Harborne Court

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?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good overall. The service has not been inspected before.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Harborne Court (also known as HealthHarmonie Ltd) as part of our inspection programme.

As part of this inspection we visited the provider's head office; Suite B, Harborne Court 67-69 Harborne Road, Birmingham, West Midlands B15 3BU and five sites from which services were delivered. The sites we inspected were:

- Cobridge Community Health Centre, Church Terrace, Cobridge, Stoke-on-Trent, ST6 2JN. Inspected on 7 November 2019
- Sparkhill Primary Care Centre, 856 Stratford Road, Sparkhill, Birmingham, B11 4BW. Inspected on 13 November 2019
- Monkspath Surgery, 27 Farmhouse Way, Shirley, Solihull, B90 4EH. Inspected on 18 November 2019.
- Marysville Medical Practice, Brook Street, Shrewsbury, SY3 7QR. Inspected on 20 November 2019.
- Bentilee Neighbourhood Centre, Dawlish Drive, Bentilee, Stoke-on-Trent, ST2 0EU. Inspected on 6 December 2019.

This service is registered with CQC to provide the following regulated activities: Diagnostic and screening procedures, Surgical procedures and Treatment of disease, disorder or injury.

The chairperson of HealthHarmonie Ltd is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection, 90 people provided feedback about the service. Feedback was positive about the service and included that staff were kind and caring. People using the service told us they felt listened to and staff treated them with respect and dignity. People described the service as excellent, professional and efficient.

Our key findings were:

- The provider had implemented a wide range of policies and processes to keep people using the service safe. We found while most policies and processes were operating as intended, there were some gaps. The provider responded immediately to our concerns to ensure all policies were operating as intended and/or made improvements to systems where appropriate.
- All staff had appropriate access to information to deliver a safe and effective service.
- The provider monitored the effectiveness of their service through satisfaction surveys and audits. We saw evidence of action plans and subsequent improvements in quality.
- Patient feedback was positive about clinical staff and the service overall. The provider had identified where patient satisfaction was lower; for example telephone access and administration errors and responded appropriately to improve the quality of the service.
- Staff we spoke with at all levels were passionate about providing patient centred care.
- The leadership team were experienced and listened to concerns from people using the service, staff and external organisations to improve the quality of services.
- The leadership team encouraged staff to develop and be involved in research and innovation to improve the quality of the services delivered.

We saw the following **outstanding** practice:

- There was clear evidence of the senior leadership team actively seeking out feedback on their services from a variety of sources, listening to concerns, identifying and taking prompt and appropriate action and then closely monitoring the effect on quality.

The areas where the provider **should** make improvements are:

- Continue to monitor and assess how effective and well embedded systems and processes are in order to make further improvements were needed.
- Continue to explore ways to communicate with staff who work remotely to keep them updated with learning from patient feedback and incidents.

Overall summary

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included four CQC inspectors, a CQC inspection Manager, a GP specialist adviser and a governance specialist advisor.

Background to Harborne Court

HealthHarmonie Limited is the registered provider of Harborne court. The provider's head office and the location that is registered with CQC is Suite B, Harborne Court 67-69 Harborne Road, Birmingham, West Midlands B15 3BU. More information about the service can be found on their website www.healthharmonie.co.uk.

Harborne Court (referred to as HealthHarmonie Ltd in this report) provides community-based NHS healthcare services to patients nationally. HealthHarmonie Ltd provides ophthalmology, minor surgery, gynaecology and ultrasound services to adults. The service provides dermatology services to adults and children.

The service does not have a registered list. Patients are referred into the service by a GP or optometrist from the Clinical Commissioning Group (CCG) or NHS trust they have a contract with. Services are provided from mostly GP practices or health centres. At the time of the inspection HealthHarmonie Ltd had 78 service level agreements in place for the use of facilities from which services were delivered from.

The provider ensures staff have remote access to patient care records and their quality assurance system, this allows staff to deliver services nationally.

