Bespoke Healthcare Limited

Bespoke Healthcare Limited

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?	Insufficient evidence to rate
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location. 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, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for a diagnostic procedure.
- 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 public to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not always ensure that all staff underwent appropriate checks as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The service did not always indicate which risks were accepted risks with no further actions to take to minimise those risks.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Good 	We have not inspected this service before. We rated it as good. See the summary above for details. Children and young people was a small proportion of the provider activity. The main service was diagnostics and screening. Where arrangements were the same, we have reported findings in the diagnostics and screening section. We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

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Summary of this inspection

Background to Bespoke Healthcare Limited

The service is located in a building at a Preston business park occupying two floors with secure intercom access. No patients are seen at the location which only houses the head office of the business.

The service provides diagnostic and screening procedures (neuro physiological investigations) which are non-invasive. These are provided to patients in both the NHS and independent hospitals throughout the UK where the treating hospital does not provide the service. This supports the hospitals to meet referral to treatment targets. Patients remain under the care of the client hospital or NHS trust.

The neuro physiological investigations undertaken are nerve conduction studies (NCS) or electromyogram (EMG); electroencephalogram (EEG); sleep-deprived EEG and ambulatory EEG.

These services can be variable, dependent on the needs of the client trust or hospital. For example, in some trusts they provide a full service where they receive the referral from the referring clinician, manage the appointment process, onsite clinic provision with chaperone, physiologist and/or consultant and provide the report. In other services they may only provide a physiologist who conducts the tests. Tests may also be conducted on inpatients, for example, patients in critical care.

The service also undertakes intra-operative monitoring (IOM) mainly for spinal surgery. A physiologist, employed by the service, works in operating theatres with surgical teams to manage nerve reactions during spinal, and occasionally, vascular surgery.

The service provides diagnostic and screening procedures for children at two NHS trusts in the south of England, though children only make up a small proportion of the total patients seen.

From September 2020 to August 2021, the service carried out 11,759 nerve conduction studies (NCS), electromyogram (EMG) and electroencephalogram (EEG) procedures at 19 locations. Of these, 375 (3.2%) were carried out on children and young people at two locations.

During the same period, the service also participated in 586 surgical procedures carrying out intra-operative measurements at 24 locations.

The service has a Care Quality Commission registered manager and nominated individual.

We have not inspected this location before.

The main service provided by this hospital was diagnostic and screening. Where our findings on diagnostic and screening – for example, management arrangements – also apply to other services (children and young people), we do not repeat the information but cross-refer to the diagnostic and screening service.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected this service using our comprehensive inspection methodology.

Summary of this inspection

Two inspectors carried out the inspection on 29 September 2021 with off-site support from an inspection manager. During the inspection we met with the registered manager, the co-owner and executive director, the nominated individual (governance and risk lead) and the business lead.

We reviewed five sets of patient records and five staff records. We also reviewed policies and procedures held by the provider and other associated 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.

Outstanding practice

We found the following outstanding practice:

- The service provided individualised photographic guides to patients with learning disabilities and those living with dementia to enable them to understand what would happen during their scheduled test and to have a better experience.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust 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:

Diagnostics and screening

- The service should ensure that that all staff undergo appropriate checks as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, disclosure and barring checks are valid and in date and written references are obtained for employed staff or those working under practising privileges. Regulation 19(2)(a) (3)(a)
- The service should consider reviewing the risk register to identify those risks that are accepted risks with no further actions necessary to minimise those risks.

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	Insufficient evidence to rate	Good	Good	Good
Overall	Good	Inspected but not rated	Insufficient evidence to rate	Good	Good	Good

Good

Diagnostic and screening services

Safe	Good
Effective	Inspected but not rated
Caring	Insufficient evidence to rate
Responsive	Good
Well-led	Good

Are Diagnostic and screening services safe?

