Mediservices Healthcare Ltd

Unit 28, Greenlands Business Centre

Inspection report

Unit 28
Greenlands Business Centre, Studley Road
Redditch
B98 7HD
Tel: 02038686249

Date of inspection visit: 23 March 2022, 10 April 2022
Date of publication: 11/07/2022

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

Ratings

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

Summary of findings

Overall summary

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

- The service had enough staff to care for patients and keep them safe. Staff were offered training in key skills and understood how to protect patients from abuse. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of 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.

However:

- Staff did not always understand local safeguarding processes across the different sites.
- The provider submitted evidence of good protocols in relation to managing patient safety across various clinical settings. However, staff knowledge during our site visit identified room for improvement.
- Completion rates of mandatory training, appraisals and supervisions were lower than the service's target.
- Staff did not always have a good understanding of appropriate care management for patients living with dementia.
- Governance systems had not ensured staff working remotely were fully engaged and up-to- date with the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Good 	We rated this service as good because it was safe, effective, caring, responsive, and well led.

Summary of findings

Contents

Summary of this inspection

Background to Unit 28, Greenlands Business Centre

Unit 28, Greenlands Business Centre is operated by Mediservices Healthcare Ltd. The service provides neurophysiology services to NHS and private patients in intensive care units, surgical theatres, and outpatient settings. Neurophysiology studies how the nervous system is working.

Tests and scans are provided nationally in a range of settings, all of which are operated by other providers, with staff employed or working on behalf of Mediservices Healthcare Ltd.

A dedicated administration, leadership, and operations team is based at the registered location and provide support to patients and staff working in national clinics. All services are led by qualified professionals, such as consultant neurophysiologists, clinical physiologists, sonographers, and healthcare assistants.

The service sees patients referred by NHS or private consultants, physiotherapists and GPs for patients with suspected neuromuscular disorders as well as those who needed electromagnetic monitoring during intensive care treatment or surgery. Neuromuscular conditions are a range of conditions that impair the functioning of the muscles.

At the time of our inspection, the service provided care from seven hospitals and offered ad-hoc clinics to reduce NHS waiting lists.

In the previous 12 months the service received 2742 referrals.

A registered manager was in post.

We had not previously inspected the provider or location.

How we carried out this inspection

We carried out an inspection of the service using our comprehensive methodology. We spent one day at the provider's registered head office and one day at a diagnostic outpatient clinic operating from an independent hospital. This represented a small proportion of the provider's clinical work and our ratings reflect additional evidence submitted after our inspection.

We reviewed evidence such as patient records, incident reports, complaints, and other material relating to governance and the safe running of the service. We spoke with the medical director and eight other members of staff representing a cross-section of roles.

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.

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

- The service was focused on relieving pressure on NHS capacity and reducing waiting lists. To meet this goal the team was highly flexible and used an agile method of working to establish clinics at short notice for NHS patient referrals. This had resulted in short notice tests of up to 150 patients per month with minimal notice.
- The service established innovative training opportunities for new practitioners. This included a bespoke training programme and accreditation for clinical neurophysiologists.
- The service had introduced an innovative real time reporting system in partnership with an NHS trust's critical care and IT departments. This enabled consultants to make rapid bedside decisions for critically ill patients.

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 all staff undergo regular appraisals and supervisions. Regulation 18 (2) (a).
- The service should ensure all staff understand local safeguarding processes. Regulation 13 (1) (2).
- The service should ensure all staff have a full understanding of local emergency safety and escalation procedures at every site from which they provide care. Regulation 12 (2) (c) (d).
- The service should ensure they continue to implement location risk assessments for each site from which services are offered. Regulation 15 (1).
- The service should ensure they monitor the application of clinical governance processes to maintain consistency across all clinical sites. Regulation 17 (2) (a) (b).
- The service should ensure staff understand their responsibilities to provide care in accordance with the Mental Capacity Act (MCA). Regulation 11 (1).
- The service should ensure staff have a good understanding of appropriate care management for patients living with dementia. Regulation 9 (1)(b).
- The service should ensure all staff engage fully with communications and governance messages shared by the senior team to ensure they remain up-to-date. Regulation 18 (2) (a).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Inspected but not rated	Good	Good	Good	Good

Good

Diagnostic and screening services

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

Are Diagnostic and screening services safe?

Good

We have not previously inspected this service.

We rated safe as good.

Mandatory training

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

Staff received but did not always keep up-to-date with their mandatory training. In April 2022 86% of staff were up-to-date. This was an average across staff groups and reflected a range from 100% completion amongst healthcare assistants (HCAs) to 71% amongst clinicians. This did not meet the provider's target of 92%. The senior team had implemented a plan to improve training completion.

Mandatory training was comprehensive and met the needs of patients and staff. It included 12 programmes including moving and handling, conflict resolution, and infection prevention and control (IPC). The training programme reflected the nature of the service and meant learning from modules could be applied to any clinical environment from which staff delivered care.

Mandatory training was suitable for the service provided to patients. For example, staff completed standard safety modules such as fire safety and health and safety and then supplemented them with site-specific training at each location. This reflected good practice and enabled staff to move between sites and work safely.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, and dementia. The provider had recently improved this training with a more advanced focus on consent and safeguarding. This was being rolled out across all staff groups.