The provider has a management board, which is made up of a chairperson, managing director, operations and commercial director, finance director, governance director and medical advisory committee chairman. The chairperson of the board is registered with CQC as the registered manager.

The provider employs a total of eight clinical and 141 non-clinical staff. In addition to this, 127 clinical staff work under practising privileges (permission granted through legislation to work in an independent hospital clinic).

The service operates between 6am and 8pm Monday to Sunday. Opening times vary for each service and site they are delivered from. The call centre at Harborne court, is open for queries and booking appointments between 8am and 8pm Monday to Thursday, 8am and 5pm on Friday and between 9am and 5pm on Saturday.

How we inspected this service

Before the inspection we reviewed information the provider sent us, any information we held on the service and any information that was available to the general public. We also contacted Clinical Commissioning Groups (CCGs) that hold contracts with the service.

During the inspection we spoke with clinic staff, administration and call centre staff, members of the board and senior leadership team and people using the service, we reviewed feedback from people using the service, made observations and reviewed documents and patient records.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Good

Are services safe?

We rated safe as Good because:

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff including locums. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training. The service had systems to safeguard children and vulnerable adults from abuse.
- Staff could access policies through the provider quality assurance computer system. Staff we spoke with knew who the safeguarding leads were for adults and children. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.
- The service had systems in place to assure that an adult accompanying a child had parental authority.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- At each clinic there was a trained chaperone who had received a DBS check. All chaperones we spoke with were clear on their roles and responsibilities.
- There was an effective system to manage infection prevention and control.
- We inspected five sites from which, services were delivered. We found all sites were visibly clean and tidy. Staff had the necessary equipment for their clinic.
- Staff told us if there was a problem with infection control before they started their clinic, they would follow the escalation process and report this to management and await further instructions.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- Before deciding to use a site to deliver services from, the provider reviewed the most recent CQC inspection report for that site and carried out a host site risk assessment to ensure it met their requirements. The provider had a service level agreement with each site to ensure certain responsibilities were carried out. For example, cleaning, provision of emergency equipment and medicines and management of clinical waste. The provider carried out yearly and random spot checks throughout the year to ensure the host site provider was adhering to the agreement. The agreement with each site varied to suit the needs of the service being delivered from that site.
- We saw some host sites submitted Legionella risk assessments as part of the host site risk assessment, however this had not been requested by the provider from all sites. The provider told us they did check the host sites CQC inspection report to see if the management of legionella had been reported on. The infection prevention and control lead was aware there were gaps in the infection prevention and control/host site risk assessments and was working on improving the assessment and subsequent audits.
- Staff did not receive local inductions to sites from which, service were delivered. However the provider had produced information sheets for each site that staff could access through the quality assurance computer system. Staff told us they had to familiarise themselves with this information before attending each site and we saw that the provider checked staff knowledge during spot checks. Staff could access the computer system remotely and could do this in their own time if needed or they had allocated time before a clinic started.
- We saw that staff were provided with relevant information such as where emergency medicines and equipment were located, how to access the site and the location of fire assembly points. All staff we spoke with could access the system and were familiar with the information relevant to the site they were working on that day.
- However, we found the information for some sites lacked detail or that information was confusing. For example, at Sparkhill Primary Care Centre staff told us spill kits used to clean up bodily fluids were provided by

the host site however the information sheet said staff needed to bring their own. At Monkspath Surgery, the information sheet said spill kits were in the nurse's room, however staff told us they brought one with them. Where services were provided from a first or second floor, there was not sufficient information for staff on what do in the event of a fire. The sites we inspected all had arrangements in place for evacuating people out of the building, however this information had not been passed onto the HealthHarmonie Ltd staff. The provider sent us evidence to show, following the inspection, they had reviewed and amended the information sheet template so they could provide staff with more detailed and accurate information.

Risks to patients

The provider had put in place systems to assess, monitor and manage risks to patient safety. However, not all systems were well embedded.

