Unit 10.1.1 The Leathermarket

Quality Report

Unit 10.1.1, The Leathermarket, 11-13 Weston St,
London SE1 3ER
Tel: 020 3189 4604
Website: http://www.communityoutpatients.co.uk/

Date of inspection visit: 26 and 27 October, 3 November, 9 November, 11 November 2016
Date of publication: 09/03/2017

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

Letter from the Chief Inspector of Hospitals

We carried out an unannounced responsive inspection of the provider's head office on 26 October 2016. On 27 October 2016 we made an unannounced visit at an ENT clinic at the City Care Centre, Peterborough, however, the centre was not in operation that day. On the same day, we inspected an ENT clinic at Woodlands Medical Practice, Cambridge. On 3 and 9 November we carried out unannounced inspections on ENT clinics at Tynemouth Road Medical Practice and Broadwater Farm Medical Practice, London, respectively. On 11 November we carried out an unannounced inspection of the Referral Management Centre at Leathermarket.

This inspection was responsive and unannounced based on a number of concerns raised by a variety of stakeholders about Concordia Community Outpatients' clinics across England. There were particular concerns about ENT services provided within Peterborough and Cambridge Borders CCG and we visited two hubs within this CCG area.

Our key findings were as follows:

- HR records were incomplete for both clinical and managerial staff. Interviews were not collated, recorded or stored by the HR team. Further, doctors records that we reviewed did not include reference to a responsible officer, in accordance with General Medical Council (GMC) guidelines.
- A number of policies had not been reviewed within the review date and one policy ws unclear. Further, policies were not independently scrutinised, for example by a medical advisory committee (MAC), often being ratified by the individual who had written it.
- There were issues with the sharing of learning from incidents. There was a procedure in place for reporting and escalating incidents. However, there was no clear procedure in place for sharing learning. Further, staff that we spoke with said that they had not been made aware of learning from other areas of the country or other services. In addition, staff were not aware of incidents within their own CCG areas.
- A number of staff we spoke with were not aware of the whereabouts of the resuscitation equipment within the locations at which they worked. The Medical Emergency Policy stated that emergency equipment and medication should be that provided by the location at which the hub clinic is being held. However, from a sample of 14 Service Level Agreements ('SLAs') with locations we looked at, none made direct reference to the provision of emergency equipment, for example a resuscitation trolley, by the location under the title "Practice Obligations". As such, it was possible that there was no emergency equipment at locations and the governance team had no way of assuring themselves of this.
- Following consultation and treatment, patients were either referred onwards to a secondary provider, or discharged from the service. Whilst the provider worked with the relevant CCGs to measure the overall impact that the service was having on the local health economy, for example monitoring the impact on the performance of local acute outpatients as a consequence of our localised services. It did not, however, monitor the outcomes of care for indivduals discharged from the service.
- Whilst the provider benchmarked similar hubs against one another in terms of the patient demographic, and the conditions with which patients presented at the clinics, there was no benchmarking between hubs or areas across the country in terms of other factors, for example impact on the local health economy, or patient feedback.
- Referral to Treatment (RTT) times were not monitored or audited. However, this was reportedly less than six weeks, and most patients we spoke with were satisfied with their waiting times.

However,

- The majority of patients we spoke to during our inspection were satisfied with the standard of care they received.
- The service made innovative use of technology to remotely triage and assess patients and to contact them throughout their engagement with the service.

Summary of findings

- Safeguarding training was up-to-date and was embedded in the service. All of the staff we spoke to had a clear understanding of safeguarding; recognising abuse and their role in reporting and escalating concerns.
- We observed staff in hubs following appropriate Infection Prevention and Control techniques. Further, all of the hubs we visited were clean and well-ordered.
- Some staff we spoke to said they received support from their colleagues, managers and head office, including the service managers and clinical leads who were very accessible by phone or the online instant messaging system for advice.

During our inspection, we did not observe any areas of outstanding practice.

There were areas of poor practice where the provider needs to make improvements. Importantly, the provider must:

- Ensure that learning from all incidents is shared across the organisation, both geographically and across services to comply with Reguation 17 (2) (a) of the Health and Social Care Act .
- Ensure that emergency equipment is provided at all locations where it carries out clinical practice. Reg 17 (2) (b).
- Ensure that all clinical staff are made aware of the whereabouts of emergency equipment in the locations at which they are working Reg 17 (2) (b).
- Ensure that interview notes for all newly appointed staff are provided to the HR team for review, are collated and stored on file. Reg 17 (2) (d)[i].
- Ensure that all clinical staff have a Responsible Officer (RO) recorded in their HR file. Reg 17 (2) (d)[i], [ii].
- Ensure formal oversight of clinical policies and procedures, including the independent ratification of new or amended policies and procedures and ensuring policies are reviewed within the stated date Reg 17 (2) (d)[ii].