Managers monitored mandatory training and alerted staff when they needed to update their training. Completion rates were below the provider's standard due to pressures relating to the COVID-19 pandemic and the temporary nature of

the workforce. The provider offered protected time for training although there was room for improvement in how senior staff mandated this. For example, some staff said while they had protected time to complete training, this required them to take time out of their other commitments to complete. The senior team was focused on this area for improvement. Staff spoke positively about the training and said it was useful for their role.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All clinical staff were required to maintain level three adults and children safeguarding training. All non-clinical staff held level two training. The service required all staff to complete UK government 'Prevent' training, which aimed to identify and report evidence of extremism, as a safeguarding measure. All staff were up-to-date with their required level of training.

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

Staff described how to make a safeguarding referral within the provider and could explain who to inform if they had concerns. Each clinical site had a named safeguarding lead who worked for the host organisation. The provider had a named national safeguarding lead trained to level four. In the event of a safeguarding incident staff said they would contact both individuals and then decide how to proceed jointly.

Staff followed safe procedures for the care of children and young people (CYP).

Before the service implemented clinical services from a new site, the senior team obtained local safeguarding point of contact information and escalation protocols. They included this information to staff working from these sites. We saw evidence this information was kept up- to-date.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The provider had established safeguarding protocols and shared these with host site governance teams to ensure a consistent standard. However, there were differences in staff understanding of local safeguarding policies based on whether staff worked from an independent hospital or an NHS hospital. For example, during our clinical site inspection staff were unfamiliar with local escalation arrangements. While staff did not fully understand the local safeguarding process, they demonstrated good knowledge of the principles of safeguarding and how to act to protect someone from harm.

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 worked in clinical environments that belonged to other organisations. The provider had service level agreements with host sites to ensure clinical areas and furnishings were clean and well-maintained. Staff working from clinical sites were responsible for checking local standards and ensuring the environment was ready for use.

Good

Diagnostic and screening services

Staff followed infection control principles including the use of personal protective equipment (PPE). Host organisations provided PPE under a service level agreement. This meant staff were always assured of access to appropriate stock at any clinical site. Staff wore and managed PPE appropriately during our clinical site inspection. Audits indicated staff maintained standards across clinical sites, including in hand hygiene

Staff cleaned equipment after each patient contact. Disposable privacy curtains were dated and within their expiry date. We observed this during our clinical site inspection and clinical hygiene audits indicated staff maintained standards consistently.

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.

Staff delivered services from multiple sites such as NHS hospitals, independent hospitals, and GP practices. The provider also delivered ad-hoc services on short term tenders from premises such as gyms and leisure centres. The provider allocated staff to sites based on their clinical competencies, patient demand, and availability of clinical space.

The service had enough suitable equipment to help staff safely care for patients. Staff carried clinical equipment with them to clinics. This reflected the nature of the service and meant staff could work safely at different sites using equipment with which they were familiar. Staff carried out daily safety checks of specialist equipment and the provider maintained a central log of maintenance checks and issues.

The operations team maintained a central register of clinical equipment and planned servicing in line with manufacturer guidance. The provider had a servicing contract that enabled them to secure replacement equipment at short notice in the event of a failure.

The provider ensured clinical care was delivered from sites that complied with national guidance. At the clinical site we inspected, the design of the environment was suitable for the service.

Staff managed clinical waste safely including the storage and disposal of hazardous waste.

Staff were responsible for ensuring they received a local fire safety induction from the site management team. This supplemented the standard fire safety training undertaken by the provider. Staff demonstrated good knowledge of escape routes and local policies during our clinical site inspection.

There was a limited process to ensure staff underwent a local induction for safety and escalation processes. The senior team had recently introduced a location risk assessment for two permanent hospital sites. This included contact details for safeguarding and whistleblowing escalation as well as operational contacts and processes. This reflected good practice and the registered manager was developing risk assessments across each site. However, this meant we were not assured staff always had a full understanding of specific local protocols.

Assessing and responding to patient risk

The provider had processes to assess and respond to deteriorating patients. However, clinical practice was inconsistent across local sites.

Good

Diagnostic and screening services

Staff delivered care in two broad types of environment and their responsibility for managing patient risk differed between them. During tests in NHS hospitals, staff worked alongside ward or theatre teams who maintained overall responsibility for clinical deterioration. In outpatient settings, staff were responsible for all aspects of patient care, including emergency management in the event of a cardiac arrest or other incident.

The provider required a specialist to be present for tests with any patients fitted with an automatic internal defibrillator during nerve conduction studies. This reflected the increased risk of side effects.

The provider had standard operating procedures for reporting urgent findings in the event of unexpected diagnoses. Consultants made an immediate referral to the originating doctor and contacted the provider's on-call manager to log the findings. Each referring hospital had a protocol for reporting urgent concerns and staff were familiar with this before carrying out tests. However, there was no fail-safe system in place for urgent findings at weekends. For example, the consultant sent an e-mail to the referrer, or added an alert to their results, but there were no arrangements for rapid access to support for the patient. In all cases staff reported urgent findings to the provider's head office. The on-call manager then progressed the escalation.

Referrers were required to complete a safety risk assessment and screening questionnaire for each patient, which included key medical information needed for care to be safe. However, during our clinical site inspection we saw staff did not carry out checks for patients without this information. This meant staff may not always be aware of potential tests which need to be avoided because it may be harmful.

