist who remains in the scan room throughout.

Staff documented the contrast used, batch number and expiry date in both the contrast log and the patient's records. Staff requested patients to remain at the clinic for 20 minutes after their scan before being reviewed by the radiologist and cleared to leave. Staff called 999 if there was any indication the patient was suspected of having a contrast reaction.

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.

The service had enough staff to keep patients safe. There was access to an appropriately trained clinician when contrast was administered in the diagnostic service. Contrast scans were only performed when a consultant radiographer was physically present. There was a comprehensive and detailed policy that outlined the referral and staffing requirements for these types of scans.

Records

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

Staff mostly stored records securely. Most patient records were stored electronically either directly typed in or via scanned written paperwork, which was password protected. However, the service did not use picture archiving and communication systems (PACs) for MRI digital images. These were kept on the screen for five months and then transferred to a Digital Video Disc (DVD) and stored in an unlockable area. The DVDs were not encrypted, which meant unauthorised people could have access to them.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and knew how to report them.

Staff knew what incidents to report and how to report them, which included concerns near misses and reportable incidents. The was one clinical incident in the last 12 months from March 2022, which related to a piece of diagnostic equipment that was serviced and required repair work. The service engineer was not qualified to carry out the work required, and the equipment was taken out of use until it was repaired later.

Good

Diagnostic imaging

Staff were aware of when and how to report incidents in relation to The Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). These regulations are specific to diagnostic imaging and requires staff to report accidental or unintended exposures judged to be 'significant' or 'clinically significant.' They also require staff to report if radioactive substances are administered without the correct licence in place. There had been no patient safety or reportable incidents in the last 12 months.

Are Diagnostic imaging effective?

Insufficient evidence to rate

We do not currently rate the effectiveness of diagnostic services. This is due to insufficient evidence attributable to the service.

Please see Outpatients.

Are Diagnostic imaging caring?

Outstanding

We rated caring as outstanding

Please see Outpatients.

Are Diagnostic imaging responsive?

Good

We rated responsive as good.

For, meeting individual needs, access and flow, and learning from complaints and concerns, please see outpatients. Only aspects of service delivery to meet the needs of local people specific to diagnostic services are included in this report. Please see outpatients for general aspects of service delivery to meet the needs of local people.

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.

Facilities and premises were appropriate for the services being delivered. The magnetic resonance (MR) scanner was a walk-in scanner and easily accessible. However, the building was very old and during hot days the MR room was uncomfortable. The building was leased and not owned, which limited what could be done in terms of the building structure. A portable cooler or air conditioning unit would have benefitted patients in the MRI room.

Good

Diagnostic imaging

Are Diagnostic imaging well-led?

Good

We rated well-led as good.

For vision and strategy, culture, and learning, continuous improvement and innovation, please see the outpatients report. Only aspects of leadership, governance, management of risk, issues and performance, information management, and engagement specific to diagnostic services is included in this report.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. Senior radiologists worked closely with the registered manager to ensure all relevant radiation legislation was followed and any concerns with radiography equipment was addressed. There were plans in place to ensure aging equipment was replaced.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations.

The service managed, monitored and reviewed service level agreements (SLA) well with external organisations. There was an SLA in place for maintenance of equipment and diagnostic service compliance. We saw evidence of new contracts being established when performance was not satisfactory. For example, the contract previously in place for x-ray maintenance had supplied an engineer who was not qualified to fix an issue with the machinery. This meant the service had to close the x-ray down until it could be fixed. This led to a new maintenance contract that started in April 2022.

The SLA with the external radiation consultancy service included biannual meetings with the radiation protection advisor and an annual quality assurance audit. In addition, the radiation protection supervisors internal to the service met quarterly.

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.

Senior diagnostic staff regularly monitored performance through assessing diagnostic reference levels and quality of imaging. Staff responded appropriately and had taken action to address highlighted risks resulting in improvements. Staff continued to monitor diagnostic reference levels for spine and pelvic x-rays to further improve efficiency.

Staff undertook comprehensive risk assessments of the x-ray and MRI equipment that included operational and financial risks, as well as risks to staff and patients.

The risk register was comprehensive and detailed, and reflected risks identified in the individual risk assessments for equipment. Staff reviewed the risk assessments and risk register regularly.

Good

Diagnostic imaging

Information Management

The service collected reliable data and analysed it. Data or notifications were consistently submitted to external organisations as required.

Staff were aware of and understood what data and notifications required submission to external bodies. They knew to report incidents to the CQC in with IR(ME)R 2017. Senior staff regularly submitted data to the radiation consultation service.

Engagement

Leaders and staff actively and openly engaged and collaborated with partner organisations to help improve services for patients.

Staff had a transparent and open relationship with stakeholders about performance. Staff evidenced regular involvement of the radiation protection advisor when they identified an issue with the performance of x-ray equipment. They demonstrated drive and persistence to improve and kept in regular contact with the radiation protection advisor to obtain advice on how to best address the concerns.