Further, the provider should:

- Introduce a benchmarking system across the hubs, to ensure that those which are not performing to the expected standard can be monitored and supported to improve.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Summary of findings

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Unit 10.1.1 The Leathermarket

Services we looked at
Outpatient services (for people of all ages);

Summary of this inspection

Our inspection team

Our inspection team was led by Margaret McGlynn, Care Quality Commission.

The team included a CQC Head of Inspection, inspectors and two specialists: a GP and a community-nursing matron.

Why we carried out this inspection

This inspection was carried out in response to a number of concerns raised about the Ear Nose and Throat service by patients, former staff members and Clinical Commissioning Groups (CCGs) with which it works.

In particular, the concerns related to governance arrangements, including a lack of local oversight and leadership in some areas, poor patient experience, loss of patient records and patients being 'lost in the system'.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we asked the following three questions of the provider:

? Is it safe?

? Is it effective?

? Is it well-led?

We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities, which it provides.

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

We carried out an unannounced focussed inspection on 26 October 2016 at Concordia's head office, Unit 10.1.1 Leathermarket. Between 3-27 November 2016 we carried out a number of unannounced inspections at the following locations; City Care Centre, Peterborough, Woodlands Surgery, Cambridge, Tynemouth Medical Practice, Tottenham and at Broadwater Farm Health Centre, Tottenham. On 11 November we visited the Referral Management Centre at Leathermarket.

At Leathermarket we spoke to board members and senior staff, service managers and administrators. At the hubs we spoke to three doctors, two healthcare assistants (HCAs), three receptionists and with ten

Information about Unit 10.1.1 The Leathermarket

Concordia Community Outpatients Limited provides Ear, Nose and Throat (ENT) and Teledermatology diagnosis clinics across England. The provider is contracted to provide services by local Clinical Commissioning Groups (CCGs). Clinics are held at various locations across a CCG area (the number of locations determined by the contract and population requirements). Clinics are held in hospitals, care centres and GP surgeries. There are individual Service Level Agreements (SLA) with each of the locations at which the clinics are held. The clinics are supported by a central head office and a Referral Management Centre, both based in Leathermarket, through which new and follow up referrals are managed and letters generated.

The ENT services offers non-urgent diagnosis and treatment in a community environment; including microsuction, endoscopy and onward referral. The ENT clinics also offer in-house audiology services and generates audiology reports for patients.

Summary of this inspection

The ENT Services employs 53 staff, both clinical and non-clinical. Governance staff work across Concrodia as a whole.

Services were overseen by a clinical lead, whilst service managers were responsible for the day-to-day running of clinics across the country. A number of service managers managed services that were allocated to them across county, or CCG boundaries.

The provider was last inspected on 23 December 2013. Following that inspection, the provider was found to be non-compliant under Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010 . We issued compliance actions requiring the provider to take action to support independent staff. The provider took steps to respond to this positively, and introduced a lone working policy and procedure.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Start here...

Are services effective?

Start here...

Are services well-led?

Start here...

Outpatients and diagnostic imaging

Safe	
Effective	
Well-led	

Are outpatients and diagnostic imaging services safe?

