London Street Surgery

Inspection report

72 London Street
Reading
RG1 4SJ
Tel:

Date of inspection visit: 14 April 2022
Date of publication: 01/06/2022

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

Overall summary

We carried out an announced comprehensive inspection at London Street Surgery on 14 April 2022. We undertook this inspection as the provider registered in 2019 and had not received an inspection under this registration with CQC. We inspected all five key questions and identified significant risks to patients and that improvements to services were required. We have issued the following ratings.

Ratings:

Overall Rating – Inadequate

Safe - Inadequate

Effective – Requires Improvement

Caring - Good

Responsive - Good

Well-led - Inadequate

The full reports for our inspections under the previous provider can be found by selecting the 'all reports' link for London Street Surgery under the old profile, on our website at www.cqc.org.uk

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.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site.

The inspection included:

- Conducting staff interviews using video conferencing facilities
- Completing clinical searches on the practice's patient records system and discussing findings with the provider
- Reviewing patient records to identify issues and clarify actions taken by the provider
- Requesting evidence from the provider
- A short site visit
- Speaking with members of the patient representative group
- Obtaining patient feedback from external sources

Our findings

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.

Overall summary

We have rated this practice as Inadequate for providing safe services.

- There was poor identification of risks to patients.
- Repeat prescribing and medicines were not managed safely, posing a risk of harm to patients.
- There were significant backlogs of test results and care-related tasks.
- There were risks associated with the storage of blank prescriptions.

We have rated this practice as Requires Improvement for providing effective services.

- Some patients with long term conditions were not having their conditions managed appropriately.
- Patients with learning disabilities were not provided with health checks to ensure their wellbeing was being monitored.
- Staff training was not monitored appropriately.

We have rated this practice as Inadequate for providing well-led services.

- There was limited independent quality improvement on the part of the practice and leaders did not have sufficient audit and monitoring processes to ensure the safety and effectiveness of services.
- There was insufficient capacity to ensure appropriate governance systems were in place, particularly clinical governance.

We also found:

- The practice had taken action to improve patient access and experience when speaking or consulting with staff, in response to patient feedback.
- Patients had a range of appointments to access and variety of ways to communicate with the practice.
- Staff were caring and compassionate towards to patients.
- There had been a loss of GPs and practice manager during the COVID pandemic and this had impacted on the provider's ability to provide quality and sustainable services.

We found two regulations were being breached as a result of our findings.

The provider must:

- Ensure care is provided in safe way for patients
- Systems or processes must be established to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. .

Additionally, the provider should:

- Review their carer's register and the means by which they identify carers.
- Consider implementing best practice guidance in regards the monitoring of medicine fridge temperatures.

Overall summary

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve

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

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 spoke with staff using video conferencing facilities and undertook a site visit. The team included a GP specialist advisor who spoke with staff using video conferencing facilities and completed clinical searches and records reviews without visiting the location.

Background to London Street Surgery

Provider: Dr Najat Essa

Location: London Street Surgery is located in Reading with one site providing services to approximately 5,600 patients, from the following address:

72 London Street

Reading

Berkshire

RG1 4SJ

The practice website is: www.londonstreetsurgery.co.uk/

The provider is registered with CQC to deliver the following Regulated Activities:

- Diagnostic and Screening Procedures
- Maternity and Midwifery Services
- Treatment of Disease, Disorder or Injury
- Family Planning Services

The practice is part of West Berkshire Clinical Commissioning Group (CCG).

There is one lead GP and three long-term locums working at the practice. There are also three part-time practice nurses and a care coordinator who also undertakes phlebotomy. The clinical team is supported by a practice manager and administration and reception staff.

The practice is in the fifth most deprived decile, meaning it has a significant number of patients living in economic deprivation. It has a high proportion of patients from ethnic minority backgrounds (31%), with 19% of the patient list describing themselves being from an Asian background. There are fewer patients diagnosed with long-term conditions than the national average.

The practice does not provide Out of Hours (OOH) GP services when the practice is closed. Patients can access OOH services by contacting the NHS 111 telephone service.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Family planning services Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider was failing to assess, monitor and improve the quality and safety of the services. There were not appropriate systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activities. This was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Family planning services Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider was failing to provide care in a safe way for service users. They were not assessing the risks to the health and safety of service users in receiving care or treatment or doing all that is reasonably practicable to mitigate any such risks. This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.