PAM Group London Wall Clinic

Inspection report

4 London Wall Buildings
London
EC2M 5NT
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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 well-led?	Good

Overall summary

This service is rated as Good overall. (Previous inspection 09/2021– Requires improvement)

The key questions are rated as:

Are services Safe? – Good

Are services effective? – Good

Are services well-led? – Good

We previously carried out an announced inspection of PAM Group London Wall Clinic on 8 September 2021 where the service was rated requires improvement overall and for the key questions of effective and well-led. The key questions safe, caring and responsive were rated good. During the last inspection on 8 September 2021, we identified a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The full report of the previous inspection can be found by selecting all reports linked for PAM Group London Wall Clinic on our website: www.cqc.org.uk.

We carried out a focused inspection of PAM Group London Wall Clinic on 22 March 2022, to review whether the service had made improvements in response to the breach of regulation we identified in September 2021.

PAM Group London Wall Clinic is an independent health service which provides health screening.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some general exemptions from regulation by CQC which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At PAM Group London Wall Clinic services were provided to patients under arrangements made by their employer or a government department or an insurance provider with whom the servicer user holds an insurance policy, other than a standard health insurance policy. These types of arrangements are exempt by law from CQC regulation.

The clinical nurse director 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.

The provider submitted a report for January 2022 which stated 98% of patients would recommend the service.

Our key findings were:

At the previous inspection, we found improvements were required in regard to clinical staff supervision, standards of record keeping and the systems to ensure patients were followed up appropriately. At this inspection, we found the provider had responded to our findings and made the required improvements.

- The provider had an induction programme for all newly appointed staff. Staff had completed the necessary training for their roles.
- Patients received a detailed report about the findings of their health checks and were asked if any abnormal results could be shared with their NHS GP provider.

Overall summary

- Clinical staff had monthly clinical notes audits to ensure the quality of their work.
- The service learned and made improvements when things went wrong.
- Staff told us team leaders were available and supportive.
- The practice demonstrated that there was a focus on continuous improvement.

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

- Review the arrangements for checking all required equipment was ready for use in an emergency available.
- Review and risk assess the decision to carryout standard Disclosure and Barring Service Checks on clinical staff.

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**,** who was supported by a GP specialist adviser.

Background to PAM Group London Wall Clinic

The CQC registered provider of PAM Group London Wall Clinic is To Health Ltd.

PAM Group London Wall Clinic is registered to provide the regulated activities of treatment of disease, disorder and injury, and diagnostics and screening at: -

London Wall Buildings

London

EC2M 5NT

At the time of the inspection, the only service it provided which was under the scope of registration with CQC was health screening. The service had stopped providing travel vaccination and private general practitioner services.

Patients could self-refer for an assessment by telephone or online. The clinic was opened to meet the patient demands.

The service does not treat service users under the age of 18 years.

How we inspected this service

We reviewed information about the service in advance of our inspection visit. This included:

- Data and other information we held about the service;
- Material we requested and received directly from the service ahead of the inspection;
- Information available on the service's website.

During the inspection visit we:

- Spoke with staff.
- Reviewed policies, procedures, risk assessments, and patient records.
- Reviewed patient feedback.
- Carried out checks and observations of the premises and equipment.

This was a focused inspection, and therefore we looked at the following key questions:

- Is it safe?
- Is it effective?
- Is it well-led?

Good

Are services safe?

Safety systems and processes

- The service had two safeguarding leads. Staff had received safeguarding training appropriate for their role. The safeguarding procedure was last reviewed in September 2021 and clearly outlined who to go to for further guidance.
- The service did not see patients under the age of 18 years.
- The premises were clean and tidy, and the service had a system in place that prevented and managed the risk of infectious diseases. This included an annual risk assessment which was most recently completed on 8 March 2022, various weekly and monthly audits, and policies and procedures for staff to follow.
- In response to COVID 19, we saw patients were asked if they had any COVID 19 symptoms, hand sanitiser was available in reception and consulting rooms and social distancing was encouraged in waiting areas.
- Staff confirmed the service had a policy in place, which encouraged staff to test twice weekly to identify if they had COVID 19 but were asymptomatic.
- The service had oversight of the legionella risk assessment carried out by the property owner on the 7 April 2021.
- 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.
- The provider employed a human resource team, who carried out staff checks at the time of recruitment and on an ongoing basis. 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). The human resource manager explained that because staff did not see children or adults who may be vulnerable, all staff had standard DBS checks.
- Staff who acted as chaperones had been trained for the role and had received a DBS check.
- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

- Staff had completed training on how to recognise sepsis.
- The service had a protocol for the management of blood tests.
- The service had a system in place to ensure that the number and mix of staff needed was appropriate for patient's needs.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- Staff who worked at the location had completed basic life support training.
- There were medical and public indemnity arrangements in place.

Information to deliver safe care and treatment

- At the previous inspection we found staff had not signed or dated entries and the information provided to patients about abnormal blood results was not detailed in the patient record.
- At this inspection a review of patient records found that staff had the information they needed to deliver safe care and treatment to patients. In addition, the provider was operating a system to regularly audit the quality of the patient records.
- Patients received a detailed report about the findings of their health checks and were asked if any abnormal results could be shared with their NHS GP provider.
- 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 was not prescribing or administering medication for the self-referral health assessment service.
- There were medicines to deal with medical emergencies which were stored appropriately and checked regularly.
- The service had emergency oxygen that was checked weekly, however we found this did not have an adult face mask, the registered manager agreed to respond to this immediately.
- The service had a system in place to safely store and manage vaccines.