Incident reporting, learning and improvement

- There were no never events from 1 July to 30 September 2016. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
- There were 30 incidents of moderate harm or serious incidents from 1 July to 30 September 2016. Of these, four were identified as having presented an "extreme" risk to patients, albeit that no actual harm occurred. These were documented, and action plans put in place to mitigate against their repetition.
- Staff we spoke with were aware of the process for escalating incidents and were able to provide examples of when they had done so.
- Staff escalated incidents at hubs via the electronic incident reporting system. Clinical incidents were reported to the clinical lead for the relevant service, whilst non-clinical incidents were reported to the service manager for the relevant region. We saw the electronic reporting system, and the pathway followed by incidents that had been raised.
- We saw examples of incidents that had been reported and investigated. Patients had been kept informed of the progress and outcome of investigations.
- Service managers and clinical leads told us the process for escalating incidents further to the governance team. Incidents were discussed at governance meetings and the learning from incidents was then fed back to service managers at management meetings. It was the clinical leads and service managers' responsibility to cascade learning from incidents to their teams. However, they acknowledged that there was no formal process for this. The service managers we spoke with were able to give examples of when there had been an incident that had occurred within their team and the learning from this had been shared back to their team. However, they were unable to give examples of where they had shared learning within their team from an incident which had occurred elsewhere in the organisation or in the country, nor did we see any evidence of this. For example, one of the service managers we spoke with told us that there had been an incident at a hub in Manchester where a courier had collected Concordia patients' samples from the GP practice reception along with the practices' own blood samples. This meant that Concordia's patients' samples went to the wrong place and patients had to be recalled to give blood again. She told us that following an investigation, actions had been put in place to prevent this from happening again in that hub. However, she was not aware that the learning from this incident had been disseminated to other hubs across Concordia Community Outpatients.
- Staff we spoke with told us that they could not recall having had learning from incidents that had occurred outside of their immediate practice being shared with them. Neither could they tell us about incidents that had occurred elsewhere in the organisation or country, for example the incident in Manchester. One of the clinicians we spoke to in Cambidge was not aware of the then ongoing issues within the Cambridgeshire and Peterborough CCG.
- The clinical lead for ENT carried out a monthly audit of a randomised selection of 5% of each clinicians' records. We saw a selection of results for the audits, none of which required further action. The audit forms contained a section entitled 'red flags', where serious issues, that could amount to incidents could be highlighted.
- One of the doctors we spoke with said that he had had feedback from this audit. However, we were told that

feedback was only provided where there was an issue with the notes. This was then fed back to the doctor in question by the clinical lead, but common themes of issues in the notes were not shared.

Duty of candour

- During the inspection, we found that the 'duty of candour' (DoC) regulations were being implemented appropriately following patient harm. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We saw examples of this process and were satisfied that the process was in line with organisational policy and national guidance. Records showed that patients were involved in and updated about investigations, invited to discuss the circumstances with senior staff and received an appropriate apology for the harm caused. This was done where there were unexpected or unintended safety incidents.
- The service kept electronic records of verbal interactions and written correspondence relating to the DoC.
- The DoC was part of the mandatory training completed by all clinical staff. However, one of the doctors to whom we spoke was unaware of the DoC and its underlying principles. All of the other staff we spoke to were aware of the DoC and its principles.

Safeguarding

- All administrative and clerical staff, clinical leads, clinicians, allied health professionals (AHPs), RMC staff and service managers under took Safeguarding Children and Young People Level 1. The mandatory training matrix indicated that this was up to date, however, we did not see certificates from the training provider.
- All clinical leads, clinicians, and allied health professionals (AHP), for example Healthcare Assistants, had completed Safeguarding Children and Young People to Level 3. The mandatory training matrix indicated that this was up to date, however, we did not see certificates from the training provider.
- All administrative and clerical staff, all clinical leads, all clinicians, and practice service Managers had Safeguarding Adults Level 1 as part of their mandatory training. The mandatory training matrix indicated that this was up to date, however, we did not see certificates from the training provider.
- All clinical leads, clinicians, and AHPs undertook Safeguarding adults Level 2 as part of their mandatory training. The mandatory training matrix indicated that this was up to date, however, we did not see certificates from the training provider.
- One of the RMC team told us that patients failing to attend appointments could be a trigger for a safeguarding referral, particularly when children did not attend more than one scheduled appointment. He told us that he had escalated such an incident to the patient's GP and the clinical lead for the service.

Medicines management

- In the hubs which we visited, the only medicine used was lidocaine spray to numb the throat during endoscopy. This was securely stored in a trolley in the clinic, the keys to the trolley were held by the HCA. All of the sprays we saw were in date.

Safety of equipment and facilities

- The consultation and treatment rooms in the hubs we visited were clean, tidy and free of clutter. Where the rooms were used by the provider only on certain days, and by other providers on other days, their equipment was securely stored on site.
- Decontamination of the endoscope after each patient was the responsibility of the HCA on duty, and they followed a three-step antiseptic process. At the hubs we visited we saw a log book recording the de-contamination.
- One doctor told us that the disposable nozzles for the micro-suction device used to clear patients' earwax had had sharp edges. He said that he had reported this to his Service Manager via the electronic system and micro-suction nozzles were now provided by an alternative supplier. He was unaware of the arrangements for procurement at other hubs.
- The Medical Emergency Policy stated that emergency equipment and medication should be provided by the location at which the hub clinic is being held. However, from a sample of 14 SLAs with locations we looked at,

none made direct reference to the provision by the location of emergency equipment, for example a resuscitation trolley, under the title "Practice Obligations".