The provider had protocols for patient deterioration, including for the escalation of an acute medical need. However, we were not assured all staff fully understood local procedures. During our clinical site inspection, staff were unfamiliar with local clinical escalation processes. They did not know the location of the nearest resuscitation equipment and their description of what they would do in an emergency did not match local requirements. Our checks with other staff and the provider confirmed this was a local issue to a specific site and did not reflect wider practice.

After our inspection, the senior team provided evidence from conducting spot checks that staff in remote clinics understood emergency processes. They also worked with the team present at our inspection to improve their knowledge.

Staffing

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

The service had enough staff to keep patients safe. Thirty-nine staff worked for the service under a range of contracts and self-employed arrangements. This included eight clinical neurophysiologists, 15 consultants, two sonographers, and three Health Care Assistants (HCAs). The service employed eight permanent members of staff, including operations and administration staff. Consultants worked under practising privilege arrangements and most were substantively employed elsewhere.

Managers accurately calculated and reviewed the number and grade of staff for each clinic. They planned staffing based on bookings which was possible as the service did not offer walk-in services. The provider had a policy of no lone working as part of a consistent approach to staff safety.

Good

Diagnostic and screening services

The service reported a turnover rate of 25% in 2021. However, this reflected turnover of permanent staff only. As this was a small team, the percentage appeared high and reflected only two members of staff who left the service.

The service had low sickness rates. The service reported a sickness rate of 2% amongst permanent staff in 2021.

The service had a suitable skill mix of medical staff on each shift and reviewed this regularly in line with patient needs. The administration team pre-booked clinics based on the types of referral and allocated appropriate staff in advance.

The provider maintained a record of each clinician's medical indemnity insurance, designated body, annual appraisal, and Disclosure Barring Service (DBS) status. The provider required all staff to undergo a new DBS check every three years. The service was in full compliance with this measure at the time of our inspection.

The service was compliant with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe recruitment of staff.

An on-call senior manager was available whenever clinical services were provided. This individual held local escalation plans to support staff experiencing difficulties in any clinic.

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. Staff carried a laptop with them to complete patient reports and outcomes in a timely way, which were transmitted securely to the provider for sharing with referrers. This process varied slightly between clinics and service level agreements, such as where staff worked with NHS surgical teams in a theatre environment. Some consultants dictated results letters through their medical secretary, who then submitted this to the provider. The administration team handled all results letters centrally, which meant the provider had oversight of outcomes and clinical decision-making. The team handled this in a timely way and in line with targets set by NHS trusts.

Records were stored securely on an electronic record system. This system was password protected and secure.

Staff prepared different types of patient records depending on the clinical service offered. For example, consultants prepared a report with test conclusions and neurophysiologists prepared a technical report.

Sonographers worked from one NHS site and adhered to a local care pathway that included specific requirements for record keeping. This was managed locally by the NHS team.

Medicines

The service did not administer, manage, dispense, or prescribe medicines.

Incidents

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

Good

Diagnostic and screening services

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy.

In the previous 12 months, staff reported 16 incidents. The senior team documented investigations in each case, including multidisciplinary responses where an incident involved consultants or hospital staff. None of the incidents resulted in patient harm.

The provider identified opportunities for improved communication as a result of incident reports. For example, the operations team worked with hospitals to ensure referrals were appropriate to the service. This reflected learning from an incident in which a hospital referred two children for tests.

Incidents included two needlestick injuries to staff, both of which occurred when they were repositioning patients. This is a known risk for the type of procedure conducted. In both cases, staff carried out a reflection on their practice and the clinical environment to identify opportunities for learning.

Staff used the incident reporting system to highlight near misses or potential risks as opportunities for improvement. One incident related to a delayed report. While this did not impact patient care, it had the potential to do so and the operations team worked with physiologists to provide workload support during periods of high demand.

Staff dual-reported incidents that took place at sites operated by other organisations. This meant both the provider and the responsible organisation for the location maintained oversight of incidents.

The senior team was responsible for implementing the duty of candour in line with the provider's policy. Staff we spoke with understood the principles of the duty of candour. In the previous 12 months there had been no incidents that required a duty of candour disclosure.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. For example, the service involved a patient and their partner when they received an inaccurate appointment letter in error and attended a closed clinic.

Staff received feedback from investigation of incidents, both internal and external to the service. The senior team distributed a monthly newsletter to all staff, including agency and temporary staff, that included incidents and related learning.

Staff met virtually to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. For example, the senior team implemented clearer requirements for consultant's manner and their approach to personalised care in response to feedback

The senior team monitored national safety alerts, including those issued by the Medicines and Healthcare products Regulatory Agency (MHRA), and communicated systems with relevant staff in a timely manner.

Are Diagnostic and screening services effective?

Inspected but not rated

We do not currently rate effective for diagnostic and screening services.

Good

Diagnostic and screening services

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. Policies were stored electronically, which meant staff had remote, on-demand access.

Clinical staff used protocols for each type of test or scan based on sector-specific best practice. The provider reviewed these annually or more often if national guidance changed.

Clinical protocols and standard operating procedures (SOPs) were based on national guidance issued by appropriate organisations such as the British Society for Clinical Neurophysiology (BSCN) and the National Institute for Health and Care Excellence (NICE). The provider had used BSCN guidance during COVID-19 pressures to ensure clinical staff worked safely. Staff used additional tools to deliver care based on the type of test or procedure. For example, staff who carried out spinal or brain monitoring services in NHS theatres contributed to the World Health Organisation (WHO) surgical safety checklist with the rest of the team.

