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Greenwood Surgery at Charles Stanley & Co. Limited

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 17 May 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

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 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 Greenwood Surgery at Charles Stanley services are provided to patients under arrangements made by their employer. These types of arrangements are exempt by law from CQC regulation. Therefore, at Greenwood Surgery at Charles Stanley, we were only able to inspect the services which are not arranged for patients by their employer.

The clinical lead 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.

Thirteen people provided feedback about the service. All patients noted their experiences had been positive and

Summary of findings

each individual commented the service always felt individualised, caring and compassionate. Eight patients commented positively on their involvement in health check results or treatment plans and each patient said the service was convenient and easily accessible.

Our key findings were:

- Care and treatment was delivered by a well-trained team that maintained up to date knowledge of the latest clinical guidance.
- There was a clear and demonstrable focus on patient-centred care and staff monitored changing needs and adapted the service accordingly.
- The clinic offered highly flexible accessibility options and patients placed great value on this.
- Clinical staff used a holistic approach to GP appointments and screenings and had detected the early signs of serious illness as a result. Referrals to specialist services were made promptly and in discussion with patients.
- There was a strong focus on lifestyle-related health and the clinical team worked closely with patients and the contracting organisation to improve mental health and support healthier living.
- Staff demonstrated passion, motivation and a drive for innovation that promoted high quality care.

Greenwood Surgery at Charles Stanley & Co. Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Services are provided from:

Greenwood Surgery at Charles Stanley

55 Bishopsgate

London

EC2N 3AS

The service is open on Thursdays from 7.30am to 5pm.

The inspection was led by a CQC inspector who was supported by a specialist advisor who:

- Carried out an announced inspection on 17 May 2018.
- Spoke with both members of staff who provide the service.
- Reviewed a sample of patient records.
- Looked at the comments made by patients on seven CQC comment cards and spoke with three patients about their experiences.
- Reviewed audits, internal reports and governance systems.

We informed stakeholders that we were inspecting the service; however, we did not receive any information of concern from them.

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.

A GP and a registered nurse provide clinical treatment for eligible employees of the company that contracts the service. There are no other staff in the service. The clinical team provides corporate annual and new employee health checks and GP appointments, which can be booked in advance or attended on a drop-in basis. The service provides access to GP services for patients who would otherwise need time off work to attend routine appointments and check-ups. The service provides direct referrals to specialist consultants through a corporate insurance plan or to NHS services.

The service sees an average of 20 patients per month for phlebotomy and corporate health screens and 50 patients per month for GP appointments and walk-in appointments. The number of patients who can access the service depends on the workforce of the contracting organisation and is usually between 500 and 700 people.

There is a main consulting and examination room and a second room for nurse reviews and discussions. Both rooms are located in the building occupied by the

Detailed findings

contracting company and are secured, managed and maintained by that organisation. There are facilities on site to take blood samples and the rooms are self-contained for infection control purposes.

Are services safe?

Our findings

Safety systems and processes

The clinical team had up to date training in safeguarding adults and safeguarding children; the nurse to level 2 and the doctor to level 3. Both individuals had completed safeguarding children training. The nurse had up to date training in the prevention of radicalisation and processes were in place to escalate concerns to the corporate senior team.

Both clinical staff had an up to date Disclosure and Barring Service (DBS) check.

Both members of the clinical team had revalidated in the previous 12 months and both individuals held professional indemnity insurance.

The clinical team maintained up to date training in their substantive roles with other providers. The training enabled them to maintain a safe environment and provide safe care and treatment at this location and included 12 subjects such as health, safety and welfare and infection prevention and control.

Care and treatment was provided from two dedicated rooms within the contracting organisation's offices. The organisation was responsible for maintaining the premises, health and safety and fire safety. A facilities manager was available to arrange urgent repairs or to resolve issues and ensured the clinical team had up to date information on the fire and evacuation plan.

The service had an up to date Legionella certificate for all water outlets in the clinic. Legionella is a type of bacteria that can live in areas connected to a mains water supply but that is not used regularly. A check for this bacterium means the service manages the risk effectively.

A chaperone service was in place and provided on request.

The contracting organisation was responsible for the management of the environment, including health and safety. Arrangements were in place for annual electrical testing of equipment.