- At one of the hubs we visited, staff were unaware of where emergency equipment and medication was stored. They told us that if a patient collapsed, they would seek assistance from the location staff, including as to the whereabouts of the resuscitation trolley.

Records management

- All records were electronic. The electronic record keeping system was secure, with password protection. During our inspections of the head office and the RMC we saw staff locking their screens when leaving their desks.
- Clinicians had access to the patient's referral notes from their GP through the electronic database. It was the responsibility of clinicians to complete the notes of their consultations with patients during the clinic. The system had checks in place to ensure all relevant aspects of the notes were completed. For example, it was not possible to progress to the next screen without having completed all of the relevant fields.
- Clinicians' notes were used to generate letters to patients, or referral letters to specialists. All such letters were sent to the patient's GP. All correspondence sent to patients was stored on the electronic record management system. We saw examples of this.

Cleanliness and infection prevention and control

- In the 14 sample SLAs we saw, infection prevention and control was the responsibility of the location at which the clinic took place. The SLAs stipulated that copies of infection prevention and control audits were to be provided to Concordia. We saw a sample of completed audits that had been returned to Concordia.
- There were handwashing facilities in the clinic rooms we visited and hand gel available in reception areas and corridors (provided by the location in which the clinic was taking place).
- All of the staff we observed in clinical areas adhered to the "bare below the elbows" protocol.

Mandatory training

- The mandatory training matrix listed the mandatory training requirements for all staff roles. Mandatory training included fire training and health and safety. We had sight of the mandatory training matrix following our inspection. We did not see any mandatory training certificates, however, only the matrix indicating that it had been undertaken. During our inspection, the HR team were unable to access or provide us any information regarding mandatory training completion rates.
- All clinicians were up to date with their mandatory training. All HCAs were up to date with their mandatory training, except for three who were currently revalidating their training. All administrative support staff were up to date with their mandatory training, except for two managers who had their courses in basic life support booked. All administrative staff were up to date with their mandatory training, except for two who were undergoing revalidation.
- Training was delivered by e-learning or face-to-face workshops. There was no information in the mandatory training matrix as to whether particular training had been delivered face-to-face or via e-learning.

Assessing and responding to patient risk

- We saw the Medical Emergency Policy, updated 13 March 2016. The policy had been saved with "Track Changes" edits. Dated 31 October 2016, making it unclear as to the definitive, up to date policy The policy stated that emergency equipment and medication should be that provided by the location at which the hub clinic is being held. At one of the hubs we visited, staff were unaware of where emergency equipment and medication was stored. They told us that were a patient to collapse, they would seek assistance from the location staff, including as to the whereabouts of the resuscitation trolley.
- From the 14 SLAs with locations we looked at, none made direct reference to the provision of emergency equipment by the location, for example a resuscitation trolley, under the title "Practice Obligations".
- There were different exclusion criteria for each of the services and hubs, dependent on the contract with the CCG. There was no universal exclusion criterion based on age.

Outpatients and diagnostic imaging

- Referrals were triaged remotely, based on the referring doctor's referral letter and the patients records. Patients who were not suitable under the relevant exclusion criteria or who were not suitable for the service offered would be referred back to the original referrer. Patients could also be flagged as requiring an appointment urgently by the triage team. However, there was no formal process for this and no key performance indicator ('KPI') for urgent referrals to be made.
- Patients who had been referred by Concordia for surgery would be offered follow up appointments with the service to assess the impact of the procedure. We spoke to a patient attending such an appointment.
- We saw the providers' chaperone policy. The HCAs that we spoke to demonstrated an awareness and understanding of this policy.
- The 14 sample SLAs we saw indicated that providing chaperones to patients was the responsibility of the location where the clinic was taking place.
- Staff told us they knew how to identify a deteriorating patient and knew how to escalate when needed. There were different procedures in place for doing so at each of the hubs, according to the SLA.