- There were effective arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for agency staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Staff told us of pathways the provider had implemented if they needed to urgently refer a patient to A&E or back to their GP for urgent follow up.
- The provider had implemented a checklist to monitor clinical observations on patients in dermatology and minor surgery clinics. Staff told us they had the necessary equipment and would always check the measurements. However, during our inspection at head office, we found, from the sample of patient records we viewed, the checklist was not always fully completed. We discussed this during the inspection with the provider's lead for the Medical Advisory Committee and found the provider had responded to our concerns when we visited Bentilee Neighbourhood Centre, on 6 December 2019, a minor surgery clinic, and found all observation checklists had been completed appropriately.
- Before a surgery clinic, staff had to complete a risk assessment, to ensure they had everything they needed including appropriate medicines and equipment. This helped staff risk assess and decide if it was safe to continue with the clinic that day or if any additional supplies or equipment were needed. During this inspection we visited two sites that carried out minor surgery clinics. At the first clinic we visited, staff had only partly completed the checklist before commencing the clinic. Staff told us this was due to time constraints. It was the provider's policy that staff handed these completed risk assessments in at the end of the day, however the provider did not have an effective system in place to monitor that the risk assessment was being fully completed before the clinic started. When we visited the second minor surgery clinic, we saw the provider had responded to our concerns and improved their system for monitoring that the checklist had been completed before the start of the clinic.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- The provider directly employed staff and clinicians could also work under practising privileges (permission granted through legislation to work in an independent hospital clinic).
- We saw the provider had effective systems in place to manage staff information and monitor training records, revalidation and appraisal information and all staff had appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

Good

Are services safe?

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, emergency medicines and equipment minimised risks.
- The provider had effective systems to keep prescription stationery secure. However, we found their system to monitor its use was not effective. We informed the provider of this during the inspection and they made immediate changes to their protocol to ensure prescription stationery was being monitored effectively. Staff we spoke with were aware of the changes to the process and were adhering to the amended protocol.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.
- The service did not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.
- Staff prescribed and administered medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines.
- There were effective protocols for verifying the identity of patients including children.

Track record on safety and incidents

The service had a good safety record.

- The provider had completed a range of comprehensive risk assessments in relation to safety issues. For example, the service had access to health and safety and fire risk assessments for each site they used to deliver clinical services. The provider had risk assessed staff working hours, the storage and transportation of nitrogen. Before taking on a new contract the provider risk assessed the service to see if it was financially viable and if they could provide an effective service.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned, and shared lessons identified themes and acted to improve safety in the service. Staff told us how the provider had changed the system to manage incoming referrals after identifying problems with the previous system. Staff told us of an incident where surgery had been performed on the wrong site and the provider had implemented the world health organisation (WHO) surgical safety checklist to reduce the risk of this type of incident happening again. The provider had introduced urgent templates for clinicians to use when writing back to GPs, after identifying that GPs were not always responding to letters where patients required urgent follow up. The provider had listened to staff concerns, learnt from complaints and invested in new equipment.
- The provider had introduced monthly meetings called patient advocate days in July 2019 for all staff working at the head office. The meeting was used to share positive feedback from patients, learning from complaints and incidents.
- The provider communicated with all staff through email and their quality assurance computer system. We found that clinical staff working remotely had knowledge of learning from some incidents, however they were less aware of learning following complaints.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.
- When there were unexpected or unintended safety incidents, the service gave affected people reasonable support, truthful information and a verbal and written apology. We saw evidence of this in patient records we viewed.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective system in place to disseminate alerts to staff and check that relevant staff had read alerts and taken necessary action.

Good

Are services safe?

- The service told us of how they had reported a fault with a product to the Medicines and Healthcare products Regulatory Agency (MHRA), they were still awaiting an outcome, and in the meantime had taken the product out of use.

Good

Are services effective?

