Electrodiagnostic Services Ltd

Electrodiagnostic Services Ltd

Inspection report

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

Ratings

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

Summary of findings

Overall summary

The service had not been inspected previously.

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. The service controlled infection risk well and understood and reported incidents appropriately. The service-controlled infection risk well and they kept equipment and the premises visibly clean. The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm.
- The service provided care and treatment based on national guidance and evidence-based practice and monitored the effectiveness of care and treatment. Staff worked well together for the benefit of the patients. The service made sure patients had enough information to make decisions about their care.
- The service had a strong, visible person-centred culture. Staff were highly motivated and passionate. Patients were treated with compassion and kindness and staff respected their privacy and dignity.
- The service planned and provided care in a way that met the needs of local people and people could access the service when they needed it. It was easy for people to give feedback and raise concerns about care received.
- Leaders had the skills and abilities to run the service. The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

However:

- Some governance processes were not embedded such as the monitoring of staff records and the development of service risk registers and incident investigations.
- The provider did not collate or review data regarding patient referral numbers and timescales in which patients were seen this meant there was no formal process to ensure patients were seen in a timely way.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	

Summary of findings

Contents

Summary of this inspection

Background to Electrodiagnostic Services Ltd

Electrodiagnostic Services is operated by Electrodiagnostic Services Limited. The service is registered with CQC to provide diagnostic and screening procedures. The registered manager had been in post since 09 August 2018. The service provides electrodiagnostic procedures including nerve conduction studies (NCS), Electromyography (EMG) and Electroencephalography (EEG) to contracted NHS patients in the Northeast. The service is available to both adults and children and provides approximately 2500 diagnostic appointments across a year. The service currently operates from two hosting hospitals within the North East of England. Diagnostic procedures are carried out in a leased room subject to a service level agreement. The Registered Manager is also the Consultant Clinical Neurologist and is supported by a second director and a clinical assistant who acts as chaperone.

We have not inspected this service previously.

How we carried out this inspection

We carried out a comprehensive unannounced inspection of the service under our regulatory duties on 22 February 2022. The inspection team was made up of one CQC inspector, one specialist advisor and one offsite inspection manager. We spoke with the registered manager who was also the clinical lead, a clinical assistant, director and seven patients. We reviewed a range of policies, procedures and other documents relating to the running of the service including consent, diagnostic reports and referral letters. We reviewed five patient records and three staff records.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that they have a robust process in place to ensure mandatory training is reviewed in accordance with the provider's training policy. Regulation 17 (1) (2) (a)(b).
- The service must ensure they have the systems and processes to assess, monitor and mitigate risks. This includes specific risk assessments for high-risk patients such as those diagnosed with epilepsy and the development of a risk register. Regulation 17 (1) (2) (a)(b)
- The service must ensure that incident investigation processes are further developed to include dated actions taken by the provider. Regulation 17 (1) (2) (a)(b)
- The service must ensure that effective processes are in place to manage patient outcomes including the monitoring of patient referral / waiting times and cancelled appointments. Regulation 17 (1) (2) (a)(b)
- The provider must ensure that staff records are produced and stored appropriately as per the requirements of the Registered Manager regulations. 17 (2) (d)(i)

Summary of this inspection

Action the service SHOULD take to improve:

- The service should ensure that staff have received training to support patients with a specific need such as learning difficulties.
- The service should consider producing an information leaflet specifically designed address any patient queries regarding the diagnostics undertaken.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good

We rated it as good.

Mandatory training

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

The mandatory training was comprehensive to meet the needs of patients and staff.

The registered manager who was also a director, employed two staff directly and utilised the services of an administrative assistant who was self-employed. We saw all staff had completed training appropriate to their role. Only the registered manager and the clinical assistant had direct patient contact, as part of their role

The provider had developed a training policy which outlined the training needs of each staff member depending on their role. Mandatory training topics included safeguarding, infection control, consent, moving and handling, first aid and resuscitation.

We reviewed mandatory training information for all staff and saw that the two clinical staff had completed all mandatory training.

In addition, we saw some mandatory training had also been completed by the second director, which was deemed relevant to their role.

Information governance training had been completed by staff working within the service.