Good

We had not previously inspected this service. We rated safe as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. The mandatory training curriculum included fire safety; control of substances hazardous to health (COSHH) awareness; health and safety awareness; equality diversity and human rights; emergency first aid; moving and handling of people; mental capacity act and deprivation of liberties awareness; conflict resolution; duty of care; dignity privacy and respect; disability awareness, RIDDOR awareness; communication and record keeping; complaints handling awareness; risk assessment awareness; duty of candour; coronavirus awareness and infection control and infection prevention and control advanced.

In addition, the service also ensured that all consultants working for them under practising privileges had immediate life support (ILS) training that was up to date.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service used an electronic system to deliver and monitor mandatory training and managers could monitor which staff had undertaken courses and whether the course had been passed.

At August 2021 the mandatory training completion rate for all staff was 100%. In September 2021 mandatory training was relaunched for staff with an expected completion date by the end of October 2021. At the time of our inspection the completion rate for all mandatory training was 34.16%.

Although some courses were only mandatory every two to three years, staff undertook all the courses on an annual basis as a refresher.

Good

Diagnostic and screening services

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

Staff knew how to identify adults and children at risk of, or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to talk about examples where they had made a safeguarding referral. When there were repeat cancelled appointments by a relative, the service worked with the referrer to make a safeguarding referral. Similarly, if a care home refused to make appointments for a resident, a safeguarding referral was made.

All staff were trained to level two in safeguarding adults and children. Training for staff included the PREVENT government strategy, that was developed to assist in signposting organisations where there was a suspicion of an adult or child having been radicalised, and female genital mutilation and child sexual exploitation.

The service had a safeguarding policy. However, routinely staff used the policy of the host trust or hospital to make appropriate referrals or to escalate concerns so that the trust could make a referral.

The service had a chaperoning policy and provided a chaperone in every trust or hospital that did not provide a nurse for the clinic. Chaperones were only used for adult patients.

Staff followed safe procedures for children attended for a clinic appointment.

In the hospitals where children underwent diagnostic tests, hospital staff were trained to level three in child safeguarding. They were able to support paediatric patients on the paediatric wards or in

outpatient clinics. The paediatric consent policy included the need to have a registered nurse available in clinic who was trained to level three in child safeguarding.

Where children were treated, the host provider was responsible for providing paediatric trained staff.

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 clean.

The service had procedures to ensure that clinical areas used by their staff were clean and had suitable furnishings which were clean and well-maintained.

The host trust or hospital were responsible for cleaning the environment, but Bespoke Healthcare staff checked that the environment was clean before the start of every clinic and the chaperones or physiologists completed a clinic audit/ feedback form for every clinic.

Good

Diagnostic and screening services

Staff followed infection control principles including the use of personal protective equipment (PPE). Use of PPE and hand hygiene was audited at unannounced visits to clinics to carry out a quality audit.

Staff cleaned equipment after patient contact, where possible, but also used a lot of disposable consumables that were disposed of after a single use. Patient appointments were more spread out during the pandemic to allow extra time for cleaning between patients.

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.

Clinics were visited prior to the service being set up to ensure that the environment was suitable, and an environmental audit was carried out.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients.

Staff carried out daily safety checks of specialist equipment. There was a daily clinic audit carried out by the chaperone or physiologist to ensure that the environment and equipment was safe for patients. This covered accessibility for patients; cleanliness; suitable lighting; temperature; equipment, trolleys and beds being in working order; necessary disposable equipment available and whether equipment had been checked by the clinician before use.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient when appointments were booked by telephone and on arrival at a clinic. The organisation carried out a clinical triage for each patient to determine the urgency of the referral and any special needs.

All patients were provided with a letter informing them of the details of the procedure and any risks and they were invited to contact the service for further clarity or to discuss concerns.

Pre-assessment clinical documents were completed for patients undergoing nerve conduction studies (NCS) or electromyogram (EMG) tests.

The identity of the patient and medical history was checked by the consultant on site before commencing the test procedure.

Where physiologists were attending surgical procedures to carry out intra-operative measurements, they were always included in pre-operative safety huddles and the WHO checklist.