We rated effective as Good because:

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- The provider had a medical advisory committee (MAC) which formally met twice a year to discuss updates in guidelines, safety alerts, polices and processes. The lead for the MAC told us members of the committee met weekly informally to monitor progress with quality improvement projects.
- Each speciality had an experienced clinical lead and met quarterly as a team to discuss updates in guidelines and processes. Each speciality met at least once yearly for formal clinical professional development.
- Clinical staff had access to best practice guidelines and assessed needs and delivered care in line with relevant and current evidence-based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines and the British Association for Dermatology standards.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis. Where information was missing for example referral information, the provider had an escalation process in place. Staff we spoke with understood the process and knew who to contact to get the information they needed.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients, for example patients attending for six monthly ophthalmology appointments or patients attending for phototherapy treatment.
- The service did not provide an out of hours service. We saw that staff provided patients with appropriate verbal and written post-operative care information.
- As part of aftercare, once a patient was discharged, patients were informed they could call the service back within 12 months if they felt they needed further support without needing another referral.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service made improvements through the use of patient and GP satisfaction surveys and completed audits. There was clear evidence of action to resolve concerns and improve quality.
- Staff told us the provider had audited the two week wait service to assess how well the service was meeting its targets. The audit showed they were achieving below the target. One of the reasons for this was because staff were not recording the information that was needed. The provider updated the templates used by clinicians to record information and the re-audit showed the service had recorded the necessary information and they were meeting their targets.
- Through other audits the provider identified that inclusion and exclusion criteria for dermatology services needed to be updated to ensure patients were being reviewed in the correct setting.
- The ultrasound service amended its templates, after an audit showed that necessary measurements were not always being recorded. The new templates ensured all staff were working from a standard template which included all relevant information.
- The provider audited 5% of each clinician's consultations each month. Feedback was anonymised and displayed on the quality assurance computer system which all staff had access to. Each clinician had their own unique identifier, so they could monitor their own feedback as well as comparing how well they were performing to others. Staff we spoke with us told us they valued the feedback system as it allowed them to improve quality of the service they provided.
- The audits allowed the provider to monitor the quality of the consultation, the quality of the record keeping and the onward referral and monitor antibiotic prescribing and compliance with the WHO (World Health Organisation) surgical checklist. The provider told us compliance with the WHO surgical checklist had improved compared to when it was first implemented in April 2019. The provider had a process in place if there were concerns about a clinician's performance and we saw evidence of this being followed.

- The provider carried out other audits for example it audited histology results to monitor if the outcome matched the diagnosis. The provider also carried out infection control audits on each site they used to deliver clinical services.
- The provider informed us that most patients attending for a surgical procedure would attend once and then be discharged back to their GP. Patients were given post-operative care information and could contact the service for advice if they needed. The provider monitored the number of patients contacting them for post-operative advice and told us seven patients had contacted them between December 2018 and November 2019 for advice regarding a post-operative complication. The service did not however, routinely contact patients regarding post-operative complications.
- The provider carried out quarterly GP surveys to get views from GPs that used their services. The provider used feedback to make further improvements and monitored progress through action plans. Information the provider showed us was that feedback from GPs was positive about the service and feedback had improved from quarter one (April to June 2019) to quarter two (July to September 2019) following service improvements.
- In quarter one 33 GPs had responded, of those that responded 11 (33%) thought the overall quality was excellent ,13 good (39%), five (15%) poor.
- With regards to quality of reporting nine out of 32 GPs responded it was excellent (28%), 11 good (34%), three (9%) satisfactory and four poor (13%).
- 27 out of 33 GPs (81%) would recommend HealthHarmonie Ltd's services to a family member or friend.
- From data for quarter two we saw that GP satisfaction had improved. In total 58 GPs replied to the survey, of those that responded 18 GPs thought the overall quality was excellent (31%), 26 good (45%) compared with two GPs that considered the quality to be poor (4%).
- 17 out of 58 GPs thought the quality of reporting was excellent (29%), 24 good (41%), seven satisfactory (12%) and five poor (9%).
- Of those GPs that responded 51 out of 58 GPs (89%) would recommend HealthHarmonie Ltd's services to a family member or friend.
- The provider sent a link to each patient for a patient survey after their appointment, one of the questions asked how patients rated the quality of their consultation. Between May and October 2019, 4946 people answered the question. Of those people that responded 63% of people rated the quality of their consultation as excellent, and 20% as good.
- Another question asked if people were likely to recommend the service to their friends and family. Between May and October 2019 4881 people answered the question. Of those people that responded 88% of people were likely to recommend the service.
- The provider had introduced another patient survey in July 2019 for patients with chronic conditions. The survey link was sent to patients on their mobile phone using text message to gather patients' views on their current condition, and then on discharge patients were asked for views on their treatment post discharge. This information would allow the provider to monitor how effective treatments were considered by patients.