Staffing levels and caseload

- Between December 2015 and November 2016, there were 29,132 'episodes of care' provided.
- The number of patients seen at clinics varied widely from hub to hub and between the services. At one of the ENT clinics we visited, there were 15 patients for one clinician on the list that day. The clinician told us that he did not have sight of the patient list prior to arrival at the clinic and therefore would not have an idea of the caseload until the list commenced. Further, this meant that the clinician could not plan ahead for patients or procedures that may take longer. The service did not monitor patient waiting times at the clinics.
- Due to the variation in demand aross the hubs, the provider had a flexible workforce todeliver services across the UK. To facilitate this there was a significant number of self-employed and directly booked locum medical staff. There was a protocol for using the same locum staff in the same location wherever possible, in order to ensure consistency and continuity.
- There were 651 ENT clinics in August, September and October 2016. There was a 2% cancellation rate. The highest cancellation rate was for West Hampshire in August 2016, when 17% of clinics were cancelled. No reason was given for this cancellation.In Sussex 7% of clinics were cancelled in August 2016 when the clinician left and the service was unable to find a replacement in time.
- We spoke to a locum doctor in Tottenham, who worked only occasional shifts for the provider. He told us that he felt supported and enjoyed working with Concordia.
- One of the HCAs we spoke to in Cambridge told us he also worked as an HCA at Concordia clinics in Sussex when there was a requirement.
- Staff we spoke with said there was always enough staff available to ensure patients had sufficient time and never felt rushed during appointments.

Major incident awareness and training

- In the 14 SLAS with locations that we saw, provision of facility services induction, including fire safety and emergency procedures, was the responsibility of the provider.
- We saw the business continuity plan. This identified potential risks, for example a "full loss of computer system" and action plans to minimise the impact of such risks.

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- Policies and protocols were drafted in accordance with relevant national guidelines, including those of National Institute for Health and Care Excellence.
- There were different exclusion criteria for different hubs. There was no universal exclusion criteria based on age.
- Newly referred patients' notes and referral letters were triaged to ensure that they met the criteria for treatment by the service.
- Staff had access to policies and procedures through the intranet. At least one of the policies we saw, however, had 'tracked changes' in it that had not been finalised, meaning that it was unclear exactly what the up to date policy was.

Outpatients and diagnostic imaging

Pain relief

- In the ENT hubs which we visited, the only pain relief was lidocaine spray, used to numb the throat during endoscopy. This was securely stored in a locked trolley at the clinic the keys were held by the HCA. All of the sprays we saw were in date.

Use of technology and telemedicine

- Patients' referral notes were triaged remotely by clinicians working from home on the service's secure IT system, to assess their suitability for treatment by the service.
- In addition to appointment letters, patients received SMS text messages informing when their next appointment was. Patients could also be sent reminders to attend their appointments.
- The RMC had system listing all of the queued calls, allowing staff to manage busy periods, by answering calls on behalf of other team members. This list could also be audited to monitor call response times. The system also logged the number of missed calls. RMC staff told us that missed calls were uncommon. One of RMC team told us that all missed calls were followed up with a call back the next working day.
- The online recording system used diagnosis codes and subcodes, to allow for the generation of accurate, detailed letters to patients, and for onward referrals.

Approach to monitoring quality and people's outcomes

- Following consultation or treatment, patients were provided with a paper feedback form to return to the provider via a freepost envelope. The form also included a link to an online feedback form.
- The results of the feedback forms were collated on a monthly basis against the clinic to which they related. The answer to the question 'How likely are you to recommend our servicews to friends and family if they needed similar care or treatment?' varied widely across the country, as did the number of patients responding to requests for feedback. In May 2016 in Cambridge, 47.4% of patients said that they would not recommend the service, whereas in the same month in Haringey 94.7% of patients said that would recommend the service. In both cases there were 19 respondents to the survey.
- We requested evidence of any actions arising from patients' feedback. Initially, we did not receive any. However, we were later told by the governance team that the provider had increased the numbers of hubs, improved signposting, increased the appointments desk opening times, introduced SMS text reminders for appointments and introduced evening and weekend surgeries to accommodate patients' lifestyles.
- We were told that the provider sought to measure patient outcomes in a number of ways and completed reports in respect of a number of metrics. We were provided with extracts from reports, however, these also related to the demographics of patients and the care and treatment they had accessed, as opposed to the outcome of the treatment for the patient. Therefore, the service did not evidence that they measured the impact or effectiveness of the treatments provided.

Outcomes of care and treatment

- The provider recorded the treatments provided and patient demographics across each of the CCGs within which it operates. We were told that the provider sought to measure patient outcomes in a number of ways and completed reports in respect of a number of metrics. We were provided with extracts from reports, however, these also related to the demographics of patients and the care and treatment they had accessed, as opposed to the outcome of the treatment for the patient.