Although the service did not conduct any imaging procedures, the service had a radiation protection supervisor to support those clinicians in surgical procedures who may be exposed to radiation from radiological procedures during

surgery. The service had provided those staff with dosimeter badges and thyroid collars. They also wore lead aprons throughout the procedure. The radiation protection supervisor was responsible for sending the dosimeters to a Manchester NHS trust that acted as the service radiation protection advisor, every three months. The radiation protection advisor provided a report of any exposure to excess radiation.

Staff we spoke with told us that hospital staff responded promptly to any sudden deterioration in a patient's health. Staff in clinics ensured that they were familiar with the location of resuscitation trolleys in the department in which they were working and could facilitate a crash team bleep should this be necessary. Staff in clinics and conducting tests on hospital wards followed the escalation policy of the trust or hospital that they were working in.

There was only one clinic that was not carried out on NHS trust premises, that was owned by Bespoke Healthcare Limited and there was an emergency transfer procedure in place to ensure that a deteriorating or collapsed patient could be transferred safely to a nearby NHS hospital.

Staff we spoke with told us that key information to keep patients safe, was shared, when handing over their care to others.

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 provider used the services of nine consultant neurophysiologists and physiologists who worked for them under practising privileges. They also employed four physiologists directly.

In addition, the intra-operative monitoring team comprised four consultant neurophysiologists who were working under practising privileges.

Where NHS trust nurses were not available to support clinics at the NHS location, the service employed four chaperones who accompanied patients during their appointments and ensured that the clinic ran efficiently. The service had a chaperoning policy.

The service had a policy that specified the minimum staffing levels for a clinic to be able to run safely and would rearrange any clinic where they could not be met.

The service actively recruited consultants and physiologists to meet the needs of new contracts with NHS trusts. Each new consultant employed under practising privileges was screened by a group on independent neurophysiologists.

In the two locations where children received tests, clinics were supported by a paediatric nurse or play specialist provided by the NHS trust.

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.

Good

Diagnostic and screening services

Records were stored securely on an electronic record system. The system held patient details, details of the referral and all correspondence to the patient and referring clinician.

Neurophysiology reports, following procedures were sent by secure email to the referring consultant and occasionally the patient's GP. They were stored on the patient record system.

Medicines

The service did not prescribe, administer or store medicines.

One EEG investigation, regarding melatonin induced sleep, involved a pre-prescription and medicine but this was prescribed and administered by the parent trust or hospital.

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.

Staff knew what incidents to report and how to report them.

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

The service had no never events and there had been no serious incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The service had had no incidents that required formal duty of candour.

Staffreceived feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. Feedback was given to staff and they were encouraged to report incidents, in team briefs and training and in a regular newsletter

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after incidents.

The service had reported 11 incidents over the last 12 months. These had been investigated. They were all no harm incidents and the majority were not related to patient safety, for example, cancelled appointments.

Are Diagnostic and screening services effective?

Good

Diagnostic and screening services

Inspected but not rated

We have not previously inspected this service. We do not rate the effective domain for diagnostic 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 protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

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

We reviewed the policies and procedures held by the service. We saw that these were held electronically and were well organised. The service held a spreadsheet for control of the policies and procedures with an implementation date, review date and next review date. All the policies had been reviewed within the timescale and were up to date.

Clinical policies were updated in line with British Society for Clinical Neurophysiology (BSCN) guidelines. The clinical governance committee were responsible for reviewing and agreeing policy changes in line with clinical guidelines. Changes to practices were discussed at the medical advisory committee (MAC) and disseminated to clinicians by email and in a newsletter.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Outcomes for patients were positive, consistent and met expectations. The service regularly received formal feedback from other providers with whom they held contracts to monitor service delivery. We reviewed feedback from providers and saw that this was very positive.

Managers and staff used the results to improve patients' outcomes.

Managers and staff carried out a programme of repeated audits to check improvement over time. Each location underwent a quality audit on at least an annual basis. This audit was in five parts and was carried out by a designated employee of Bespoke Healthcare, nominated by the board.