Risks to patients

The service had a stock of emergency medicine in line with guidance from the British National Formulary (BNF). Automatic electronic defibrillators (AEDs) were available in the building and were for use by trained first aiders, who could be contacted urgently by clinical staff.

Both members of the team had up to date resuscitation training.

Chemicals were stored according to best practice standards in the Control of Substances Hazardous to Health (COSHH) Regulations (2002). This included an up to date register of the materials kept on site and the procedures to follow in the event of a spillage or contact with skin.

Sharps bins were labelled and dated and within the safe storage capacity, which meant the service was compliant with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Processes were in place to ensure waste was disposed of in line with the Hazardous Waste Regulations (2005).

An infection prevention and control policy was in place and hand-washing guidance based on World Health Organisation hand hygiene standards was posted at each sink. The clinic was visibly clean and free from dust and dirt and up to date cleaning checklists were maintained by the cleaning contractor in line with a cleaning schedule. This included a monthly deep clean, a weekly clean and a monthly sink clean and decontamination.

Information to deliver safe care and treatment

Care records were managed in a way that kept people staff and were maintained in line with General Medical Council (GMC) guidance. This included contemporaneous records that were accessible to both clinical staff.

Medical records were stored securely with restricted access on site and both clinical staff had access to records remotely. This meant they had timely access to test results and medical histories even when they were not in the clinic.

There was clear evidence of timely and detailed referral documentation that reflected patient choice and included evidence of existing conditions and diagnoses. Referrals were of a consistent standard in both private insurance referrals and NHS documentation.

Safe and appropriate use of medicines

Are services safe?

The doctor prescribed medicines using blank proformas that were stored securely and tracked using identifier numbers. A copy was saved to the patient's medical records, which meant staff maintained a continual record of prescribed medicines.

An up to date prescribing protocol was in place and had been updated in 2018. The clinical team prescribed a limited range of medicines directly from the service and did not prescribed Schedule 2 and 3 Controlled Drugs. The team was responsive to information regarding the misuse of medicines and as a result had stopped prescribing certain pain medicines.

Track record on safety

Up to date policies were in place for incidents and significant events and there had been no reported incidents in the previous 12 months.

The nurse monitored national safety alerts from the National Patient Safety Agency (NPSA) and checked them against patients receiving ongoing treatment. Where patients were contacted about an NPSA alert staff recorded this in the patient's records.

The nurse carried out an annual infection control audit to assess environmental standards and practice against the provider's standards. The latest audit in January 2018 found two areas for improvement; more consistent cleaning of equipment and the replacement of fabric chairs in the clinical room. Both actions had been completed by March 2018.

Lessons learned and improvements made

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

There had been no unexpected or unintended safety incidents. There was a protocol in place to ensure people would be offered reasonable support, truthful information and a verbal and written apology in the event of an incident. The protocol also ensured staff would keep written records of verbal interactions and written correspondence.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The provider 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.

The clinical team audited walk-in appointments to identify the most common reasons patients attended the clinic and the outcome of each appointment. This meant staff could identify if they were effectively meeting patient demand and if outcomes were appropriate based on best practice guidance.

The team audited patient records to identify correlation between attendance for stress-related symptoms and the department the patient worked in. They found no significant outliers and noted all patients had higher than desirable stress levels. As a result, the team implemented a stress management programme.

Clinical staff referred to national guidance when providing patients with explanations of treatment and medicines. We saw detailed examples of this in three patient records we looked at. For example, where a patient had raised cholesterol levels the GP quoted NICE and British Heart Foundation guidance to help them understand their results.

The nurse managed local policies and maintained these in line with national guidance, such as a recently updated urinalysis policy. Policies and guidance were available electronically and were stored in a protected online system locally.

Monitoring care and treatment

The clinical team maintained up to date records for each patient, including ad-hoc appointments and corporate medicals. This meant there was continuity of care between different types of appointment and clinical staff could use the outcomes of either to schedule tests, scans and referrals.

Staff monitored patients for health trends and changes in their needs or routine blood tests. This meant there was a continuous record of care and treatment.