The registered manager audited the service's policies and checked they were up-to-date every three months. This included checks of staff practice and knowledge at clinical sites and reviews of consultant work. In the past 12 months, the service reported average compliance of 76%, which was below the service target of 82%. In this period, the service performed variably, with quarterly achievements from 82% to 54% in the most recent results. The registered manager took action to address this decrease in performance and was working with staff to ensure they understood and applied policy-based care. There was no evidence of a negative impact on patient care or outcomes.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Staff assessed patients' pain using a recognised tool where appropriate during certain tests or scans. Some patients were referred to the service as part of long-term pain management or exploration studies. Staff did not prescribe pain relief but provided patients with advice and guidance when required. They worked with referring doctors to provide test outcomes that may help improve the effectiveness of pain relief.

Patient outcomes

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

The medical director audited the service for the effectiveness of reports for nerve conduction studies (NCS) and needle electromyography (EMG) studies as part of the diagnostic neurophysiology service. Nerve conduction studies help to identify the function of nerves in the body. The audit included a review of a random sample of reports to check if they addressed the original clinical query and whether the referrals were effective. The audit found most reports to be excellent or good using a quality scale. The audit graded some reports as acceptable. While these demonstrated safe practice, the audit found areas for improvement. The senior team worked with the consultant involved to develop their practice.

Good

Diagnostic and screening services

Outcomes for patients were positive, consistent and met expectations. The senior team monitored this through feedback from NHS trusts, referring clinicians, and patients. For example, the service had been asked to tender to expand nerve monitoring services due to the success of its existing work in improving outcomes for patients with brain damage.

The service had a referral triage system to ensure requested tests and care were appropriate and had a good chance of contributing to positive outcomes. The medical director reviewed complex referrals and worked with clinicians to explore the most beneficial tests and setting available.

Staff used clinical protocols to ensure approved referrals for time-critical tests took place within the best time frame for success. For example, the team carried out electroencephalography (EEG) for hospital inpatients within 24 hours of approval. EEG is a test to detect abnormalities in brain electrical activity.

The medical director investigated disputed test reports and worked with referring clinicians to optimise the standard of reporting. For example, a referring doctor queried whether a consultant's conclusions cold be justified by the scope of the test they had carried out. The medical director worked with both individuals to carry out a review and used outcomes to drive improved practice.

During monitoring in NHS theatres or critical care, staff gave contemporaneous verbal feedback to NHS colleagues. They completed an activity log and report and sent this to the NHS team detailing everything that happened.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff work performance however, staff supervisions were inconsistently conducted.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service employed staff for specific clinical pathways and diagnostic tests and required specialist training for each. This meant staff delivered care based on individual competencies and proven skills.

Managers carried out routine quarterly spot checks on clinics. This included a review of clinical quality, infection control practices, and patient feedback. The most recent five spot checks found good standards of practice with adherence to provider policies and best practice.

The provider had an up-to- date continuing professional development (CPD) policy that provided staff with guidance on how to access specialist training and development. The senior team supported individual development and staff spoke positively about opportunities. This reflected an improvement in the previous six months when staff reported limited opportunities in the annual staff survey. In response the senior team established an annual CPD budget for all staff and supported them to use this to benefit their practice.

Consultants and neurophysiologists were registered with the General Medical Council (GMC) or the Registration Council for Clinical Physiologists (RCCP). Sonographers were registered with the Health and Care Professions Council (HCPC) and healthcare assistants were required to hold or complete the national care certificate.

The provider had established a training programme for clinical neurophysiologists. This required trainees to hold a degree in neuroscience followed by a practitioner training programme This was an experimental programme for the senior team to test the process. It was evidence of the team's focus on sustainability and expansion and demonstrated a cautious and methodical approach to development. We spoke with one trainee who described a very positive experience, including pre- and post-clinic briefings and three-monthly formal reviews with their trainer.

Clinical staff reflected a wide range of professions and specialties, which reflected the part time nature of the workforce. For example, staff held qualifications such as leadership and management and counselling accreditation. Staff said the provider valued such experience and they were able to explore how to use it to the benefit of patients.

Managers gave all new staff a full induction tailored to their role before they started work. The induction included the provider's policies and governance processes but was not always supplemented by site-specific information. For example, the standard induction ensured staff understood provider policies and had access to systems such as patient records and incident reports. However, during our clinical site inspection, staff were unfamiliar with some local processes.

The provider required staff to undergo yearly, constructive appraisals of their work. However, in the previous 12 months only 64% of clinical staff and 20% of administration and operations staff had completed an appraisal. We raised this with the registered manager who noted significant challenges in carrying out appraisals with a part-time or self-employed workforce during COVID-19 pressures. They implemented an improvement plan to ensure appraisals were completed.

The provider carried out supervisions, although these were sporadic. Examples of supervisions held were constructive and contributed to improved practice but not all staff had these routinely. For example, one healthcare assistant said they had not had a supervision in 18 months. There was no evidence this had resulted in poor outcomes for patients.

