Unit 10.1.1 The Leathermarket

Quality Report

Unit 10.1.1, The Leathermarket, 11-13 Weston St,
London SE1 3ER
Tel: 02031894604
Website: www.communityoutpatients.co.uk

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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

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Summary of this inspection

Our inspection team

The team that inspected this service was led by an Inspection Manager Margaret McGlynn comprised of a CQC lead inspector, a CQC assistant inspector, and a specialist advisor with expertise in governance. The inspection team was overseen by Helen Rawlings, Head of Hospital Inspection for South London and South Central.

Why we carried out this inspection

We carried out this focused inspection to follow up on the requirement notice that we issued following our last inspection in October and November 2016. Specifically that the provider must:

- Ensure that learning from all incidents is shared across the organisation, both geographically and across services to comply with Regulation 17 (2) (a) of the Health and Social Care Act (2012);
- 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].

In addition, a the previous inspection, we stated that the provider should:

- Introduce a benchmarking system across the hubs, to ensure that those which are not

How we carried out this inspection

We carried out an unannounced visit to Concordia's head office at Leathermarket, London on 6 and 7 June 2018. We spoke with 16 staff, including the senior leadership team, governance team, HR staff, service managers and administrative staff. We examined data relating to performance and service provision nationally and had sight of policies and HR records. In addition, on 21 June 2018, we visited the Ear Nose Throat (ENT) service held at Tynemouth Road Medical Practice in Tottenham, London, where we spoke with a doctor and healthcare assistant.

Information about Unit 10.1.1 The Leathermarket

Concordia Community Outpatients Limited provides Ear, Nose and Throat (ENT), Dermatology, Ultrasound and Cardiology services in clinics across England. In this inspection, we focussed on the ENT services as it was that service that formed the basis of our 2016 inspection and therefore, it is to that service that the requirement notice relates. The provider is contracted to provide services by local Clinical Commissioning Groups (CCGs) under contract. 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, based in Leathermarket and a Referral Management Centre, also based in Leathermarket, through which new and follow up referrals are managed and letters generated.

Summary of this inspection

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

The ENT Services employs 53 staff, both clinical and non-clinical. Governance staff work across Concordia 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. Since our last inspection, the structure had changed, meaning that service managers were responsible for 'end to end' service provision within a given area, including having line managerial responsibility for those administrative staff assigned to a given service.

The provider was last inspected in on 26 and 27 October, 3, 9 and 11 November 2016.

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.

The service met all of the stipulations of the requirement notice, which has now been lifted. The service has made significant improvements in respect of governance and oversight practices to ensure a high level of care provision for patients.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Outpatients

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are outpatients and diagnostic imaging services safe?

Detailed findings

As this was a focussed inspection, we looked only at those Key Lines of Enquiry which related directly to those areas relevant to the requirement notice.

Incident reporting, learning and improvement

- At our inspection in October and November 2016, we identified concerns surrounding the sharing of learning from incidents. In particular, we were concerned that learning from incidents was not being shared across the organisation, both geographically and, where relevant, between services. At that time, we issued a requirement notice, that learning from all incidents should be shared across the organisation, both geographically and across services. We were satisfied that the service had met this requirement.
- The service had an effective system for staff to report incidents and for them to be monitored. The service had introduced a custom-built electronic incident reporting platform to which all staff in the organisation had access. This meant that all staff were able to report incidents. Once reported, incidents could be assigned to the relevant service manager for investigation and/or escalation. The governance team reviewed all incidents that were reported. In addition, they could monitor the progress of the investigation of the incident and development of action plans.
  - Once learning from an incident was agreed by the governance team, it could be disseminated to all relevant staff via the electronic portal. We had sight of incidents that had been investigated and saw that the learning from the incidents was now being shared nationally and across services where relevant. Where the learning was shared electronically as a document to be read by staff, they were required to click to indicate that they had read the learning that was sent to them. Staff who did not indicate that they had read the learning within a given timeframe would receive an automatic reminder to do so. In addition, the clinical director informed us that where staff did not indicate that they had read the learning within the allotted time frame, he would email them personally to ask them to do so. We saw examples of this.
  - All of the staff we spoke with, both at the head office and in clinic were able to describe changes to their practice which had arisen from learning from an incident. They said that they felt confident to raise concerns and always received a response.

Environment and equipment

- At our previous inspection, we had concerns about the availability of emergency equipment in the locations in which clinics took place, and staff's awareness of the whereabouts of the equipment. Our requirement notice stated that the service must ensure that emergency equipment was provided at all locations where it carries out clinical practice and that it must ensure that all clinical staff are made aware of the whereabouts of emergency equipment in the locations at which they are working. The service met this requirement.
- The provider ensured that emergency equipment was provided at each of the locations that it provided services. Emergency equipment in each of the locations at which the clinics were held was provided and maintained by the main provider operating out of the location, this was set out in Service Level Agreements (SLA)s with each of the locations. Following our last inspection, the service had introduced a system of "unannounced" inspections of clinics, to ensure that each clinic met various standards in key areas of focus for the particular inspection as well as adhering to the requirements set out in the SLA with the provider at

whose location the service was based. We had sight of 12 reports from across the country, where the requirement was met. Staff we spoke with in clinic were able to guide us to the emergency equipment. They told us that they were aware of the whereabouts of emergency equipment in the other locations in which they worked. Making staff aware of the equipment also formed part of the induction process for new starters, which we had sight of.