The provider did not have a formal system to review the training and ensure it was up to date. The registered manager acknowledged this and told us they would implement this. However, there remained a risk that staff training may not be reviewed in accordance with the provider's policy.

Safeguarding

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

Good

Diagnostic imaging

All staff received training specific for their role on how to recognise and report abuse.

We saw the provider had developed a safeguarding policy which outlined what levels of safeguarding training staff were required to complete, according to their role.

We reviewed the safeguarding training certificates for all clinical staff and saw that they had completed level 3 adults and children safeguarding training. However, the provider's policy stated that the safeguarding lead would be trained to safeguarding level 4 and the registered manager to level 5, prior to the business being launched. Whilst the lack of level 4 and 5 training did not impact of the provider's compliance with intercollegiate guidance, as the safeguarding lead always had access to designated staff trained to a higher level, the service was not following its own policy.

The staff member providing administrative support had completed levels one and two adults and children safeguarding training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we spoke with were able to describe how to identify a safeguarding concern and how it should be reported. All staff were aware of the local safeguarding organisations to contact and who to escalate concerns to.

Staff followed safe procedures for children visiting the service department. Staff understood the additional checks required and importance of the obtaining the correct consent. Staff ensured children were accompanied by the appropriate guardians or family members prior to arrival of appointments. The provider did not produce any guidance of information leaflets regarding child sexual exploitation; although information leaflets were available through the referring trust, which the provider had access to.

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. We observed the room in which treatment was offered and saw the room was clean and well maintained. The host hospital was responsible for the overall cleanliness of the room and in addition we saw the provider carried out additional cleaning checks.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff wore personal protective equipment where required and we saw access to face masks, alcohol hand gel and appropriate handwashing facilities. We saw staff undertake appropriate handwashing prior to and following each patient appointment.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff cleaning the equipment in-between each consultation and performing effective handwashing prior to and following the procedures. Needles and electrode stickers were discarded appropriately after each patient use.

We saw all clinical staff had completed level 2 infection control training.

All patients received treatment in isolation, however patients noted to have a potentially infectious condition or disease were identified through the referral process and triaged by the registered manager as appropriate. The provider was able to demonstrate the additional cleaning processes and personal protective equipment which would be used in these scenarios.

Good

Diagnostic imaging

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 service had suitable facilities to meet the needs of patients' and their carers/families. The provider operated from a room provided by the hosting hospital. We observed the room to be bright and airy and we saw clear signage for patients attending appointments.

Staff carried out daily safety checks of specialist equipment which included the mains operating control box and the additional attachments depending on which diagnostic procedure was being undertaken. The main control machine had been checked in accordance with portable appliance testing regimes (PAT). We saw electrodes were thoroughly cleaned in between each patient. Calibration of the equipment was not required in accordance with the manufacturers advice that we reviewed.

Staff disposed of clinical waste safely using appropriate colour coded bags which were disposed of by the hosting hospital.

The provider had access to a resuscitation trolley in the event if an emergency, which was visible during the inspection. We saw the provider had developed a checklist in conjunction with the host hospital to ensure the trolley had the appropriate equipment checks in place. Paediatric resuscitation masks were available on the resuscitation trolley at the host NHS trust and full paediatric resuscitation equipment at the second host venue.

Assessing and responding to patient risk

Staff identified risk for each patient and were able to identify quickly and act upon patients at risk of deterioration. However, risk assessments were not in place for patients with specific concerns.

Patients were referred into the service through the NHS central booking system. A provider referral form included risks that the provider needed to be aware of such as general frailty of the patient, mobility issues or specific needs such as dementia. We saw that risk assessments were not completed for the patients attending, however the provider acknowledged that this will be developed for patients presenting with a specific concern. For example, epilepsy or falls. These were not in place at the time of inspection, although risk was identified clearly within the referral form.

Staff knew about and dealt with any specific risk issues and the registered manager was able to describe specific risks which may affect some of the patients undergoing this diagnostic procedure, for example patients prescribed anti coagulants and the use of needles. Needles are used as part of the EMG procedure in which they are placed into the muscle to record the electrical activity. The consultant clinical neurologist was able to outline a number of episodes in which serious concerns were escalated immediately, for example cervical spinal compression.