The quality audits included; a staff questionnaire for chaperones, clerical staff and clinicians, which included medical equipment and data storage; patient questionnaires relating to their experiences of the care provided; unannounced observation of care and practices of individuals; a review of records and a review of expected management practices against the company's designated procedures.

The service employed a clinical auditor to give independent validation. They carried out "double-blind" audits on 10 cases for clinician on an annual basis. A "double-blind" audit meant that the auditor and clinician were not identified to each other. Clinician reports were audited and given a grading of one to four, one being the most positive showing excellent practice and four meaning that a re-test was required.

Managers used information from the double-blind audits conducted by an independent advisor to improve care and treatment.

Improvement was checked and monitored.

The service was accredited by UKAS in Improving Quality in Physiological Diagnostic Services (IQIPS) and were the only independent UK neurophysiology provider with this accreditation. We examined the reports produced following the accreditation assessment and saw that the provider had complied or had made plans to comply with necessary actions identified.

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.

Managers gave all new staff a full induction tailored to their role before they started work. The service had a welcome pack for all new staff.

New clinicians, employed by the service under practising privileges or otherwise, underwent a senior review and competency assessment at their first clinic or surgical procedure (for intra-operative measurements).

Clinicians had a private social media support group in order that they could give peer support to one another. They were also supported by the clinical auditor who could give expert advice on images if required.

Managers supported staff to develop through yearly, constructive appraisals of their work. Clinicians working for the service under practising privileges were expected to complete a document on an annual basis with a summary of their appraisal received in their substantive post and mandatory training dates.

The service had a practising privileges policy that included restriction, suspension and withdrawal of practising privileges, training requirements and checklist in support of grant and renewal of practising privileges.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers could give examples of staff who had developed their skills and knowledge in areas of the business and had subsequently been promoted to a role that they could continue to develop.

Good

Diagnostic and screening services

Managers made sure staff received any specialist training for their role. The service had a policy and ensured that staff were trained on new equipment before using it in clinics and the competency of using the equipment was then subsequently assessed. Refresher training or peer review for equipment used took place every two to three years, dependent on the risk of the equipment to patient safety.

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

Multidisciplinary working

The clinicians 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.

The meetings were led by the lead clinicians, along with the clinical advisor and the advisory consultants for neurophysiology and intraoperative monitoring. The referring consultants or surgeons were also involved in the meetings where possible.

Complex cases and new practices were discussed at the meetings.

Seven-day services

Key services were available seven days a week to support timely patient care.

Although clinics did not always take place at weekends, physiologists were available to carry out tests in NHS trusts for inpatients in medical wards and critical care seven days a week. The service had a senior manager who was on call to support any clinicians working over the weekend and out of hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The provider had an adult patient consent policy that was comprehensive and had been regularly reviewed.

For neurophysiology tests, this was informed (implied) consent and was recorded by the clinician on the patient record.

For patients undergoing intraoperative monitoring, written consent was obtained separately by the surgeon, at the same time as consent to the surgery, as the electrodes were often placed in sensitive places.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Good

Diagnostic and screening services

Staff made sure patients consented to treatment based on all the information available. The provider ensured that each patient was sent written information about their procedure within two days of receiving the referral from the referring consultant. The patient information, included details of what the procedure would involve, benefits and potential side effects and necessary preparation.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

One member of staff had undertaken a mental health act course and was able to act as an advocate for patients and staff.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The provider had a separate consent policy for paediatric patients that included consent for Gillick competent children who had capacity to make decisions about their own care and treatment. The policy also included parental responsibility.

Are Diagnostic and screening services caring?

Insufficient evidence to rate

We have not previously inspected this service. We do not have enough information to rate the caring domain.

Compassionate care

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

Patients said staff treated them well and with kindness. The provider took feedback from patients. We examined patient feedback from two locations and saw that 90% and 82% respectively rated helpfulness and friendliness of staff as excellent. There were no negative ratings. One hundred percent of patients giving feedback at both locations said that the consultant had been professional with a rating of excellent.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients were asked about their individual needs during a telephone triage call, during which, the appointment for their tests was arranged. Staff used a script to ensure that no patients were missed when taking account of their individual needs.