Are outpatients and diagnostic imaging services effective?

Detailed findings

As this was a focussed inspection, we looked only at those Key Lines of Enquiry which related directly to those areas relevant to the requirement notice.

Competent Staff

- At our previous inspection, we found that the service did not keep records of interview notes for doctors or service managers at the time that they were recruited. We issued a requirement notice that they must ensure that interview notes for all newly appointed staff are provided to the HR team for review, are collated and stored on file. The service met this requirement. During our inspection, we had sight of 10 HR files, all of which had interview notes recorded in them. Where a member of staff had been with the service before the requirement notice was issued, the service had included on their HR file a waiver, indicating that the interview notes were not available. HR staff we spoke with told us that the interviews provided an opportunity to asses an individual's English language ability. They said that all new staff would meet with a member of permanent staff in person prior to commencing work at Concordia.
- At our previous inspection, we were concerned that a significant number of medical staff did not have their Responsible Officer (RO) recorded in their HR file or elsewhere by the service. All doctors working in the UK are required to have an RO by the General Medical Council (GMC). Employers should be aware of a given doctor's RO in case they are required to contact them to confirm the doctor's credentials. As such, following the previous inspection, we issued a requirement notice that the provider must ensure that all medical staff have an RO listed on their HR file. The provider has met this requirement.
- We were provided with a list of all of the doctors working for the service and their RO, this meant that the service was assured that the doctors were complying with this requirement of their registration.

Are outpatients and diagnostic imaging services caring?

Caring did not form part of this focussed inspection.

Are outpatients and diagnostic imaging services responsive?

Responsive did not form part of this focussed inspection.

Are outpatients and diagnostic imaging services well-led?

As this was a focussed inspection, we looked only at those Key Lines of Enquiry which related directly to those areas relevant to the requirement notice.

Governance, risk management and quality measurement

- At our inspection in October and November 2016, we identified concerns relating to the quality measurement across the service. In particular, we were concerned that there was no way of assessing the performance of each of the clinics objectively. We therefore issued a Requirement Notice that the service must 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. The service has met this requirement.
- We saw how the service's new electronic governance system allowed for the benchmarking of services (made up of one or more hub within a defined contract with a trust or Clinical Commissioning Group (CCG)) against each other in a range of metrics, including number of serious and other incidents raised, number of complaints, mandatory training

compliance and meeting the specific key performance indicators (KPI)s stipulated in the service's contract. Although each of the services had slightly differing KPIs, according to the requirements of the contractor, the hubs could still be effectively benchmarked on their ability to meet the KPIs as a whole. In addition, the benchmarking process took account of the geographic and demographic challenges presented in the areas they were based.

- The governance team had oversight of how each of the hubs were operating. Service managers were required to compile a weekly report reflecting their performance to be presented to the senior service managers. Every four weeks, these reports were compiled into a monthly report, which would then be discussed at the monthly governance meetings, attended by service and senior service managers, the governance team and the clinical lead. We reviewed the minutes of four monthly meetings, and had sight of the monthly reports and evidence that they had been discussed.
- The service had introduced an effective benchmarking system to measure the performance of each of the hubs. Service managers told us that benchmarking of the services was effective in inspiring them and their staff to achieve excellence. They said that where their services performed badly they would be afforded the opportunity to explain the reason for the score and then supported to make improvements. They said that this often took the form of advice or budding with the service manager of a high performing service. Service managers told us that where they performed well, they were praised and their contribution, as well as that of their staff was recognised. For example, the governance team's monthly newsletter contained a section celebrating best practice, innovation in clinics or positive outcomes. We had sight of four governance team newsletters.
- At our previous inspection, we also identified concerns relating to the service's policies and procedures. In particular, policies and procedures were not always reviewed in line with the stated date for review, there were inconsistencies in the versions of policies available to staff and they were not always independently reviewed outside of the individual or individuals that had written them. Following the inspection, we issued a requirement notice that the service must 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. This requirement had been met.
- All of the policies and procedures were now available electronically through the staff portal, meaning that all staff had access to the most up-to-date version of the policy. We had sight of the electronic system recorded when the policies were nearing their review date and sent a reminder to the governance team.
- Policies were written by members of the governance team working in conjunction with relevant team members in accordance with the area to which the policy related. They were then reviewed by the governance committee, which included senior staff from across the organisation. We had sight of the minutes of meetings of the committee, and saw that policies had been reviewed and ratified. In addition, we had sight of five policies, all of which were complete, and had been reviewed within the required period.