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	Requires Improvement
Are services safe?	Good
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall. (Previous inspection April 2019 – Inadequate)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

CQC inspected the service on 25 April 2019, rated the service as inadequate overall and required the provider to make improvements when providing a safe, effective and well-led service and placed the service into special measures.

We carried out an announced comprehensive inspection at PAM Group London Wall Clinic on the 8 September 2021. We carried out this inspection to follow up on breaches of regulations.

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

Therefore, the services registered under the regulated activities of treatment of disease, disorder and injury, and diagnostics and screening, was the self-referral by patients for health screening, a travel vaccination clinic and the private general practitioner service. However, at the time of the inspection on the 8 September, the service was not operating the vaccination and GP service. This meant the finding of this report were based on our findings of the self-referral screening service.

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.

Our key findings were:

At this inspection we found the service had made improvements, but some systems required further review and embedding to ensure they were effective.

Overall summary

- At this inspection we found the provider had responded and made improvements against all of the previous inspections finding. The service had a new leadership team who had put systems in place for the management of safe staff recruitment, significant events, safety alerts, training and quality improvement audits.
- However, further improvements were required in regard to clinical staff supervision, good standards of record keeping and the lack of a fully effective system in place to ensure patients were followed up when they had an abnormal test result.
- The team leadership responded promptly to resolve any issues found at the inspection.
- 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 which was developing services
- Patient feedback was positive about the service they had received.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

(Please see the specific details on action required at the end of this report).

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

- Implement a system to identify staff who may have COVID 19 but be asymptomatic.
- Improve the safegaurding intercollegiate guidance to check staff are trained to the appropriate level.
- Improve the system to share appropriate information with the patients GP.

I am removing this service from special measures due to the improvements it has made.

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 and a general practitioner 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

The services which it provides that are under the scope of registration with the CQC are self-referral by service users for health screening, travel vaccinations and a private general practitioner service. However, due to the pandemic the general practice and travel vaccination services were not operating.

At the time of the inspection 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

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently to minimise risk.

This included: -

- Speaking with staff,
- Reviewing patient records to identify issues and clarify actions taken by the provider,
- Requesting evidence from the provider,
- Review of service user feedback,
- A site visit.

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:

At the previous inspection in April 2019, the provider was rated inadequate for providing a safe service. This was because staff had failed to monitor the safeguarding, recruitment, infection control and safety alert systems and processes effectively to ensure a safe service.

At this inspection we have rated the service as good for providing a safe service. This was because improvements had been made by the management team about the concerns found at the previous inspection.

Safety systems and processes

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

- At the previous inspection in April 2019 the service did not have clear systems to keep people safe and safeguarded from abuse. For example, the service did not have operational leads or systems in place for safeguarding, infection control and recruitment.
- At the previous inspection, the service did not have an allocated safeguarding lead and staff were not aware of the safeguarding policy. At this inspection, the service had two allocated leads for safeguarding. Staff had received safeguarding training to level one and two dependent upon their role. However, they had not yet achieved the levels required by the new intercollegiate guidance on safeguarding which required all nurses to be trained to safeguarding level 3 and safegaurding leads to level 4 by August 2021. At the time of the inspection the registered manager agreed to review the safeguarding training to ensure it met the guidance.
- The service had systems to safeguard children and vulnerable adults from abuse. However, the policy was not clear about the prompt actions to take if staff had a concern. This was discussed with the registered manager and safeguarding lead who following the inspection amended the safeguarding policies.
- The service did not offer a provision for patients under the age of 18 years.
- At the previous inspection, the provider did not have an infection control lead and the service had not undertaken a risk assessment since 2018. At this inspection we found the premises were clean and tidy, and the service had a system to manage infection control. An infection management risk assessment and a Covid19 clinic preparedness tool London Wall were in place. We saw signage that asked patients if they had any symptoms, hand sanitiser on reception and in all rooms, the wearing of masks was mandatory unless there were contradictory reasons for not doing so and social distancing encouraged in the waiting areas. However, the provider did not have a system in place to identify staff who may have COVID 19 but be asymptomatic.
- 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 and a bodily waste spillage kit
- 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).
- Staff who acted as chaperones had trained for the role and had received a DBS check.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- At the previous inspection we found there was a lack of leadership at the location, staff had not completed training to recognise sepsis, and the service did not have a policy for the management of blood results.
- At this inspection, we found the site had a strong leadership team.