The provider had a set of expectations for clinicians that was set out in the welcome pack for new clinicians. These included, speaking in clear, simple terms, explaining the reason for referral, explaining each step of the testing process and explaining the next stage once the test was complete.

Emotional support

We were unable to gather enough information to make a judgment on emotional support as we did not see care being delivered.

Good

Diagnostic and screening services

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. The provider made sure that all patients were sent information about their care and treatment and what they could expect on the day and afterwards.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The provider had used an electronic device to capture feedback from patients, prior to the Covid-19 pandemic. They were currently using a paper survey to gather feedback from patients or were telephoning patients as an alternative.

Patients gave positive feedback about the service. We examined patient feedback results from two locations and saw that feedback responses were 100% positive. The survey covered whether they had received enough information; whether staff were helpful and friendly; whether the consultant was professional; whether the procedure was explained to them and how likely they were to recommend Bespoke Healthcare. The majority of responses rated the service as excellent.

Are Diagnostic and screening services responsive?

Good

We had not previously inspected this service. We rated responsive as good.

Service delivery to meet the needs of local people

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

The services provided by the service in partnership with NHS trusts meant that local people had a wider choice about where to receive care.

Most patients underwent the diagnostic tests within the host hospital or NHS trust or more locally in a health centre so that patients did not need to travel long distances to specialist neuro centres to receive the tests.

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

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention. Chaperones were in clinics to give additional support to adult patients.

Managers monitored and took action to minimise missed appointments. Patients were given a choice of two or three appointment dates and could sometimes be offered a choice of venue, dependent on the NHS trust that was facilitating the service.

Good

Diagnostic and screening services

Managers ensured that patients who did not attend appointments were contacted. Missed appointments were reported back to the head office at the end of each clinic so that staff there could contact the patient to discuss this and rearrange the appointment as soon as possible.

The service relieved pressure on other departments when they could treat patients in a day. The provider was able to provide same day tests for inpatients on wards or in critical care when required.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The provider was able to facilitate appointments at the start of clinics so that patients living with dementia or learning difficulties did not have to sit in the waiting room.

Staff supported patients living with dementia and learning disabilities. The servicer provided a pictorial guide to help patients with learning disabilities or living with dementia. These were individualised to the patient and included photographs and an explanation of what the photograph showed. They included photos of the outside and entrance to the clinic; the reception; waiting room; the physiologist or consultant who would be treating them with the date and time of their appointment and all the equipment involved in the test.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community. They were able to get patient information leaflets translated into other languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service used a well-known telephone interpretation service and could also access British sign language interpreters online.

When patients required an interpreter, the service made sure that the consent process was explained by an independent interpreter, rather than a relative or carer of the patient.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service was meeting the waiting times for diagnostic tests against national standards of these being offered within a six-week time frame.

Managers worked to keep the number of cancelled appointments to a minimum. The service was able to give patients short notice appointments if there was a slot available. Chaperones called patients in advance of the clinics to remind patients of their appointment.

Good

Diagnostic and screening services

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Managers and staff worked to make sure patients did not stay longer than they needed to. A clinic monitoring sheet was completed at the end of each clinic. This recorded the time that the clinic was due to start and actual start time and the end time. Staff told us that very few clinics started late but the clinic monitoring allowed them to adjust clinic times to ensure that appointments ran on time.

The service had key performance indicators with referring providers to provide diagnostic reports within five days but were meeting their own internal three-day target. More complex intraoperative measurement reports were provided within the agreed target of five to seven days. Reports for tests undertaken on patients in critical care units were provided within 24 hours.

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. Details of how to complain was included in information sent to patients.

The service had a complaints management policy and procedure which included reference to the duty of candour procedure.