The provider did not have a separate sepsis policy but followed sepsis management policies as directed by the host hospital. The registered manager had also completed training on sepsis management and escalation.

The registered manager outlined pathways for patients requiring additional escalation or referral to other services. For example, motor neurone disease.

Good

Diagnostic imaging

Staff responded promptly to any sudden deterioration in a patient's health. The provider had access to crash / emergency responders within the hosting hospital. In addition, we reviewed the training records of both clinical staff and saw that both had completed resuscitation training for adults. The clinical assistant had also completed resuscitation of children training.

The service had access to mental health liaison and specialist mental health support through the host hospital and we saw information displayed within the hospital to offer this and saw a contract which enabled the providers access into these services.

Staff shared key information to keep patients safe when handing over their care to others. We reviewed four patient reports and saw that they were comprehensive and adhered to Royal College of Radiologists report guidance. The provider told us that all reports were followed up to ensure the referring consultant had received the information and any treatment or ongoing care was in place.

Staffing

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

The service was led by the registered manager who was also the consultant clinical neurologist for the service and a director. A clinical assistant was employed, who provided chaperone support and general assistance during the diagnostic procedures.

A second director of the company was also appointed and a clerical assistant who typed the reports as and when required.

The team numbers were enough for the number of patients referred and kept patients safe. There were no vacancies in the service.

Occasionally chaperone assistance was provided by the host hospital staff and these staff were always supervised. No bank or agency staff were used by the provider.

Records

Staff kept 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 but specific to the procedure only. We saw referrals were submitted to the provider through the NHS central booking system, which were detailed and included allergies, risks, medical history and the purpose of the referral.

The registered manager could also access the full patients' medical records, should there be any areas of further information needed.

Records were stored securely. Diagnosis information and dictated findings were typed and sent to the referring professional within 48 hours. All information was sent through a secure platform and no paper records were kept.

Good

Diagnostic imaging

Medicines

The service did not provide any medication as part of their service.

Incidents

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

Staff knew what incidents to report and how to report them. We saw staff received training as part of their induction, regarding incident management and investigation.

Staff raised concerns and reported incidents and near misses in line with the service's policy. We saw the provider had reported two incidents within the last twelve months. One was in relation to a patient's personal items left in the main corridor of the hospital and the other regarding a table defect. Neither incidents resulted in patient harm.

We reviewed the provider's incident documentation and saw they outlined actions to be taken following an incident, but they were no dates for completion to ensure further reoccurrence was mitigated. We saw both incidents were closed as the incidents had been resolved.

The service had no never events and no serious incidents in the last twelve months, but understood when to report them.

Staff understood the duty of candour. When speaking to staff they understood the principles of duty of candour and were able to articulate an explanation for patients.

Are Diagnostic imaging effective?

Inspected but not rated

Inspected but not rated

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. During our inspection we reviewed a selection of policies and found that these were all within their review date and had been ratified and approved for use. Policies were accessible to staff via an electronic system. The Registered Manager told us that they regularly reviewed guidance from the British Society for Clinical Neurophysiology (BSCN), Royal College of Radiologists (RCR) and the National Institute of Health and Care Excellence (NICE) and updated the services' policies, procedures and guidance accordingly.

Patient outcomes

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

Good

Diagnostic imaging

Accuracy of the tests undertaken by the clinician was assured, as the electrodiagnostic machine used, had pre-set profiles and protocols programmed within the base unit. This ensured that the results of diagnostic tests undertaken were clear and were able to be quickly sent back to the referrer. The provider told us that in some cases for example the identification of a serious concern, the results were sent immediately.

The Registered Manager told us that test results were always submitted to the referrer within a couple of days. However, we did not see any evidence of monitoring or audit activity to corroborate this.

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. The service was led by an experienced consultant clinical neurologist and supported by a clinical assistant. Peer support for the clinical neurologist was provided by associated colleagues working within neurological services across both NHS and private sectors. Consultant clinical neurologists working within the country are limited and the opportunity to discuss clinical practice standards was a challenge, however the registered manager ensured that current practice was in line with the BSCN guidance, through active membership and was also a fellow of The Royal College of Physicians.

The registered manager provided all new staff with a full induction tailored to their role before they started work.

The clinical assistant had undergone an induction training programme and undertaken mandatory training requirements.