Good

Are services safe?

- 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 patients needs.
- There was an effective induction system for agency staff tailored to their role.
- 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 appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment to patients.

- At the time of the inspection, due to the pandemic, the service had seen five patients from reopening of the service in April 2021 for health assessments.
- We reviewed all five patient records and found staff had not signed or dated entries, and the information provided to patients about abnormal blood results was not detailed in the patient records. Following the inspection, the provider put a new system in place to regularly audit the quality of the records.
- 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.
- The service did not have a system in place to check the oxygen was safe for use regularly. Following the inspection this was added to the weekly premises check list.
- At the time of the inspection the defibrillator was being serviced.

Safe and appropriate use of medicines

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

- At the previous inspection, when the GP service was operational, we found that the service had reliable systems for appropriate and safe handling of medicines.
- At this inspection, we found that 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. If items recommended in national guidance were not kept, there was a risk assessment to inform this decision.

Track record on safety and incidents

The service had a good safety record.

- At the previous inspection in April 2019 the service did not have a good safety record. For example, premises and health and safety risk assessments were not in place.
- At this inspection there were risk assessments in relation to safety issues.
- Staff had received health and safety and fire safety training.
- The provider submitted a copy of the building's legionella assessment dated 7 April 2021.
- The service had 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

Good

Are services safe?

The service learned and made improvements when things went wrong.

- At the previous inspection in April 2019 the service did not have an effective system in place to manage, review and learn from significant events and the Medicines and Healthcare products Regulatory Agency MHRA safety alerts.
- At this inspection, 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.
- 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
- 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, in June 2021 patient blood results were not appearing on their computer system, the issue was raised and in response they contacted the laboratory and manually uploaded results onto their system. Also, an incorrect blood test was sent out to a patient, this was investigated and found to be an IT issue which was resolved.
- 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.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

- At the previous inspection in April 2019, we rated the service as requires improvement for providing an effective service. This was because the provider had not undertaken any quality assurance audits, staff had not received role specific training or had regular appraisals.
- At this inspection we have rated the provider as requires improvement for providing an effective service. This was because the system in place to review clinicians' consultations and share information with the patients NHS general practitioner was ineffective at the time of the inspection.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice.

- Most 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.
- Following the previous inspection in April 2019, the GP service had ceased operating, due to the pandemic the vaccination and self-referral health assessments services also closed. The self-referral service recommenced in April 2021 and had only had five patients.
- 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 concerns and 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. However, when we reviewed the patient records, we found where abnormal results were explained the records did not provide a full account of the conversation. Which meant that the next clinician would be unable to follow up any further ill health.

Monitoring care and treatment

The service was now involved in some quality improvement activity.

- At the previous inspection in April 2019 the service was not actively involved in quality improvement activity.
- At this inspection we found the service had achieved the International Organization for Standardisation (ISO) certificate in 2020.
- The lead physiologists carried out annual observations of peer work to improve the quality of the assessment. Points they had raised were regarding bone health were explored and acted upon.
- The service had access to and could learn from the improvement audits carried out within the providers whole organisation, such as referral, business, and well-being.

Effective staffing

Most staff had the skills, knowledge, and experience to carry out their roles. However, further improvements were needed to provide regular oversight of clinical work.

- At the previous inspection in April 2019 the service did not have an effective system in place to ensure staff had the necessary training and supervision for their roles.

Requires Improvement

Are services effective?

- At this inspection we found most staff had completed mandatory training, and role specific training, however training was held on personal files, in the computer management system and team leaders put them on spreadsheets, which did not supply an oversight of all staff. As a result, we identified one member of clinical staff whom the provider did not have any assurance at the time of the inspection that they had completed the necessary training for their role.
- Non-clinical staff reported they had monthly supervision and an annual appraisal.
- The physiologists had six monthly supervision and an annual appraisal, which included observation of their work, which did not include regular patient record reviews.
- The nursing staff did not have patient record reviews or supervision or an annual appraisal.
- The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC), 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.
- 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

The service did coordinate care with other organisation; however, the system did not fully ensure patients were followed up when they had an abnormal result.

- At the time of the inspection, the service did not have a system in place to share information with the patient's NHS general practitioner (GP) or ask the patient for the GPs details. Following the inspection, the registered manager, put a system in place to share information if appropriate with the patients GP.
- 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, such as a very high blood pressure. to ensure they received the necessary treatment.
- With the patients consent, staff directed patients to other services.
- Before providing treatment, clinicians ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.