Competent staff

- The Recruitment and Selection Policy and Procedure set out guidelines for appointing competent staff.
- The clinical lead reviewed CVs for doctors' applications to ensure they had the correct skill set and their GMC registration was checked by the HR team. Once a candidate had been approved, there was a telephone interview. We were told that the telephone interview was used as a means to ensure applicants spoke English to the required standard, although there was no formal means for doing so. Following the telephone conversation, successful candidates for part time roles would then be appointed and undergo induction. Applicants for full time roles were required to attend a further face to face interview with the clinical lead and a service manager, the policy indicated that it was desirable but not compulsory for a member of the HR

team to attend these interviews. Notes of the interviews were to be returned to the HR team. The HR team told us that they did not always receive the notes of interviews.
- All relevant documentation for a new employee, for example copies of their qualification certificates was meant to be stored on their HR file. We reviewed a number of HR files for doctors. The records were incomplete. There was no record of who the doctors' responsible officers were or of when their GMC revalidation was due This was fed back to the provider during the inspection.
- The staff that we spoke to at the RMC had a good understanding of the work undertaken in the hubs.
- All staff we spoke with were positive about the training and development opportunities they had access to.
- There was no formal performance management policy for clinical staff.
- The HR manager was unable to locate the HR files for any of the directors, meaning that there was no information available as to what pre-appointment checks had been carried out.

Multidisciplinary working and coordination of care pathways

- We spoke with an ENT pathway manager working in the RMC. He demonstrated an in depth understanding of the pathway for ENT referrals.
- Teams within the RMC were based on the pathways for which they were responsible, rather than the geographic location of services. As there were different contracts with different CCGs, offering slightly different services and with their own unique exclusion criteria, staff within the teams had to share knowledge of different contracts and hubs.

Referral and discharge

- Patients could be referred to the service either through their GP or through a hospital within the CCG where the service was offered.
- There was no formal record of referral to appointment time, nor was this audited. Expected referral to treatment times varied according to the contracts with individual CCGs. However, most of the patients we spoke to were impressed with the referral to first appointment time. Most of the patients had had their first appointment within two weeks of referral.
- On the electronic records system, in order to close a patient's records, a clinician would have to whether the patient was to be referred on, and to what service; should have a follow up appointment; or was to be discharged from the service.
- Where a patient received an onward referral or was discharged, it was the responsibility of the RMC to generate and send letters to patients and their GP or the consultant to whom the patient was referred. We saw examples of such letters.
- Failure to attend scheduled appointments could lead to a patient being discharged from the service. The RMC staff that we spoke to said that children and adults known to be vulnerable would never be discharged for a failure to attend. We did not see a specific reference to this in policy, however, the service's Safeguarding Children Policy recognised that where a child is delayed in seeking medical help this may be a sign of abuse by neglect.

Availability of information

- Clinicians could access patients' notes and referral letters with ease through the electronic records system. One of the doctors told us that if there was ever anything missing from the notes, he could contact the service manager, and the information would be forwarded to him.
- Staff had access to all relevant policies and procedures on the intranet. There were also physical copies of policies and procedures supplied to each of the hubs. However, the online version of at least one of the policies had been updated without sign off during our visit, meaning that there would have been a difference between the physical and online policies at that time.

Consent

- None of the ENT services carried out procedures sufficiently complex to require written consent. All of the doctors to whom we spoke however understood the importance of gaining verbal consent from patients for examination and procedure. They were clear that they explained the examination or the procedure, its purpose, risks and intended outcomes and gained verbal consent before doing so. Verbal consent was not recorded in the patients' notes that we reviewed.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services well-led?

Leadership and culture across the provider

- Overall leadership was provided by the Concordia Health Group board.
- There were service leads for each of the core services, including Ear, Nose and Throat.
- Board members and senior staff were visible in the head office at the time of our unannounced inspections.
- Senior staff welcomed the opportunity of the CQC inspection and said that they saw it as an opportunity to drive improvement. They recognised the need for more robust systems to monitor the standard of care provided across the hubs.
- Some staff we spoke to said they gained job satisfaction and felt they worked in an open and transparent culture. They told us the team was supportive and caring towards each other. They were proud of the impact they had on patients' lives.
- Some staff we spoke to said they received support from their colleagues, managers and head office, including the service managers and clinical leads who were very accessible by phone or the online instant messaging system for advice.
- We received correspondence from some former employees stating that clinicians felt unsupported, that senior staff and board members did not listen to their concerns and that governance structures were insufficient to protect patient safety.
- The recruitment and selection policy and procedure stated that "junior posts will always be advertised internally in the first instance, to provide continuous development of existing members of staff unless the Management team agrees that this is not appropriate due to the specialist skills required for the post involved". We spoke to a number of members of staff in the head office and the RMC who had been promoted through this system. They said that they had been very well supported in doing so.