The registered manager told us that all staff were supported through yearly, constructive appraisal and regular ongoing supervision of their work. We saw that the clinical assistant was not yet due to complete the appraisal process, but we saw documented supervision offering clinical support for the role undertaken.

The registered manager received an annual appraisal through an NHS substantive position and attended a twice-yearly specialist forum that consisted of other consultants working in this field. We saw appraisal records and evidence of peer discussion with senior health care professionals. Globally the registered manager connected to other specialists working across a variety of different countries to seek new and innovative developments within the electrodiagnostic field, which potentially could be developed within the country.

Multidisciplinary working

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

Staff held regular meetings to discuss patients and ensure diagnostic reports were submitted to the referring health care professional in a timely manner.

The Registered Manager worked closely with referring professionals to ensure all reports submitted were followed up and to ensure reports were understood and comprehensive.

Good

Diagnostic imaging

Seven Day Services

The provider did not offer a seven day service at the time of inspection. This was due to the availability of the Consultant clinical neurologist.

Appointments were not available out of hours or at weekends.

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.

The provider did not provide information leaflets regarding health promotion, although we saw information leaflets and information access points in the host hospital waiting areas.

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 were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Relevant staff training compliance for Mental Capacity Act 2005 mandatory training module was 100%. Staff made sure patients consented to treatment based on all the information available. The service also had referral routes for specialist advice and support for those patients who were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patient consent for the diagnostics were obtained by the referrer. The Registered Manager verbally checked patient consent before the tests were undertaken. We saw staff provided information relating to the procedural steps prior to the start of the test.

All children attending the service were supported by a parent or guardian. Staff were able to demonstrate their understanding of Gillick competency and the issues in relation to obtaining children's consent.

Are Diagnostic imaging caring?

Good

We rated it as good.

Compassionate care

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

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

We observed nine patients undergoing the procedures and saw that staff were professional and patient and treated patients with kindness. Patients were not rushed in any way and appeared relaxed during their appointment.

Staff followed policy to keep patient care and treatment confidential and we saw information shared in a confidential and respectful manner.

Staff understood and respected the individual needs of each patient. We saw the Registered Manager explain the procedure clearly and took time to answer any questions that patients had.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were able to articulate the needs of a potentially diverse group of patients who were referred by the host hospital.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff worked together and we saw a verbal exchange of information between clinicians during the diagnostic appointments. Time was taken to ensure patients understood how the results of the tests were used and where the information would be sent.

The provider actively sought feedback from patients and those who used the service. We reviewed the results of the last patient survey dated 2021/2022 and saw that 94% of patients stated they felt listened to during their appointment.

In the same survey 95% of patients stated they felt they were able to place total trust and confidence in the doctor treating them.

The Registered Manager had undertaken training on breaking bad news, although no test results were given to patients by the service as it was deemed inappropriate. Staff recognised that potentially life changing test results were discussed by the referring consultant and supported by specialist advice and information from the service as required.

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. We observed the Registered Manager explaining the purpose of the diagnostic tests and the procedure to be undertaken.

Patients were provided with information regarding the procedure and an explanation of next steps. Staff also ensured that patients knew who to contact if they had any questions or concerns.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients who had a specific need were identified as part of the referral process. For example, a hearing loss or speech difficulty.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information was requested through the host hospital and feedback was shared directly with the provider.

Good

Diagnostic imaging

Patients gave positive feedback about the service. We spoke with five patients following their procedure and all felt the service was very professional and the staff were caring.

Are Diagnostic imaging responsive?

Good

We rated it as good.

Service delivery to meet the needs of local people

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

It had been identified there was a need for additional electrodiagnostic services in the Northeast by commissioners and the provider to ensure patients had the appropriate access to the service. The provider had developed the service to offer three types of tests which involved the testing and evaluation of the brain, peripheral nervous system and muscles for patients living in the northeast area.

Facilities and premises were appropriate for the services being delivered. Patients were able to access the service currently at two local hosting hospitals. The provider was in the process of considering expanding this service across other locations in the future, however the pandemic had prevented this. We saw patient treatment rooms were bright clean and provided appropriate access for patients with a mobility concern. The treatment room was not designed specifically to meet the needs of children. Although, we saw in the last twelve months only one child had been referred into the service.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia through the host hospital.