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. The sample of onward referrals we reviewed contained all the relevant information and were completed to a high standard.
- The service wrote back to the patient's GP after each appointment and the provider had systems in place for notifying GPs about urgent patients.
- At the end of each clinic, there was a dedicated team of administration staff that would check the patient's record had been completed and all relevant documents attached including the letter to GP and/or onward referral. The administration team would then send out any letters and arrange for follow up appointments to be booked if necessary.
- Before providing treatment, clinicians at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.

Good

Are services effective?

- All referrals were checked as they came in to ensure they contained all relevant information, if any information was missing, the referral was either declined and sent back to the GP, or administration staff contacted the GP for more information.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate, highlighted to their normal care provider for additional support. For example, where appropriate, people receiving treatments for dermatology conditions were given advice on keeping well in the sun; people attending for gynaecology treatments were informed on the importance of achieving a healthy weight and people attending ophthalmology appointments were told the importance of achieving good management of diabetes.
- Where patients' needs could not be met by the service, staff referred them to the appropriate service.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance .

- Staff we spoke with understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- The service encouraged people using the service to leave comments on the NHS choices website and carried out their own patient satisfaction surveys and GP satisfaction surveys.
- After each appointment, every patient was sent a text message with a link to a patient survey to complete. The survey contained questions and asked for feedback on how satisfied patients felt with the service they had received. Data for May to October 2019 showed that 4896 patients had responded to the question "what was your overall impression of the service". Of the patients that responded 74% rated the overall impression of the service as eight out of ten or higher (47% rated as 10 out of 10), 8% of people that responded scored the service as less than five out of 10.
- 4295 out of 4881 (88%) people that responded to the survey between May and October 2019 said they would recommend the service to friends and family.
- We saw from comments left on the NHS choices website feedback from patients was positive about the way staff treat people. We received feedback from 90 people using the service. People who provided feedback commented that staff were kind, caring, helpful and friendly.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- On accepting a referral, administration staff would check the referral to see if the patient had any additional needs for example if they needed an interpreter or if they had any learning disabilities and required additional support or a longer appointment.
- Interpretation services were available for patients who did not have English as a first language. The service had multi-lingual staff who were able to support people. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- Patients told us through comment cards, that their consultation was informative, they felt listened to and supported by staff and had enough time during consultations to ask questions.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.

Privacy and Dignity

The service respected patients' privacy and dignity.