Team meetings were held inconsistently. Although managers offered remote attendance options, staff attendance was low. This reflected the nature of the workforce. The senior team sent regular updates and newsletters to staff although did not have a system to ensure staff read these. While this meant staff were not always up to date with the organisation, it was separate from the system to inform staff of learning from incidents and other critical information.

Multidisciplinary working

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. Inpatient services were always additional to existing NHS care pathways. For example, consultants and physiologists worked with hospital teams to coordinate care for patients who had experienced brain damage following a cardiac arrest. In critical care units, staff worked with intensivists to explore the extent of brain damage to help plan post-discharge care.

Host hospitals arranged formal multidisciplinary meetings according to their schedules and invited staff from Mediservices to attend as needed. The service worked responsively in line with demand, which meant staff attendance at meetings varied.

Staff worked across health care disciplines and with other agencies when required to care for patients. This was based on who referred the patient. For example, staff worked with physiotherapists and GPs to coordinate effective care following a test.

Good

Diagnostic and screening services

The senior team demonstrated a clear focus on multidisciplinary working that supported staff learning. For example, reporting consultants and neurophysiologists worked with junior doctors in referring services to help them understand report outcomes and conclusions.

Seven-day services

Key services were available to support timely patient care.

The service operated on demand, with clinics and NHS hospital support available seven days a week.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients referred to the service were under the main care of another clinician and this service relied on referrers to include mental health needs in the referral documentation. The patient records system included notifications of mental health needs, including dementia or a safeguarding concern.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The provider had introduced more advanced training on consent law and processes following feedback from staff. If a patient could not consent to care in an outpatient setting, staff did not proceed with a test. In inpatient settings, NHS teams made best decisions for patients where they were unable to do so, such as those who were unconscious.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. This occurred in hospital inpatient settings.

Staff received and kept up- to-date with training in the Mental Capacity Act (MCA). Referred patients did not typically have mental health conditions that required specialist monitoring or care adaptations. Staff were trained to deliver care that was compliant with the MCA. However, during our clinical site inspection, staff did not demonstrate a full understanding of their role regarding this. There had been no incidents reported in relation to this.

Staff who provided spinal monitoring services during surgery did not carry out consent processes themselves. In this care pathway, NHS teams consented patients and made sure they understood part of their care would be delivered by another provider.

Are Diagnostic and screening services caring?

Good

We have not previously inspected this service.

We rated caring as good.

Good

Diagnostic and screening services

Compassionate care

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

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

Patients said staff treated them well and with kindness in the provider's survey. In the previous 12 months, 93% of patients said staff treated them with dignity and respect.

Staff followed the service's policies to keep patient care and treatment confidential. Staff kept patient information confidential when working from other organisation's buildings.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, the service offered patients appointments with clinical staff of a specific gender on request.

A healthcare assistant trained as a chaperone was always present during diagnostics tests in outpatient settings. Chaperones supported patients for all their appointment and provided reassurance to patients during procedures.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patient feedback showed staff were patient and put them at ease when they were worried or anxious.

Staff described how they supported patients who became distressed and helped them maintain their privacy and dignity. All staff undertook privacy and dignity training, including administration and operations staff.

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 took time to explain to patients what test results meant and helped to alleviate any worries.

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.

Patients gave positive feedback about the service. The provider proactively sought feedback from patients by asking them to complete a survey on their experiences from referral to completion of care. In the previous 12 months, 95% of patients reported they were satisfied with the service from a sample size of 50%.

The provider measured how staff involved patients in their care as part of the survey. In the previous 12 months, 93% of patients said staff explained the test procedure to them before it was carried out. In the same period, 89% of patients said staff gave them an opportunity to ask questions about the test before it took place.

Good

Diagnostic and screening services

Staff ensured patients knew they were undergoing tests and care provided by Mediservices Healthcare Ltd and not by the host site. This included branding and wording on appointment letters, e-mails, and during phone conversations. Staff explained the process to patients, including what would happen after their test, and how they should expect to receive the results

During our observation of a nerve conduction study clinic, staff took time to explain the process to patients and gave them time to ask questions. Nerve conduction studies check the extent to which nerves are functioning properly. Staff gave patients immediate results in this study and explained what they meant and how they would be shared with their referrer.

Are Diagnostic and screening services responsive?

Good

We have not previously inspected this service.

We rated responsive as good.

Service delivery to meet the needs of 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.

The service received referrals from a range of practitioners, including musculoskeletal physiotherapists, GPs, occupational therapists, and neurologists. The team worked with referrers to carry out patient care in a location most appropriate to patient needs. For example, staff assessed patients on inpatient hospital wards, including intensive care units, to support NHS teams to deliver care plans.

Facilities and premises were appropriate for the services being delivered. The provider worked with referring organisations to secure clinical spaces appropriate for the planned tests and care.

Managers planned and organised services to meet the needs of patients and referring organisations. The senior team proactively worked with providers to educate them about neurophysiology testing services. This reflected national differences in how different clinical specialties understood its purpose and benefits. The service rejected referrals for unnecessary tests because of the distress they could cause to patients. In such instances the medical director worked with referring doctors to improve knowledge on the specialty.

The service's clinical strategy aimed to relieve pressure on NHS services by carrying out specialist monitoring and tests for NHS services with long waiting lists. It also arranged specialist in-theatre care such as interoperative spinal cord monitoring and interoperative brain function monitoring. These procedures helped staff to identify how specific nerve functions were performing. Such services enhanced surgical services and enabled NHS teams to deliver highly specialised treatment.