Effective staffing

The clinical team maintained appraisals and supervisions through their substantive posts and had undergone a formal appraisal in March 2018. Both individuals had revalidated in the previous 12 months. Where they identified a need for additional training they arranged this through their usual place of work. Both individuals maintained up to date training in NHS primary care practice.

Coordinating patient care and information sharing

Staff prepared care summaries and referral information for GPs with consent from the patient. In most cases patients were given a copy of the summary letter so they could decide to give it to their GP.

The doctor referred patients directly to specialist consultants either through their private insurance cover or to an NHS service on request. A continual record was maintained of referrals, including the outcome and evidence of communication with the patient's usual GP.

Clinical staff received blood test results remotely, which meant they acted on these when the service was not open. All results were scanned and attached to patient's records, which staff accessed from their NHS practice to ensure they remained up to date and reduce delays in referral to specialist services.

Supporting patients to live healthier lives

Clinical staff asked patients about their mental health routinely during appointments and provided guidance and support on managing stress and other mental health challenges.

The clinical team noted all patients typically presented with high levels of work-related stress. To address this, they established a stress management and wellbeing programme that included massage, yoga and pilates. The team also encouraged patients to make use of a sponsored gym membership to manage physical wellbeing. The team had also prepared signposting information for community mental health and support services and they provided this by e-mail or in printed form during appointments.

The service provided services to support people to live healthier lifestyles. This included smoking cessation, weight management and travel advice. The clinical team

Are services effective?

(for example, treatment is effective)

tracked and documented health improvements, such as weight reduction and improved sleep from reducing alcohol intake and provided patients with signposting to services to help them keep up the momentum.

Consent to care and treatment

Both members of the clinical team demonstrated understanding of the Mental Capacity Act (2005) and this was clearly embedded in care.

Consent to care was documented in patient records, which included consent to share information with other health professionals. Before referring patients to a specialist service, staff discussed the options available including the need for further tests or diagnostics. This information was clearly documented in patient's records.

The service did not share clinical or personal information with the contracting organisation except where a patient's safety was at immediate risk.

Are services caring?

Our findings

Kindness, respect and compassion

Both members of staff who operated the service received consistently positive feedback about the care and treatment they provided. They demonstrated a dedication to providing holistic care and had built trusting relationships with patients by delivering consistent care over several years. The team recognised patients often presented with health needs related to work and lifestyle and were aware patients could feel anxious about discussing such issues whilst at work. They therefore reinforced the strict confidentiality rules the service operated within and ensured they supported patients to develop their confidence and trust in the service.

All 10 patient CQC comment cards we received noted staff treated them with kindness and respect. Each of the three patients we spoke with said staff had always been kind, friendly and compassionate when discussing sensitive issues or disturbing test results.

The service provided level one counselling as well as sessions for bereavement counselling and emotional support following a loss. Where patients experienced significant life changes we saw evidence the clinical team provided encouragement, guidance and support.

Involvement in decisions about care and treatment

Eight of the 10 CQC comment cards we received from patients noted that staff had always involved them in treatment planning, including when they felt a referral to a consultant was necessary.

The team provided a dedicated 'second opinion' service for patients who had been prescribed care or treatment elsewhere. This meant they had extended time to discuss their concerns or questions with the GP or nurse who were able to explain treatments and care plans.

The clinical team e-mailed a pre-assessment questionnaire to each patient ahead of planned GP appointments to gather information to help plan the appointment. This included an open question about what the patient hoped to get out of the appointment. This was part of a system that ensured patients were the main consideration of the service and staff were led by them in making decisions about care and treatment.

Patients decided if they wanted to see the GP or the nurse for scheduled appointments and for walk-in appointments and the team respected this decision by always providing their first choice.

We looked at three sets of patient records and saw documented evidence staff involved them in care and treatment planning and in their results. This included a detailed explanation of test results, the implications on the patient's health and information on what they could do to correct this, such as lifestyle changes. Where a referral was necessary the GP discussed the options, available and ensured the patient was supported to make an informed choice.

The GP provided positive, affirmative and engaging information following GP appointments and walk-in reviews. This included encouragement for patients who had seen a reduction in weight as a result of exercise and those who had an improvement in health as a result of reduced smoking and alcohol intake.