Vision and strategy

- Concordia Community Outpatients vision was to 'aspire to be the UK's leading champion of patients, commissioners and employees by delivering services that are clinically excellent, that reach all walks of life, and that make the best use of public money. We will evolve to meet the ever changing needs of the NHS, our employees will be proud to deliver patient-centred, responsive care, and the NHS will be better for it.' Staff we spoke with reflected this vision.
- At the time of inspection, the provider had paused its programme of seeking and acquiring new contracts in order to consolidate the services it provided.
- The RMC was developing a plan to provide a seven-day service. Staff that we spoke to were aware of this plan. Newer staff said they had been made aware at the tome of their recruitment that they would be expected to work weekends. Staff were confident that the new working hours would be fair and manageable.

Governance, risk management and quality measurement

- Governance for the ENT service was the responsibility of Concrodia's overall governance team, working in conjunction with the clinical leads for the services. The Governance Team consisted of a the Director of Governance, the Director of Medical Services, the Head of Governance, a Training Officer, two Governance Officers and two Junior Governance Officers
- There was a four person governance team. This consisted of the Director of Governance and the Director of Medical Services as well as one senior and one junior governance officer. The Governance team worked in conjunction with the clinical leads across all Concordia services.
- The governance committee, consisting of the heads of governance and the relevant clinic leads met on a monthly basis, to discuss incidents and changes to policies. We requested but were not provided with minutes of the governance committee meetings.
- The governance team reported to the board on at monthly meetings. A standing item on the agenda was the review of the governance committee meeting minutes. We saw the minutes of board meetings.
- We saw an Integrated Governance Policy, which set out the roles and responsibilities of the governance team. This policy had been issued in October 2015 and reviewed in October 2016 by the medical director, who is a member of the governance team.
- Policies were written and updated by either the director of governance or the director of medical services.

Policies were not independently reviewed or authorised, with the two senior members of the governance team either reviewing and authorising each others' policies or their own.

- We saw the Medical Emergency Policy, updated 13 March 2016. The policy had been saved with "Track Changes" edits. Dated 31 October 2016, after our intial unannounced inspection, making it unclear as to the definitive, up to date policy.
- We reviewed the provider's risk register. There was no separate clinical and non-clinical risk register. However, risks were identified within the register as being "commercial", "clinical", "operational" or a combination of the three.
- The governance lead had overall responsibility for the risk register. All of the risks on the register had an action plan against them to mitigate the risk, with a planned completion date. For example, one of the risks identified on the register was that the "organisational structure of the [Referral Management Centre ('RMC) creates blurred lines of accountability, and prevents the development of specialist expertise in areas of the pathway." At the time of our inspection, there had been a restructuring of the RMC, in line with the action plan set out on the risk register. This action had been planned for completion on 30 September 2016, and so was on target.
- Whilst the governance team acknowledged that there were concerns within the service, and the need to drive improvement, the risk register did not identify the same issues that were drawn out in the inspection.
- We were told that service managers within the same core service (for example ENT) visited each others hubs to carry out a peer review. However, this was not done to any regular timetable and there was no minimum requirement of visits. We did not see any formal records of these visits.
- There was no benchmarking system for individual hubs across the country, or benchmarking of clinics provided within one CCG against each other.
- There were appropriate indemnity insurance arrangements covering all practitioners across the service.