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

Managers investigated complaints and identified themes. There were very few complaints, there had only been four complaints within the last twelve months. No themes had been identified from the complaints.

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.

Staff could give examples of how they used patient feedback to improve daily practice, for example, re-wording one of their information leaflets to make it easier for patients to understand.

Are Diagnostic and screening services well-led?

Good

We had not previously inspected this service. We rated well-led as good.

Good

Diagnostic and screening services

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 owners of the business were both experienced managers in health and social care. The executive director also had a clinical background. The registered manager acted as the Caldicott Guardian for the service.

The service had a flat leadership structure and was led by an executive director and operational director (also the registered manager). They were supported by a director of intraoperative monitoring, a finance manager and a consultant clinical neurophysiologist who worked independently of the business.

Support to the leadership team was provided by a governance and risk lead (who also acted as the nominated individual), an HR manager and a business lead.

We observed that managers were approachable and supportive to staff.

Leaders could describe how staff had been empowered and supported to develop their skills and take on more senior roles. The service had paid for the HR manager to undertake a human resources course for them to progress into the role. This meant that HR services no longer had to be outsourced to a third-party company. The business lead had undertaken a governance course to develop the role and became the main contact with NHS trusts and worked on tenders and contract reviews.

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 service had a vision and strategy, although this had not been updated since 2019.

The service strategy was to deliver effective solutions which would streamline patient pathways and assist NHS trusts in reducing waiting times.

The service had a number of strategies to meet the vision of raising standards in neurophysiology. These included:

- enabling hospitals to provide a locally based service, meaning patients no longer have to travel outside their immediate area to large tertiary centres
- integration with partners to ensure that patients receive a seamless service from the point of referral through to diagnosis
- maintenance of short turnaround times for clinical reports
- greater treatment pathway clarity for patients, achieved by early booking of appointments, clear telephone communication, confirmation of all details by letter and the supply of succinct information sheets outlining test details, which minimises “did not attends”.
- comprehensive consultant neurophysiologist involvement in the delivery of tests and reports and in the development of the service.

The service had three brand values. These were:

- excellence – we are focused on delivering optimum care through continuous quality improvement, driven by a culture of learning and innovation
- experience – We are very proud of our strong and proven track record
- integrity – We are honest, ethical and transparent in our approach.

The service also had three core values. These were:

- agility – We are always responsive to client and patient needs whilst focused on cost effectiveness
- collaboration – We are dedicated to working together to achieve excellent results
- compassion – We respect our clients, patients and colleagues alike.

Culture

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

Staff told us that they felt respected and valued by leaders.

Leaders demonstrated that they valued staff. Physiologists working throughout the pandemic had been sent hampers and flowers to thank them for working through a difficult situation. Staff were given their birthday off and sent flowers. The managers paid for an annual dinner event for all staff and referring consultants to thank them for their work. They also paid for lunch once a month for staff at the head office.

All staff had private health insurance paid for by their employers.

Staff had nominated the business as employer of the year for two awards and had given extremely positive testimonials about the managers. Furloughed staff spoke of the support they had been given whilst unable to work and that managers had ensured that they had not been financially worse off.

The service had a freedom to speak up guardian to facilitate staff being able to raise any concerns in confidence.

Governance

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

The service had clear service level agreements with other providers that set out what service would be provided, the term of the contract; objectives; responsibilities of each organisation and terms and conditions, including the cost of the service, clinical governance arrangements and monitoring of the agreement.

We saw evidence that contracts were reviewed and monitored every three to six months and providers gave feedback on the quality of service. We examined two contract review forms where the NHS trusts had described the service provided by Bespoke Healthcare Limited as excellent.

The service had a clear governance structure. The board was made up of the executive director and operational director (the business owners); the governance lead; a medical advisor and head of clinical services.

The medical advisor also sat on the clinical and information governance group. They had responsibility for signing off practising privileges. The head of clinical services had responsibility for appraisals for physiologists, updating clinical procedures and peer reviews.

The service held an annual board meeting.