Staff delivered services from multiple sites such as NHS hospitals, independent hospitals, and GP practices. The provider also delivered ad-hoc services on short term tenders from premises such as gyms and leisure centres. The provider allocated staff to sites based on their clinical competencies, patient demand and availability of clinical space.

Good

Diagnostic and screening services

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.

Consultants and neurophysiologists reviewed referrals to ensure they were appropriate for the patient's needs. For example, some tests could cause physical discomfort and consultants could recommend a delay to them to help patients recover from inpatient hospital stays before carrying out a test. Similarly, some equipment was sensitive to other electrical equipment, which made accurate results more difficult to achieve in environments such as critical care. Consultants ensured tests in these settings were medically necessary before conducting them.

The service provided information leaflets to patients about specific tests and scans. The provider had leaflets translated into other languages on demand.

Staff made sure patients and carers could get help from interpreters or signers when needed. Staff understood how this process differed between clinical sites. For example, when delivering care to NHS inpatients, the local ward team arranged an interpreter. At an independent hospital, the Mediservices team arranged this.

Staff adapted clinic processes to meet individual needs. For example, the team worked with a patient who was anxious about their test and undertook this in a darkened, temperature-adjusted room to help calm them. The test was scheduled on the patient's birthday and they requested balloons to be in the room to further alleviate their nerves. Staff accommodated this, which was reflective of the personalised nature of care.

The provider had adapted training and care protocols to meet demand, including for increasing numbers of children and young people referred within special care baby units and neonatal clinics. Staff arranged for carers or parents to attend with children or young people to support them during their appointment.

The provider had policies to guide staff to care for patients living with mental health problems, learning disabilities and dementia. However, we were not assured staff always had a good understanding of appropriate care management for patients living with dementia. For example, during our clinical site inspection staff noted a previous patient had shown clear signs of dementia. However, this was not noted on their referral record. Staff obtained consent using appropriate processes and noted their observations on the clinical report. Staff said they had not considered contacting the referrer in the first instance despite their concerns. However, they demonstrated a good understanding of the symptoms, signs, and risks associated with dementia, which meant care was delivered safely.

Access and flow

People could access the service when they needed it. Waiting times for treatment were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed. Patients received treatment within agreed timeframes and national targets. Staff monitored waiting times at each of the seven hospitals from which the service operated. In the previous 12 months, the average wait from referral to care was three weeks. In April 2022, 47 patients were waiting for an appointment across all sites, ranging from one patient to 12 patients.

The service monitored the number of patients who did not attend (DNA) a booked appointment by site. In the case of a DNA, the administration team called the patient to rearrange and contacted the referrer if they could not make contact. The service contacted each patient in advance of an appointment to confirm the details and check their planned attendance. DNA rates were low. In the previous 12 months, the DNA rate across all clinical sites was 3%.

Good

Diagnostic and screening services

The service worked to keep the number of cancelled appointments to a minimum. In the previous 12 months, the provider cancelled 2% of appointments. This was most often caused by issues related to COVID-19. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

The provider's staffing and clinical operating model meant they could offer a service responsive to changes in demands, including unpredictable increases in referrals. As COVID-19 restrictions eased, the service implemented evening and weekend clinics for an NHS trust on demand to help clear a substantial outpatient backlog.

The service monitored patient pathway completion rates across NHS and independent hospital sites. This was the proportion of patients who completed their referred diagnostics care within a standard target of four weeks and included patients who did not attend, those who cancelled, those who deferred an appointment, and cancellations by the local site or the provider. In the previous 12 months the completion rate was 72%. As this was an average figure across all trusts, there was no target to compare it to.

Learning from complaints and concerns

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

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

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

Managers investigated complaints and identified themes. In the previous 12 months the service received 10 complaints. In each case a member of the senior team had documented an investigation and outcome for learning, which they shared with the whole team. For example, one complaint related to the lack of step-free access in a temporary clinic. In response, the provider improved its monitoring processes ahead of the clinics to ensure all facilities were appropriate. Eight complaints related to consultant reports, such as missing information or incomplete tests. The senior team worked with individual consultants to ensure referrals were acted on accurately and appropriately and monitored them for improvement.

In the same period, the service received six formal compliments from patients and NHS referring partners. The compliments noted staff flexibility and improved patient outcomes as a result of scans and tests.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. The senior team were aware the nature of the service, operating from different sites with temporary staffing, meant there was an increased risk of inconsistencies between how doctors delivered care. They had worked with a consultant to improve their approach to communication and compassion following two complaints and used learning from this exercise to establish clear guidance for staff behaviour when working with patients.

Are Diagnostic and screening services well-led?

Good

Diagnostic and screening services

Good

We have not previously inspected this service.

We rated well led as good.

Leadership

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

The company chairman, the director and registered manager, the clinical governance lead and medical director, and the operations director formed the board. A team of managers and senior administration staff supported the board and provided a central point of contact for staff working from satellite clinics. This team had a range of clinical leadership skills, including in the specialist areas of care provided. The team was focused on progressing the field and supporting NHS patients with expertise to supplement primary care.

The clinical governance lead was also a consultant and the current president of the British Society of Clinical Neurophysiology, which reflected their work in this specialist field.