- All staff had completed equality and diversity training, Staff we spoke with recognised the importance of people's dignity and respect.
- Patients told us through CQC comment cards that they felt staff treated them with dignity and respect.
- In October 2019 patients were asked through the patient satisfaction survey if they were treated with dignity and respect. Patient feedback was positive.
- The provider ensured there was a chaperone present at each clinic. Part of their role was to help maintain peoples' privacy and dignity throughout a procedure.
- At the five sites we inspected, consulting room and treatment room doors were closed during consultations and conversations taking place in them could not be overheard.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of people using their services and improved services in response to those needs. For every contract the provider accepted, they had a specific inclusion/exclusion criteria and specific targets they would achieve. Each service was tailored to meet those patients' needs.
- The service held weekly prioritisation meetings to ensure there was sufficient capacity. Extra clinics were arranged to meet demand if needed.
- From the five sites we inspected we saw that facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. The provider had inclusion and exclusion criteria that had been agreed with the CCG or NHS trust and as long as patients met that criteria, patients could access care and treatment at HealthHarmonie Ltd.
- The provider told us they were able to offer services to patients in a wheelchair as long as people could independently move from a wheelchair to the bed. If this was not possible the referrer would be informed, and the patient was referred to a more appropriate setting.
- Call centre staff told us that they asked patients on booking an appointment if they had any additional needs including if they used a wheelchair and if they could independently move from a wheelchair to the bed.. Some clinical staff told us they did not always know if patients were a wheelchair user and this could impact their appointment/waiting times, as patients in a wheelchair sometimes required a slightly longer appointment time. Clinical staff told us if they were aware the patient used a wheelchair they would ask the booking department to book a longer appointment.
- The provider told us they would review their process to ensure that clinical staff were always informed of patients' additional needs and that patients had the correct appointment time.
- Where possible patients received treatment during their appointment from a multi-disciplinary team. For example, for patients attending for gynaecology or ophthalmology services, where possible, the service tried to do all relevant tests in the one appointment as well as the consultation with the clinician.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were monitored and managed appropriately.
- Following their appointment all patients were invited to complete a survey and provide feedback on whether there was a delay in their appointment time compared with the actual appointment time. From data we viewed for May to October 2019, we saw that 5074 people had responded to the question. Of the people that had responded 3969 people (78%) had not experienced any delay. From the data we saw that most people experienced a delay between five and 30 minutes (4% five minutes, 35% 6-15 minutes, 36% 16-30 minutes). With fewer people experiencing delays of more than 30 minutes (24%).
- The provider's action plan for August 2019 showed that lateness would be reported to the clinical lead for each speciality and discussed during a clinician's biannual review to ensure effective monitoring.
- We saw cancellation data that showed the number of cancellations in particular short notice cancellations was improving and staff were recording clearly the reason for the cancellation, so this could be monitored and managed appropriately.
- The provider told us there had been issues with cancellation of appointments in the past and told us they had acted to improve the quality of services. They had employed more patient care advisors, they had purchased new equipment, they had improved their systems to report issues with equipment and they had taken appropriate action if they noticed trends with particular staff cancelling clinics at short notice. Since taking action, they told us there had been a reduction in the number of complaints they had received regarding appointments being cancelled at short notice.

Good

Are services responsive to people's needs?