The service had systems to help care for patients in need of additional support or specialist intervention. We saw access to specialist healthcare nurses such as pain management, neurotherapy nurses through the host hospital.

Managers monitored and took action to minimise missed appointments. Appointment changes and delays were reviewed by the central booking team and new clinic dates were offered as a priority. The provider did not have a waiting list as all patients were seen within seven weeks.

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. However, staff had not undertaken any specific training to support patients with additional needs.

Patients who had additional needs were identified as part of the referral information. Staff had access to specialist staff such as mental health teams, dementia champions and learning disability link nurses through the host hospital. However, neither of the clinical staff had undertaken any specialist training such as dementia or learning disability courses to support individuals with these needs.

Good

Diagnostic imaging

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We saw leaflets around the hospital offering support with translation and interpretation services and hearing loss and the service was able to access these from the referring organisation.

The service had access to information leaflets regarding health and specialist hospital services, available in languages spoken by the patients and local community. Although they were not readily available from the provider, they were able to be requested through the hospital.

Access and flow

People could access the service and receive the right care promptly.

Referrals were submitted by associated health care professionals such as NHS consultants and also GP practitioners for both adults and children. Approximately 2000 to 2500 patients were seen annually across two days each week and appointments were managed through the central NHS booking system.

We saw that patent referral information was reviewed by the Registered Manager at least seven days prior to the appointment date and contact was made with the referring health care professional should any additional information be required.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The provider ensured no one waited more than seven weeks for an appointment, we asked for this information, however, the service was unable to provide it.

The provider told us that same day appointments were available for inpatients at the hospital, although they were rarely requested.

Clinical diagnosis reports were dictated immediately and typed and sent to the referring clinician with 48hrs. We observed this practice during the inspection.

Due to the size of the service it was not possible to replace the lead clinician during periods of absence, however if an appointment was deemed urgent patients would be prioritised according to risk and need.

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.

Patients, relatives and carers knew how to complain or raise concerns. We reviewed the providers complaints policy and we saw that it provided clear timescales for the review and investigation of complaints. We saw one of the directors was the lead for complaints management.

The provider did not receive any complaints in the last twelve months. However, staff understood the policy and knew how to handle them. All staff we spoke with told us that any issues that were raised would be taken seriously and action taken to try to resolve patient concerns a quickly as possible.

None of the patients we spoke with had experienced any concerns during their appointments and were very satisfied with the service that they had received. All knew how to raise a complaint if they had one and the provider offered information leaflets to explain the process.

Good

Diagnostic imaging

Are Diagnostic imaging well-led?

Requires Improvement

We rated it as requires improvement.

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.

The registered manager told us that there were plans in place to further develop the service but currently the service was operating across two days to enable the registered manager to also fulfil a substantive post with an NHS trust.

Business continuity plans were in place which covered premises issues and the possibility of relocation to other sites in emergency if this was required.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services, despite restrictions due to the number of specialists working in this field. Leaders and staff understood and knew how to apply them and monitor progress.

The provider had developed a strategy and vision and we reviewed the document as part of the inspection. We saw the document outlined three main objectives for the service, which were to provide high quality electrodiagnostic services, address diagnostic waiting lists and produce high quality prompt reports.

All staff we spoke with were aware of the strategy and their passion to deliver timely, quality services within the North East.

The pandemic had resulted in patients having to wait longer for NHS diagnostic tests and the provider outlined aspirational plans as part of the vision, to increase the number of available clinics across the Northeast. The registered manager worked closely with local trusts and aimed to expand clinic numbers on a yearly basis, depending on the need for service growth on specific areas of the region. The provider recognised the barriers for expansion due to the lack of consultants working in this specialist area.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke with were positive and passionate about the quality of the service that they provided. Staff were proud of the team working approach and spoke about the importance of ensuring patients, and those who refer them. Patients did not receive copies of the diagnostic reports on the day of their appointment as results were delivered by the referrer. However, we observed staff providing details of the tests undertaken, next steps and provide clear answers to the questions raised by patients. All staff we spoke with were clear as to the providers objectives and outlined the ambition to provide Electrodiagnostic services on a greater scale whilst maintaining high quality reporting.