The senior team were actively involved the running of the service and the registered manager took clinical shifts. Board members were proactive in engaging with referring organisations.

The leadership team were substantively based at the provider's head office and they visited clinics and hospital on a rotational basis to meet with staff and patients. They supported staff to develop skills through professional development opportunities.

Leaders described the main challenges to the service in relation to the fragmented workforce and recovery from the pandemic. This matched what staff told us.

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

The provider's strategy focused on addressing capacity shortages and reducing waiting lists in the NHS. The service had introduced accredited training for neurophysiology practitioners to address a national shortage of registrars in this field of medicine.

The senior team had a three-year strategic plan based on projected patient needs that focused activity towards creating resources to achieve both immediate and longer-term patient clinical needs.

The provider had a vision for patient care based on innovation, safety, and quality. Staff worked within four values of putting patients first, passion for health and care, personal accountability and the pursuit of excellence.

Good

Diagnostic and screening services

All staff we met spoke passionately about the service and what they wanted to achieve.

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.

The senior team had established a set of core values and used these to define the culture of the organisation. The values focused on patient-centred, individualised care delivered by staff supported to continually improve through reflection and assessment.

The registered manager was working to improve staff involvement in future planning of the service following feedback from the 2021 staff survey. This included planning team building days and more frequent opportunities for clinical staff who worked away from the registered provider address to meet the senior team.

The provider had an up-to-date equality and diversity policy and the senior team monitored service planning and delivery against this.

The provider had a whistleblowing policy and staff we spoke with knew how to raise concerns. The senior team had acted appropriately on a previous whistleblowing complaint to ensure staff and patients were protected from a potential risk. Staff said the working culture was one of 'no blame' when things went wrong, and they felt comfortable raising any concerns.

Senior managers held care certificates as healthcare assistants and worked clinical shifts on a rotational pattern and the medical director led occasional clinical shifts. This was part of a strategy to reduce fragmentation amongst the team and build relationships with consultants and physiologists. The registered manager noted this process had led to improved induction and training processes as a result of observations and feedback from clinical teams.

The senior team said that looking after staff was key to success and they ensured staff had access to appropriate support.

Staff said they felt valued and rewarded by the senior team. They discussed receiving support and help when experiencing personal problems and said the senior team had worked hard to help them cope during COVID-19 challenges. Staff said they felt the provider supported positive work-life balance and that managers were interactive in their leadership.

The service had a Freedom to Speak Up Guardian system that enabled staff to raise concerns confidentially.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities although did not consistently accept regular opportunities to meet, discuss and learn from the performance of the service.

The senior leadership team were responsible for clinical governance and quality management in line with the clinical governance policy. The policy included a framework for expected standards of practice and was based on nine principles for a well led service. The medical director was the governance lead.

The board held monthly meetings and reviewed operations, governance, and clinical delivery of the service. Meeting minutes demonstrated a focus on quality improvement and maintaining relationships with referring organisations. The board was focused on driving capacity whilst maintaining standards.

The senior team used a quality management system (QMS), guided by an up-to-date quality policy, to ensure governance processes led to improved care and standards of practice. The senior team used the QMS to benchmark operational and clinical governance standards, such as levels of training completion and audit outcomes. This system provided assurance of due diligence with consultants working under practising privileges and meeting key performance indicators for referring NHS trusts and independent hospitals.

The senior team used a quality objective monitoring tool to assess monthly compliance with clinical governance targets and presented these during monthly clinical governance meetings. Meeting minutes showed key staff attended and the service had good outcomes in key measures. In the same period the service achieved 100% implementation of learning outcomes identified from incidents, complaints, and feedback.

The service was accredited for quality governance and management by the International Organisation for Standardisation ISO9001:2015 standard. The senior team also maintained accreditation from the Contractors Health and Safety Scheme (CASH), which demonstrated consistently high levels of risk management across multiple sites.

Governance systems reflected the geographically spread structure of the service. For example, the provider reviewed outcomes data related to each consultant, such as in the patient feedback survey. This enabled the senior team to work with individual staff to drive consistency in care.

Meetings between the senior team and staff who worked in satellite clinics were not held regularly. One member of staff said they had never attended a meeting, whether virtual or in-person, and another member of staff said that previous poor attendance at meetings meant they were held infrequently. There was no evidence of documented impact on staff knowledge as a result of this. We spoke with the senior team about this who recognised the challenges that led to the issue. After our inspection they provided evidence of improvements, including mandatory meeting attendance.

Management of risk, issues and performance

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

The senior leadership team maintained a comprehensive and contemporaneous risk management system. This had a clear structure with well-defined risk assessments, mitigation and named responsibility. The team used a risk register to keep oversight of key risks in the service. There were five active risks at the time of our inspection relating to clinical equipment management, the impact of COVID-19, stock management, and needlestick injuries related to the type of procedures conducted. A named member of the senior team was accountable for each risk and documented regular reviews and updates.

The team used a risk assessment matrix to track potential risks to governance, operations, finance, and legal obligations. This system helped to mitigate risks that could develop if not managed, such as a lack of corporate drive and objectives, interruption to the work of the board, or a disaster that interrupted the service. In addition to this process, senior staff managed a series of individual clinic-specific risk assessments.