Day to day operational matters were discussed at an operational management group meeting that was held every two weeks. Feedback was given to staff following this meeting.

The clinical and information governance group meeting was held every three months. Any changes in practice, incidents, complaints and risks were reviewed at this meeting.

The service had a medical advisory committee (MAC) that met every three months and was attended by key clinicians and managers. It was chaired by the medical advisor to the service. The committee discussed clinical audits, new practices and standards, cases of interest and reviewed complex cases.

Additionally, there was a data protection meeting held every three months attended by the operational director, IT support, the business lead and an independent data protection officer to discuss any data protection incidents or risks. The operational director (registered manager) acted as the Caldicott Guardian for the service. The Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

As part of our inspection we reviewed whether the provider ensured that all staff underwent appropriate checks as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This includes whether staff have up to date disclosure and barring service (DBS) checks and appropriate reference checks.

We found that disclosure and barring service checks had not been updated in some instances and, in other instances, the valid DBS check was only for the consultant or physiologist's substantive place of work and was not portable to enable it to be used under practising privileges in other organisations.

We also found that some reference checks had only been obtained verbally. This is also something that was picked up in the assessment for the Improving Quality in Physiological Diagnostic Services (IQIPS) assessment.

We saw that, although the employment checks for new staff, including DBS procedure, had since been reviewed and updated, to ensure that written references were obtained for clinical staff, the service had only started to ensure that all staff had appropriate and up to date DBS checks since our inspection.

Management of risk, issues and performance

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

The service had a comprehensive risk register. The register was divided into different risk groups that included Bespoke Healthcare specific risks; business continuity; communication and confidentiality; finance; governance; human resources; safety and effective care.

We saw that the register identified high risk rating (marked in red), actions required, responsible persons, timeframe for actions to mitigate the risk, revised risk rating and a column for the date the risk was closed or accepted with all mitigating actions undertaken.

Whilst the high risks appeared to have been reviewed and reduced by actions undertaken if appropriate, there were a number of risks on the register that had not been reduced or closed and the time frame for actions to be undertaken was some time in the past.

Managers told us that risks were added to the register by the operational director and governance and risk manager and were reviewed quarterly by the leads for each area, the executive director and operational director

Information Management

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

The service had secure information systems to transfer data and reports to NHS clients. The provider employed an IT security company to carry out penetration testing every year to test the firewalls and IT security. This led to a change in the IT company employed to deliver IT and internal security measures.

The IT security company tested staff knowledge of data management in an unannounced telephone interview.

The service had a policy on mobile devices and what they could be used for.

Staff had undertaken an online data management training course and the service had data destruction and retention policy in place.

New patient pathways had a data privacy impact assessment.

The service was able to transfer data to NHS and other healthcare organisations via secure means.

Engagement

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

The service regularly met with clients to review contracts, receive feedback and to discuss how services could be improved for patients. Clinical audits enabled a two-way exchange of information with clients

Clinical staff often took part in NHS trust multidisciplinary meetings to improve care and treatment for those patients on the care pathway, for example, they had been involved in improved signage for the clinics in a trust and suggested improvements to an NHS trust website to give details about the clinic and tests provided.

The provider carried out an annual staff survey to gain views on how staff viewed the service.

Good

Diagnostic and screening services

The service had a patient reading group, a group of people of a range of ages, including a lay person who sat on the clinical and information governance group. The patient reading group reviewed any new patient documents for ease of reading and understanding and suggested any necessary improvements.

Learning, continuous improvement and innovation

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

We saw that leaders were committed to expanding the company and improving patient experience.

The service had a policy and procedure on new roles and techniques. This allowed clinicians to request a change to current practice or develop a new role or technique to support improvements in patient care and diagnosis. Any proposed changes were reviewed by the governance group to ensure they would be beneficial and were in line with national guidelines.

Staff were empowered to improve the experience of vulnerable patients, for example, developing pictorial patient information packs for patients with learning disabilities.

Staff commitment to continuous improvement and dedication to the provider was demonstrated in the testimonials in award nominations.