- Patients with the most urgent needs had their care and treatment prioritised.
- Referrals and transfers to other services were undertaken in a timely way. There was a dedicated team that ensured onward referrals were sent.
- Following complaints and patient feedback on NHS choices about poor telephone access the provider had purchased a new telephone system in February 2019.
- The system allowed the provider to monitor call data such as call waiting times. During the inspection we viewed the call waiting information and saw that all calls had been answered on that day and nil were waiting and the call centre had met their target of answering calls within two minutes on that day.
- The new system allowed them to monitor call data and move call centre staff to where there was greater demand.
- The provider had identified that there was greater demand in ophthalmology and had trained more staff to take calls for that speciality.
- The provider had implemented an incentive scheme for patient care advisors and call centre staff to encourage them to cross train and cover for all five specialities. Since implementing the scheme, the provider had found the quality in services had improved however acknowledged there was still work to be done.
- Since making changes the provider had noticed a 30-40% increase in answering phones within targets and they were not receiving as many complaints now regarding poor telephone access.
- The provider had made changes to the appointment system for ophthalmology services in response to patient feedback about long waiting times, since implementing changes they had identified fewer issues and were receiving fewer complaints.
- Patient survey information showed that between May and October 2019 3102 out of 4927 (63%) patients that responded felt they had been given a choice of location and time for their appointment. The provider had identified this as part of their action plan as an area to improve on and had set measurable targets.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- The service informed patients about their complaints process in their initial letter and contacted patients after their appointment for feedback on the service they had received. We saw there was a contact us form on the website where patients could raise concerns. This was monitored by the marketing manager.
- We found there was little information at the appointment itself for patients who may have wanted to raise a complaint during their appointment. We saw there were signs to say to take a seat and there was a phone number displayed for HealthHarmonie Ltd, however there was no information about the complaints process itself and what patients should do if there was a problem. The provider sent us evidence to show, following the inspection, they had devised a patient leaflet. The leaflet contained details about the service including contact details and how people could provide feedback about their appointment. The provider told us the leaflet would be available at all sites from where services were delivered.
- Staff treated patients who made complaints compassionately.
- The service had complaint policy and procedures in place. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care.
- Following patient feedback, the provider had implemented a new telephone system to improve access, it had amended its appointment systems for ophthalmology services, it had changed its system to manage incoming referrals.
- The provider told us they encouraged patient input when improving services and gave an example of where a patient was invited into the service to help improve services.
- The provider amended patient letters to include more information about the clinician, directions to the site and how to find the clinic once on site, all following patient feedback.
- Following feedback from GPs the provider had implemented a new computer system to manage outgoing letters and had improved the quality of the reports written to GPs.

Good

Are services well-led?

We rated well-led as Good because:

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders told us that the service had expanded by a 71% increase in monthly patient appointments in the past two years. We found that leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. HealthHarmonie Ltd's senior leadership team was experienced with the skills, abilities, and commitment to lead and develop high-quality services. This had allowed the service to grow and implement change at a fast pace.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.
- The service had a management board which consisted of six members and was made up of a chairperson, managing director, operations and commercial director, finance director, governance director and medical advisory committee chairman.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with staff.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. We saw that new staff joining the service, learnt about the service's vision and values during their induction.
- The service monitored progress against delivery of the strategy.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service.
- All staff we spoke with were open and honest with us and passionate about providing a patient centred service.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. From patient records we viewed, where the patient had complained or there had been an incident involving a patient, this was clearly identified in the patient's record. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff had received annual appraisals or if working under practising privileges staff had received biannual reviews in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. All staff were considered valued members of the team. Staff were given time to complete mandatory training.
- There was a strong emphasis on the safety and well-being of all staff. The provider closely monitored the working hours of all staff, including patient care advisors. The provider had identified that certain groups of staff were at more risk of working over their agreed hours. The provider carried out staff wellbeing checks where appropriate.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

Good

Are services well-led?

- Structures, processes and systems to support good governance and management were clearly set out, understood and mostly effective.
- Staff were clear on their roles and accountabilities.
- Leaders had established proper policies, procedures and activities to ensure safety. We did find that not all processes were operating as intended, for example, the monitoring of prescription stationery, the completion of risk assessments before surgery, and observation charts during surgery clinics for all patients. The provider responded positively to all our concerns and took immediate action to amend the process to monitor prescription stationery and communicated with clinical staff on the importance of completing risk assessments and observation charts in line with processes.
- The provider had appropriate governance structures in place to discuss risk.
- The service held weekly prioritisation meetings for each department so that all staff were working to meet the same objectives for that week and to discuss low risk issues.
- The service held six monthly medical advisory committee (MAC) meetings to discuss high risk issues, audits and any updates to guidelines and policies.
- Each speciality held quarterly meetings to discuss moderate risk issues, a formal professional development event was held by each clinical lead once each year.
- All staff could access minutes of meetings through the quality assurance computer system.
- The service held monthly board meetings. Meetings included the discussion of complaints and incidents.
- The service also held monthly accountability meetings, for the senior management team to discuss risk and quality and whether they had met targets.

Managing risks, issues and performance

There were mostly clear and effective processes for managing risks, issues and performance.

