Lisson Grove Health Centre

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 summary

We carried out an announced focused inspection at Lisson Grove Health Centre on 20 and 21 March 2019 and on 5 April 2019. This inspection was triggered by information of concern received in a report from the Coroner on 13 March 2019. We concentrated on the areas of concern raised by the Coroner and associated matters. To explore those concerns, our inspection focused on the following three key questions: Are services safe; effective; and well-led? We also inspected all six population groups under 'effective'.

We based our judgement of the quality of care at this service on a combination of:

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

At this inspection we found:

- The service did not have a clear system to ensure oversight of safe prescribing. Medical records we reviewed were not consistent in recording the medical problem, the treatment being prescribed and the length of time that treatment might persist. While not mandatory it is good practice to ensure that long term medication is linked to the medical problem in the patient record.
- We found medication reviews were not well coded or documented which meant we were not assured that patients were always receiving the correct care, treatment and monitoring for their conditions. (Read codes are a national standard coding system used in general practice for recording clinical information).
- The practice had a process for managing safety alerts and we saw information was communicated and actions were followed up. However, actions from safety alerts received were not always logged or updated on the safety alert log in a timely way.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. The practice acted effectively on tasks and requests raised on the patient record system
- There was a system for reporting and learning from serious incidents. The practice had carried out a thorough investigation into the concerns in the Coroner's report. However, changes to the system of medication reviews were not sufficiently developed.
- There was an ineffective system of structured medicines reviews for patients with long term conditions.
- The nurse prescriber had received adequate supervision. The lead GP met weekly with the nurse prescriber but we found these supervision meetings were not documented..
- Despite being in one of the most deprived areas of London and having a high prevalence of diabetes we saw evidence of effective performance achievement in the care and management of patients with diabetes.
- Performance data on uptake rates for childhood immunisations was significantly below local and national averages in three of the four areas measured.
- There was a lack of formal governance structure in place to ensure the practice monitored all risks identified. Issues that could threaten the delivery of safe and effective care were not always identified and managed. For example, the practice was not managing all risks with respect to management reviews.
- While the practice had made some improvements since receiving the Coroner's report, it had not appropriately addressed concerns in relation to the scheduling and recording of medication reviews.

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

- Review systems to encourage uptake of national cancer screening programmes.
- Review the need to support staff with ongoing supervision.
- Monitor the improvements made following the Coroner's concerns to ensure that they are consistently embedded.

Details of our findings and the evidence supporting our judgements are set out in the evidence tables.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Population group ratings

Our inspection team

Our inspection team was led by a CQC lead inspector and included a CQC Inspection Manager, a GP specialist advisor and a Medicines specialist advisor.

Background to Lisson Grove Health Centre

Lisson Grove Health Centre provides GP primary care services to approximately 7,470 people living in Westminster. The practice is in a two-storey building on Gateforth Street and shares the building with two dental surgeries. The practice is part of the NHS Central London (Westminster) CCG which is made up of 27 general practices. The practice holds a Personal Medical Services (PMS) contract (an agreement between NHS England and general practices for delivering primary medical services) and is commissioned by NHSE London. The premises are purpose built and all services are provided from the ground floor of the building, providing ease of access for patients with mobility difficulties.

The practice is led by three male and two female GP partners and has two regular male locums who work a combination of full and part time hours, totalling 5.8 WTE. There is a practice manager, a team of three female practice nurses, a healthcare assistant and a team of eleven reception and admin staff.

The practice is open between 8.30am and 6.30pm Monday to Friday; with extended hours opening on Saturday between 8.30am and 12.30pm. Appointments are from 8.30am to 12.30pm every morning and 3pm to 7pm on Tuesday, Wednesday and Thursday; from 2.30pm to 7pm on Monday afternoon; and from 3pm to 18.30pm on Friday afternoon. Outside of these hours, patients are advised to contact the NHS 111 service.

Longer appointments are available for patients who need them and those with long-term conditions. This also included appointments with a named GP or nurse. Pre-bookable appointments can be booked up to two weeks in advance; urgent appointments are available for people that needed them. The provider offers a substance misuse service and can carry out home visits for patients whose health condition prevents them attending the surgery. The practice provides an online appointment booking system and an electronic repeat prescription service.

The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

Lisson Grove Health Centre is in one of the most deprived areas of London. Information published by Public Health England (PHE) rates the level of deprivation within the practice population group as one on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest. Compared to other practices in England, more patients are unemployed. Mental health prevalence among the practice population is 2%, more than double the national average of 1%. The practice has 46% of people with a long-standing health condition (compared to a national average of 52%).