The senior leadership team used a quarterly quality audit to monitor standards of practice and quality of care. The audit included 118 checks or reviews of areas of care and operations. This process provided the senior team with a comprehensive oversight of the service including incidents, complaints, and lessons learned from adverse events. It reflected the geographically spread nature of the service and enabled the senior team to identify areas for governance focus. The provider set a minimum compliance standard of 83%, with 92% and above considered to be outstanding practice. In the last 12 months the service achieved 81% compliance. This was an average and quarterly results ranged from 59% to 92%. The lower compliance rates reflected pressures on local sites during the pandemic and the senior team were working to improve consistency through more frequent supervisions and improved oversight.

The registered manager was responsible for monitoring NHS Resolution Healthcare Professional Alert Notices (HPANs) as part of risk management. This meant the service had appropriate systems to place to act on alerts about healthcare professionals who may pose a risk to patients or staff.

The board had established a framework for the implementation of a medical advisory committee (MAC). The board had external representation, which would provide additional scrutiny for the MAC. This is good practice when a service offers care across multiple specialties. The senior team were ready to launch the MAC when new specialties were implemented, which would enable them to extend existing standards of governance and performance management.

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 worked within a data protection and confidentiality policy that guided them in protecting patient data in line with national guidance and the General Data Protection Regulation (GDPR).

The provider had a contracted IT support service, whose team provided dedicated support and extra training to protect against cyber-attacks after a failed attempt.

The service had undertaken a full audit of digital data protection safety and completed assurance checks issued by the National Cyber Security Centre. This included a rapid response plan in the event of a cyber-attack or breach.

The service was licenced by the Information Commissioner's Office (ICO) to manage personal digital data according to national benchmarks. A data protection officer led training and support for staff.

Staff demonstrated a consistent standard of integrity in information and data management. The senior team had established a framework to help ensure data handling was secure and within their responsibilities. They sought alternative arrangements where proposed data sharing agreements from other hospitals would breach the established management and security standards.

Data retention standards were based on individual contracts or service level agreements with referring hospitals and this varied from immediate deletion to a 12-month archive retention.

Staff were required to complete information governance training and 72% were up-to-date the time of our inspection against a target of 90%. Administration staff had completed training in GDPR and the Accessible Information Standard.

Good

Diagnostic and screening services

Engagement

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

The senior team encouraged referring clinicians, stakeholders, and hospitals to provide feedback on services. The team maintained a record of such feedback and used it to identify areas that were working well and opportunities for improvement. Feedback was consistently positive. For example, recent feedback comments noted the team delivered services with, "confidence and accuracy," and that staff were, "professional, flexible and responsive." Referring clinicians frequently provided feedback that the service was efficient and provided meaningful reports.

In the previous 12 months, survey results indicated 94% of referrers were fully satisfied with the service and said it was "excellent." There were three areas for improvement, two of which related to clarity of information on the report and the level of satisfaction reported by the referred patient. In the same period 100% of contractors said they were satisfied with the quality of the service.

The system and culture of engagement reflected the geographically spread nature of the service. The senior team shared incidents, complaints, and feedback about the service with their counterparts at host hospitals to ensure mutual learning and transparency.

The medical director maintained a relationship with consultants' responsible officers. This was part of a governance and safety process to ensure consultants maintained appropriate standards of development and review.

The provider used an established communications process to ensure governance and corporate updates reached all staff, regardless of contract or frequency of work. While there was evidence of consistent remote engagement, there was a lack of assurance the service reached all members of staff consistently. For example, one member of the team we spoke with said they had not met any staff of the same grade in the previous 18 months. They said they received regular communications from the senior team but was unaware of recent messages. We spoke with the senior team about this who implemented improved communication standards.

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.

The senior team used feedback from NHS trusts and other referring partners as a guide to learning and continuous improvement. A recent trust had noted reports were "meaningful" and helped surgeons to coordinate complex care. This was motivational to staff and helped guide the senior team in planning increased capacity or new services.

The service had introduced an innovative approach to test reporting with the critical team in an NHS trust. Working with the trust's IT team, the service provided 'real time reporting' discussions with intensive care consultants during scans that helped them make immediate critical decisions at the patient's bedside.

The service was in the process of establishing new partnerships with national neurology centres to expand mutual capacity and reduce waiting times. This resulted from approaches from referring organisations who were happy with the standard of service provided for their patients.

Good

Diagnostic and screening services

Staff who delivered tests or care in NHS trusts often worked alongside surgical teams in theatres. The medical director encouraged feedback from surgeons and theatre staff to help establish standards of care and drive improvement. A trainee member of staff said working with theatre teams was beneficial to their development and helped them to develop.

The senior team led an environment of continual learning. Two members of staff told us they enjoyed working with clinical colleagues from other specialities and clinical sessions supported their development. One member of staff said, “I learn something new every session. I think putting us [to work] with consultants is a real benefit of working here.”

The senior team had a demonstrable sense of integrity with regards to expanding the business. Clinical governance processes were set up in advance of new specialties to ensure they could be implemented and monitored safely. The team worked with clinical specialists to establish proof of concept before implementing new services. This meant the team had evidence of effective practice and safety protections before fully launching a service.

The provider had made a commercial decision to support the sustainability of NHS services as they were aware of the impact on the public health system when trained professionals left for private practice. To address this, the service invested in joint training with NHS services that upskilled clinicians, who became a shared resource for public and private care.