Track record on safety and incidents

- We saw there were risk assessments in relation to safety issues. For example, a general risk assessment had been completed on 21 July 2021, which included a review of the premises, building structure, equipment, and fire risks.
- Staff had received health and safety and fire safety training.
- 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

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses.
- There were adequate systems for reviewing and investigating when things went wrong. They shared lessons, identified themes and took action to improve safety in the service.
- For example, the service had an incident whereby patient blood test results were not appearing on the computer system; the issue was raised with the laboratory which manually uploaded results onto their system.
- The registered manager was aware of and complied with the requirements of the Duty of Candour. They encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.
- The service had an effective mechanism in place to disseminate Medicines and Healthcare products Regulatory Agency (MHRA) to all members of the team. In addition, they had a system in place to record any actions taken.

Good

Are services effective?

Effective needs assessment, care and treatment

- Staff 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.
- At the time of the inspection, the service provided a self-referral health assessment service. Both the GP and travel vaccination service had ceased operating.
- The patients were seen initially by a physiologist (a physiologist uses specialist equipment, advanced technologies and a range of different procedures to evaluate the functioning of different body systems, to diagnose abnormalities, and to direct patients to the correct treatment). They would complete a pre-assessment questionnaire, which included the patient's medical history and any concerns, and also carry out tests.
- Where the patient had blood tests these were sent to an independent pathology service and the patient was called promptly to go through the results. Abnormal results were shared with the patient's NHS GP provider.

Monitoring care and treatment

- The service had achieved various International Organisation for Standardisation (ISO) accreditations in 2021.
- The lead physiologists carried out annual peer observations of the other clinicians' work to monitor and improve the quality of the assessment.
- The service had access to and could learn from the improvement audits carried out within the providers whole organisation, such as clinical notes reviews, referral, business, and well-being.

Effective staffing

- The provider had an induction programme for all newly appointed staff.
- Staff had completed the necessary training for their roles.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC) or Nursing and Midwifery Council and were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- Non-clinical staff reported they had monthly supervision and an annual appraisal.
- Clinical staff had monthly clinical notes audits to ensure the quality of their work.
- The physiologists had six monthly supervision sessions and an annual appraisal, which included observation of their work.
- The physiologists explained they were members of The Physiological Society (UK) which required them to provide evidence of competency to maintain their professional registrations.
- The service had a regular clinical forum which was designed as a place for all Health and Wellness Experts to come together, share ideas and learn from each other.

Coordinating patient care and information sharing

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.

Good

Are services effective?

- A copy of the health assessment report was given to the patient. If there were any abnormal results from the physical assessment, the psychologist would telephone the patient and recommend they see their NHS GP. The physiologists provided examples of how they had followed up patients with abnormal assessments.
- With the patients consent, staff directed patients to other services.

Supporting patients to live healthier lives

- 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.
- Where patients need could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

- Staff 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.

Good

Are services well-led?

Leadership capacity and capability:

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- The leadership team met regularly and kept a record of the meetings.
- The leadership team consisted of a clinical operation, and regional director, a registered manager and a customer service manager.
- 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.
- Staff told us that leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

- 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 and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service monitored progress against delivery of the strategy.

Culture

- Staff told us they felt respected, supported and valued.
- 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. 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 in the last year.
- Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training.

Governance arrangements

- At the previous inspection in September 2021, we found some of the service's new processes and systems were not fully embedded. For example, staff training was not centralised, the service did not request details or consent to inform patients' NHS GPs of any abnormal results, and reviews or audits of clinical notes were not carried out.
- Following the previous inspection, the registered manager had implemented regular clinical records reviews, and implemented a system to enable shared care with patients' NHS GPs

Good

Are services well-led?

- The registered manager explained how each of the directors were responsible for ensuring staff had completed the appropriate training.

- Staff were clear on their roles and accountabilities
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- The service had compliance champions which met on a monthly basis to discuss the clinical operations and compliance with regulations.

Managing risks, issues and performance

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient 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.
- The provider had a business continuity plan in place to respond to major incidents.

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 provider held management regular compliance board meetings where performance information which was reported and monitored.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- There were robust 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 had systems in place that encouraged and heard views and concerns from patients, and staff acted on feedback to shape services and culture. Patient feedback was sought following all appointments, which was collated and reviewed by the management team.
- Staff could describe to us the systems in place to give feedback.
- The service was transparent, collaborative and open with stakeholders about performance.
- The service had been part of the provider's annual staff survey in 2021. The results of this survey showed staff trusted their leaders and that the communication about the pandemic was effective, but staff felt more could be done to communicate future plans. In response to these findings, the provider put in place action plans in all services to address this area.

Continuous improvement and innovation

- There was a focus on continuous learning and improvement.

Good

Are services well-led?

- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There were systems to support improvement and innovation work.
- The registered manager explained the service was building their training academy.