- We found that most processes to identify, understand, monitor and address current and future risks including risks to patient safety were effective.
- The service held weekly prioritisation meetings to discuss capacity and demand.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality.
- The provider had a business continuity plan, which all staff had access to.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored and management and staff were held to account
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required. Including monthly reports to their commissioners on performance and whether they had met their agreed targets.
- The provider had made improvements to their computer systems and processes to ensure there were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture.

Good

Are services well-led?

- The provider responded appropriately to complaints and feedback on NHS choices and worked with patients to improve services.
- The provider formed monthly action plans following patient satisfaction surveys to further improve quality of services.
- The provider responded to feedback from GPs and amended their report templates. This had led to better outcomes for patients as GPs had clearer management plans.
- Staff told us that leaders were approachable and their concerns were listened to.
- Staff could describe to us the systems in place to give feedback.
- Following staff feedback the provider had implemented improvements. For example, they developed audio instructions in multiple languages to help people complete visual fields tests and they told us they had decided to change their clinical system following feedback from clinicians.
- We saw that the provider engaged with staff through email, their quality assurance computer system, patient advocate days and newsletters. We saw that the provider had identified in their action plan in July 2019 to feed patient comments back through to departments to ensure continuous service improvements.
- The service was transparent, collaborative and open with stakeholders about performance.
- The service attended external cancer multidisciplinary meetings and other external meetings for example ophthalmology steering board meetings.
- The provider told us any updates in guidelines were discussed with commissioners to ensure they could still offer the appropriate services.
- The provider carried out a yearly staff survey. Following the most recent staff survey in January 2019, the provider had responded to staff feedback and brought in a bigger training team and now offered a two-week training induction. The provider had also implemented a succession planning/incentive scheme for staff that worked across different specialities.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a strong focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- The leadership team told us they had introduced patient advocate days earlier in the year. The meetings were for all staff working at the head office and were used to share learning from recent complaints, incidents and positive feedback from patients. It was also an opportunity for the provider to obtain feedback from staff on how to develop and improve services further. Staff also received awards from the management team during these meetings for going above and beyond their role to improve services for patients.
- Leaders and managers encouraged staff to develop, review individual and team objectives, processes and performance. We saw many examples of staff receiving training to develop and be promoted within the organisation.
- The provider had a succession plan in place and had implemented an incentive scheme for patient care advisors and call centre staff to encourage them to cross train and cover for all five specialities. Since implementing the scheme, the provider had found the quality in services had improved.
- The provider was supporting patient care advisors to train as health care assistants, nursing staff to develop and become specialists and two GPs were undertaking a GP leadership fellowship role, to become specialists in dermatology.
- There were systems to support improvement and innovation work.
- The provider had found that there was high DNA (did not attend) rate on a Monday and planned to extend the opening times of the call centre to include Sundays from January 2020 to give patients the opportunity to cancel their appointment.
- In February 2019 the provider had implemented an advice and support service for GPs. This meant GPs could contact the service for advice on dermatology related conditions without needing to do a formal referral. Patients could then be formally referred if they needed to be.
- The service offered nurse-led patient self-management forums to patients using their service who had common chronic conditions. These sessions gave patients the

Good

Are services well-led?

opportunity to meet other patients with similar conditions to discuss their condition. We saw that sessions were available on weekends too for people that were unable to access the service in the week.

- Following staff feedback the service had developed audio instructions in multiple languages for conducting diagnostic tests such as visual fields tests. The provider found following the introduction of the audio guides the uptake of services had improved and feedback from local optical services was positive.
- The provider encouraged clinicians and clinical leads to be active in research and publication of research papers. We saw examples of articles that had been published including papers that's had been published internationally.
- The service had been nominated by the House of Commons and shortlisted for the Exceptional Organisations and Leadership Parliamentary Report and Awards. Staff told us they would find out in March 2020 if they been successful in receiving the award.