Privacy and Dignity

Staff offered a highly confidential service. All 10 of the patient CQC comment cards we received noted staff always acted confidentially and respected their privacy. Three patients we spoke with said they always felt the clinical team respected their privacy and carried out appointments with regards to this.

The clinical area offered privacy from the rest of the work spaces on the same floor and all discussions, care and examinations took place in a secured area with restricted access.

The clinical team provided care and treatment that respected patient's dignity and demonstrated this through sensitive responses to personal issues such as mental health or alcohol use.

The clinical team provided referrals to cognitive behaviour therapy services in discussion with patients and ensured their privacy and dignity were maintained through confidentiality open, sensitive discussion of the reason for the referral.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff responded to clinical needs and acted on concerns that came about as a result of other assessments and checks. For example, the doctor had identified one patient had clinical indications of a serious eye disease during a routine walk-in appointment. They made a direct referral to a specialist service that enabled the patient to access immediate treatment.

The clinical team had provided services to patients for over 11 years and had developed a detailed understanding of the impact of changes in the workplace on patient health. For example, they identified changes in morale, stress and physical wellness during periods of management or organisational change. To support patients during such periods the team produced a reference guide to managing stressful situations and uncertainty at work. This included a guide to recognising excessive stress levels, coping mechanisms and online sources of more detailed information.

The service had developed in line with patient demand and needs. For example, staff had introduced chronic condition management for asthma, chronic obstructive pulmonary disease (COPD) and diabetes.

The clinical team carried out regular health screens with patients who attended for a GP appointment or walk-in appointment and had detected early signs of cancer and diabetes in several patients in the previous year. Due to confidentiality arrangements with the contracting organisation and patients the team did not formally audit this but noted an average of 55 patients per month avoided taking time off work for clinical investigations because they were able to access condition management services at work. The team recognised patients typically delayed seeing their NHS GP because they would need to take time off work. The on-site service therefore detected early symptoms of developing conditions and health needs at an early stage and meant the service could refer patients immediately to specialist services.

The clinical team provided an individualised service for each patient and ensured they had detailed information on their condition or needs before they left an appointment. For example, where a patient experienced a foot condition the GP printed out a map of the foot with guidance on how to exercise it. The team also researched the prices of medicines for each patient and helped them find the most economical outlet.

The clinical team had worked with the contracting organisation on strategies to reduce workplace stress, which had resulted in the provision of break-out zones for staff to use for informal discussions and time away from their desk.

The clinical team worked with patients to identify previously unmet needs, such as mild learning difficulties. In such instances they provided a formal referral for the patient to a specialist service or signposting to community services.

The team liaised with human resources to ensure equal access to health services for all patients, including adapted access where patients were living with a learning disability or specific communication needs.

Timely access to the service

The service provided pre-bookable appointments and a walk-in service on specific dates planned and advertised in advance. Patients were offered extended time for appointments, 80% of which lasted for 30 minutes. The nurse scheduled appointments, which patients made by e-mail, phone or visiting the service when it was operating.

Appointments were always flexible and if patients were delayed or had to cancel due to a meeting or other work demands the team rearranged the appointment to the next available time.

All 10 of the patient CQC comment cards noted patients found the service convenient to access, including with phone and e-mail options. Three patients we spoke with said accessing the service was always straightforward and they appreciated late appointments being available, including up to 9pm on request.

Where the clinical team were aware of health risks specific to the local area or the building they offered proactive screening and appointments, such as when there was an outbreak of chest infections.

The service operated one day per week and clinical staff were available to discuss test results or treatment plans by phone or e-mail between clinic dates.

Listening and learning from concerns and complaints

Are services responsive to people's needs?

(for example, to feedback?)

There was a formal complaints process in place and this was clearly advertised in the clinic. Three patients we spoke with said they knew how to make a complaint.

There had been no complaints about the service at any time during its operation.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

Leadership capacity and capability;

A doctor and nurse led and provided the service jointly. Both individuals worked substantively elsewhere in the NHS and maintained communication to plan this service and the care of patients receiving ongoing treatment. Both staff held formal meetings together to review patient outcomes and service planning and to review the capacity of the service.

The two members of the clinical team maintained continual communication and coordinated annual leave between them to ensure there was no impact on the service.