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.
- 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

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making.

Requires Improvement

Are services effective?

- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect, and compassion.

Staff treated treat patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. Feedback from patients was positive about the way staff treat people
- Staff understood patients' personal, cultural and social 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.

- Interpretation services were available for patients who did not have English as a first language.
- Patients told stated in the survey, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

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 to meet patients' needs.

- The provider understood the needs of their patients and improved services in response to those needs.
- The facilities and premises were appropriate for the services delivered. The service had carried out a risk assessment of how the service met the needs of people experiencing a disability.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others.

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 minimal and managed appropriately.
- Patients reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way

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.

- Information about how to make a complaint or raise concerns was available, this was available in the reception area.
- There had been no complaints in the previous year. There was a policy for managing complaints. The provider showed us how the complaint would be dealt with and the processes that were in place for learning from complaints.
- Complaints were reviewed by the compliance board to establish any patterns or trends.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

At the previous inspection in April 2019, we rated the provider as inadequate for providing a well-led service. This was due to the lack of leadership, monitoring of the quality of the service and ineffective systems for the management of training, significant events, and Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts.

At this inspection we found the provider had made improvements, and had implemented effective systems, for recruitment, training, significant events, MHRA safety alerts and had carried out audits.

L**eadership capacity and capability.**

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

- At the previous inspection in April 2019 the leaders were not knowledgeable about the issues and priorities relating to the quality and future 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.
- At this inspection, the service had a new registered manager and leadership team who were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.

Vision and strategy

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

- At the previous inspection in April 2019 the service did not have a clear vision and strategy to deliver high quality care.
- At this inspection, the registered manager provided a list of the improvements made following the last inspection.
- There was a clear vision and set of values. These included enabling individuals to be effective and productive.
- 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

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

- At the previous inspection in April 2019, staff did not feel supported, or listened to and had not received annual appraisals.
- At this inspection, staff told us they felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- 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 positive relationships between staff and teams.
- During the pandemic, the provider had enabled some staff to work from home.

Governance arrangements

Requires Improvement

Are services well-led?

There were responsibilities, roles and systems of accountability to support good governance and management. However, some required further time to embed to ensure good governance.

- At the previous inspection in April 2019 systems and processes were sometimes ineffective and did not support good governance and management.
- At this inspection, during the pandemic the services were closed. This meant that some of the new processes and systems were not fully embedded. For example: -
- Staff training and clinical supervision information was not centralised, and the provider could not be assured that all staff were up to date with their training.
- The service did not request details or consent to inform patients' NHS GPs, which meant there was a risk in treatment follow-up. Following the inspection, the registered manager implemented a new system to enable the sharing of patient records with NHS GPs.
- Clinical notes reviews had not been carried out for some staff, which resulted in all five patient records reviewed demonstrating lack of detail and staff were not signing or dating their entry.
- Following the inspection, the registered manager implemented regular clinical record review, and implemented a system to enable shared care with the patients NHS general practitioner. We will review the effectiveness of this approach at our next inspection.

Managing risks, issues and performance

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

- At the previous inspection in April 2019, here was an ineffective process to identify, understand, monitor and address current and future risks including risks to patient safety. For example, complaints, and incidents and no business continuity plan.
- At this inspection, there was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patient.

Appropriate and accurate information

The service acted on appropriate and accurate governance 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 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 involved patient and staff to support high-quality sustainable services.

Requires Improvement

Are services well-led?

- The service had systems in place that encouraged and heard views and concerns from patients and staff acted on them 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. For example the whistleblowing policy, regular team meetings and we saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- At the previous inspection in April 2019 the was no evidence of continuous improvement.
- At this inspection we found there was a focus on learning with various training available to staff on a weekly basis.
- The service had the systems in place to make use of internal reviews of incidents and complaints.
- 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.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983 **Regulation: 17 (Good Governance) Health and Social Care Act** **How the regulation was not being met:** **The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:** • We reviewed patient records and found staff had not signed or dated entries, and the information provided to patients about abnormal blood results was not sufficiently detailed in the patient records. **The registered person had some systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:** • Oversight of staff completion of training and competency was not assured. • There was a lack of documented, regular clinical supervision.