Good

Diagnostic imaging

All staff and patients we spoke with felt able to raise concerns if it was required. Staff had received training in speaking up and raising concerns and actively sought feedback from patients and their families to ensure services met the needs of those who used them. All staff told us that services are developed in partnership with the patients and their families.

Governance

Leaders did not always have effective governance processes, however, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The provider completed audits in relation to concentric needle use and electrodes. We reviewed the results of the most recent audits and saw that needles and electrodes were regularly reviewed and changed to ensure the least discomfort for patients.

We saw the consultant clinical neurologist met weekly with colleagues to discuss patient referrals and ensure all reports were followed up.

The registered manager told us that all of the patients referred would be seen within six weeks, however the service did not collate data to ensure this standard was met. We saw local feedback provided by NHS colleagues which stated this timescale had been met, however no formal data was held.

The provider did not hold information or data I regard to cancelled appointments or the overall capacity of the service to offer appointments.

We reviewed the recruitment records for all staff working within the organisation, however, comprehensive files were not in place to show what recruitment checks had been undertaken or what training had been completed, for the staff employed by the service.

We saw the provider used safer staffing recruitment checking and had developed a checklist to ensure staff were vetted appropriately, however files had not been maintained for the staff employed and were not subject to any audits or review. We saw electronic records showing that staff had completed disclosure and barring checks and had the appropriate employments checks in place. Following our feedback, the registered manager took immediate steps to improve staff files in accordance with the requirements as registered manager, to show clearly what records were held for each member of staff. The provider sent evidence of this following the inspection.

We requested mandatory training information for all staff and we saw training records were in place but had not been collated and stored in accordance with the requirements of the registered manager role. However, the provider took immediate steps to ensure records were improved to clearly show all training that had been undertaken and reviewed.

The provider had a process in which clinical and operational policies were reviewed annually or if best practice or national guidance had changed. We saw examples of recent policy review during the inspection.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected environmental events. However, the provide did not have a risk register in which all risks within the service can be reviewed and monitored.

Good

Diagnostic imaging

Risks were identified and monitored through the provider's referral system. The provider was able to articulate understanding in relation to individual specific risks associated with conditions that patients regularly present with.

Dialogue between referring health care professionals and the Consultant Clinical Neurologist was ongoing and staff told us that follow up of all patients was assured. We saw evidence of this during our inspection.

The provider did not have a risk register at the time of inspection but identified that the lack of an additional neurology colleague to guarantee clinic stability was a risk, however this was a national issue across all health care sectors.

The service had a contingency plan in place in the event of an unexpected disruption to the service, such as buildings issues which would prevent the service from running.

Information Management

The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. However, patient data was not formally collated by the provider.

All staff had access the service's electronic systems. Policies and clinical guidance resources were all held electronically. The consultant clinical neurologist had a secure email that enabled them to receive and send patient data and information securely to referrers.

The service provided information governance training to all staff. Staff compliance with information governance training was 100% for all staff employed.

Diagnostic machines all were password protected and encrypted.

Service data was held by the NHS central booking service and could be reviewed by commissioners when required. The provider did not however regularly request this information and was unable to provide information regarding patient numbers and waiting time from referral to treatment.

The service submitted required notifications to local authorities and CQC when these were appropriate.

However, the service did not formally collate referral data and overall waiting times for the patients who used the services. The provider told us that informal localised data was known due to the small size of the service and we saw feedback from host hospitals to corroborate this.

Engagement

Leaders and staff openly engaged with patients, staff the public and local organisations to plan and manage services, however, this was limited. They collaborated with partner organisations to help improve services for patients.

The service provided information about the service for patients and referrers and leaflets were available outlining the type of services offered.

The provider had development links with local NHS colleagues and continued to development contracts with both independent and NHS providers to address the lack of service provision within the area.

Good

Diagnostic imaging

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The consultant clinical neurologist was a member of several global neurological professional bodies to support dialogue and learning from similarly trained professionals. This enabled the provider to stay abreast of research and pioneering developments in the field, which could be shared with local colleagues.

The service had plans in place for the development of additional clinics and the general promotion of the electrodiagnosis services nationally within the profession.