Both members of the clinical team were experienced senior members of staff in the NHS and demonstrated the capacity and capability to lead and manage demands on the service.

Vision and strategy

The service had an up to date statement of purpose and a service vision that outlined the standards patients could expect.

The delivery of care was clearly aligned to the working culture of the contracting organisation and promoted inclusivity and collaborative care between the clinical team and patients.

Care was planned and delivered to meet the needs of the workforce and staff demonstrated a substantial track record of successful change and adaptation to meet changing needs.

Culture

The culture of the service encouraged candour, openness and honesty. Both members of staff had up to date training in the Duty of Candour and demonstrated how they ensured communication with patients was clear and led individual needs.

The service was demonstrably centred on the needs of patients who used the service and promoted a culture of continual learning and adaptation. Staff monitored trends in patient's conditions and presenting medical concerns and used this to develop targeted health initiatives and to provide targeted information to help people manage their health.

Both members of the team had up to date training in equality and diversity and delivered care and treatment that was equitable.

Governance arrangements

There was an information governance system in place that meant patient personal details were protected from misuse and loss. The clinical computer system was maintained by the corporate IT team of the company on whose premises the service operated. However, data storage was independent from corporate systems and only clinical staff had access to patient information. The information was encrypted and backed up on the NHS computer system used by the clinical lead at their main practice. They explained this to patients and it was included in the consent process. The nurse had up to date training in data security awareness and information governance.

The team had met with the contracting organisation's cyber security team and established a confidentiality agreement for the handling of patient data. This included daily secure disposal of temporary documentation, on-site shredding and monthly password changes for the clinical computer system.

The two individuals who operated the service had sole responsibility for governance. They demonstrated an effective system that included regular meetings for business planning and consistent communication with the corporate team responsible for contracting the service.

Managing risks, issues and performance

The clinical team had developed a close working relationship with the senior team of the contracting organisation. This meant they could discuss health risks and trends openly and frankly, without compromising the confidentiality of patients. For example, where they noted increased cases of poor health or reduced wellness in one department or team they discussed this with the corporate team to identify strategies to promote better health. They provided regular summaries of the service provided and an annual report of the impact of the service.

Services were planned to adapt to the needs of the contracting organisation, such as in changes to operating

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

times. The clinical team understood the health risks associated with changes in the workplace and adapted the service according to continue to meet individual needs. Where corporate changes impacted the operation of the service the team ensured their strategy meant the service remained sustainable and viable.

Appropriate and accurate information

The clinical team used feedback from patients to drive the service, such as with the implementation of a walk-in service. This demonstrated how the team worked to improve the service over and above continual quality assurance.

Quality and sustainability were key elements of the clinical team's strategy and vision and they documented regular meetings and provided regular updates to the contracting organisation to demonstrate how they achieved this.

Data security standards met the European Union General Data Protection Regulation 2016/679 and effective processes were in place in the event of a security breach.

Engagement with patients, the public, staff and external partners

The clinical team was clearly involved in the well-being of patients and proactively engaged with them through digital channels enabled by the contracting company. They acted as a liaison between patients and the corporate senior team when they identified opportunities for wider engagement, such as when a number of patients requested blood donor services on site. The team also supported patients in recording their wishes for organ donation.

The team provided an ad-hoc service on request by different departments in the organisation, such as a mental health discussion following a human resources event.

Continuous improvement and innovation

The clinical team provided innovative continuing care support to patients approaching retirement age with the company. Care was coordinated with human resources and the patient's NHS GP as part of phased retirement plan to ensure there were no gaps in care or treatment.

The service was tailored to each individual patient and the clinical team consistently exceeded expectations by adapting care, treatment and multidisciplinary working. For example, where one patient needed a type of screening only routinely available at their usual NHS GP the nurse liaised with the patient's practice to coordinate screening on-site. This saved the patient the need for time off work and reduced the burden on their usual GP. The clinical team issued a prescription and coordinated the results with the patient's GP.

The team had taken persistent and substantial action to manage and reduce stress among patients whilst at work. They had worked with the senior team of the contracting organisation to provide reduced stress work zones and time out for massage, yoga and meditation. This was part of a broader, comprehensive approach to reducing the health impacts of harmful levels of stress and the team were monitoring patient outcomes to drive future initiatives.