Public and staff engagement

- We saw patient feedback forms to be provided to patients following consultations. In Cambridge staff told us that these were provided to all patients as they left the clinic. In Tottenham, none of the patients we spoke to following their appointments had been provided with the forms, albeit that none of them said that they had requested them. Feedback forms could be returned via a freepost envelope. Further, the forms provided directions to an online feedback form and a scannable QR code. The results of the feedback forms were collated on a monthly basis against the clinic to which they related. We did not see any evidence, nor were we told about any action that had been taken in response to poor feedback from patients, or comments or suggestions made on the forms.
- The Patient Satisfaction Questionnaire invited patients who wished to join the Patient Involvement Group to provide their contact details. None of the clinical staff members we spoke to were aware of the Patient Involvement Group.
- We were told that the Patient Involvement Group was based in Bedfordshire and administered by a contractor on behalf of the service. We requested but were not provided with any minutes of the groups' meetings. It was not clear how often meetings took place, whether these were physical or via telecommunication and the number or location of patients involved.
- We were told that as the majority of patients were seen at a clinic as a 'one stop shop' they were unlikely to want to attend a Patient Involvement Group.
- The majority of the patients we spoke to said that they felt involved in their care. One patient told us that he had been given the option of being referred for surgery, but had chosen to continue treating his condition medically. He said that he had been supported to do this by the service and given follow up appointments to monitor his progress.
- All staff, regardless of where in the country they were working, were inducted at the head office in London, allowing them to meet members of the senior leadership team. Further, the Christmas parties were held in London for all staff, with travel and accommodation provided.
- The doctors whom we spoke to told us that there were core service telephone meetings held for all of the clinicians and the clinical lead for each department to discuss common issues and themes. One doctor told us that these were held monthly, whilst others said that they were held on an ad hoc basis.
- There was no set requirement for the frequency of Service Manager's visits to the hubs under their care.

However, the doctors we spoke to said that they spoke with their Service Managers via telephone or direct messenger at least once daily when they had clinics. This was confirmed by the Service Managers we spoke to. All of the doctors we spoke to said they had a positive working relationship with the clinical leads and their service managers.

- One of the doctors we spoke to told us that he had made suggestions for improvements in processes. He said that he had not yet received a response to his suggestions, but was confident they were being looked at.

Innovation, improvement and sustainability

- At the time of inspection, the provider had paused its programme of seeking and acquiring new contracts in order to consolidate the services it provided.
- On 19 August 2016, the provider terminated its contract with Lincolnshire East Clinical Commissioning Group, having given notice in August 2015. This was because the patient groups within East Lincolnshire were too small, and spaced too far apart to be profitable, given the cost of staffing and equipping the hubs.
- At the time of our inspection, there had been a restructuring of the RMC, in line with the action plan set out on the risk register. This action had been planned for completion on 30 September 2016, and so was on target.

Outstanding practice and areas for improvement

Outstanding practice

There were no areas of outstanding practice.

Areas for improvement

Action the provider MUST take to improve

The provider must:

- across services to comply with Reguation 17 (2) (a) of the Health and Social Care Act .
- Ensure that emergency equipment is provided at all locations where it carries out clinical practice. Reg 17 (2) (b)
- Ensure that all clinical staff are made aware of the whereabouts of emergency equipment in the locations at which they are working Reg 17 (2) (b)
- Ensure that interview notes for all newly appointed staff are provided to the HR team for review, are collated and stored on file. Reg 17 (2) (d)[i].
- Ensure that all clinical staff have a Responsible Officer (RO) recorded in their HR file. Reg 17 (2) (d)[i], [ii]
- Ensure formal oversight of clinical policies and procedures, including the independent ratification of new or amended policies and procedures and ensuring policies are reviewed within the stated date Reg 17 (2) (d)[ii].

Action the provider SHOULD take to improve

The provider should:

- Introduce a benchmarking system across the hubs, to ensure that those which are not performing to the expected standard can be monitored and supported to improve.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Learning from incidents was not shared across the organisation. There was no clear procedure for sharing learning to staff working in hubs. The Medical Emergency Policy stated that emergency equipment and medication should be that provided by the location at which the hub clinic is being held. However, of 14 sample SLAs with locations we looked at, none made direct reference to the provision of emergency equipment, for example a resuscitation trolley. HR records for clinical and other staff were incomplete. Interviews were not routinely collated, reviewed or stored. There were no records of the Responsible Officer (RO) for the doctors employed. The provider must take action to: • Ensure that learning from all incidents is shared across the organisation, both geographically and across services. Reg 17 (2) (a). • Ensure that emergency equipment is provided at all locations where it carries out clinical practice. Reg 17 (2) (b) • Ensure that all clinical staff are made aware of the whereabouts of emergency equipment in the locations at which they are working Reg 17 (2) (b) • Ensure that interview notes for all newly appointed staff are provided to the HR team for review, are collated and stored on file. Reg 17 (2) (d)[i]. • Ensure that all clinical staff have a Responsible Officer (RO) recorded in their HR file. Reg 17 (2) (d)[i], [ii]

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- Ensure formal oversight of clinical policies and procedures, including the independent ratification of new or amended policies and procedures and ensuring policies are reviewed within the stated date Reg 17 (2) (d)[ii].