Lister House Surgery

Inspection report

473 Dunstable Road
Luton
Bedfordshire
LU4 8DG
Tel: 01582578989

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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	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Requires improvement**
Are services responsive?	**Inadequate**
Are services well-led?	**Inadequate**

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection of Lister House Surgery on 22 August 2018. This inspection was undertaken to follow up on warning notices we issued to the provider in relation to Regulation 12 Safe Care and Treatment and Regulation 17 Good Governance.

The practice received an overall rating of inadequate at our inspection on 18 and 19 June 2018 and this will remain unchanged until we undertake a further full comprehensive inspection within six months of the publication date of the initial report.

The full comprehensive report from the June 2018 inspection can be found by selecting the 'all reports' link for Lister House Surgery on our website at .

Our key findings were as follows:

- The practice had taken some of the actions needed to comply with the legal requirements. However, there was still concerns with the leadership and governance of the practice. The breakdown in the professional relationship between the individual GP partners had not been resolved.
- Fire safety and Legionella risk assessments had been completed. However, identified actions had not been taken. There were no risk assessments in place for the control of substances hazardous to health (COSHH).
- There had been no infection prevention and control (IPC) audits completed so areas that required attention had not been identified.
- Significant events were now identified and reported on with lessons learnt identified and shared with staff.
- There was a system in place to manage safety alerts and Medicines and Healthcare products Regulatory Agency (MHRA) alerts received by the practice. However, a log of actions taken was not kept.
- Practice policies and procedures were all in the process of review. Essential policies were in place. For example, for safeguarding, whistleblowing and business continuity. However, the practice safeguarding lead was not identified in the policy.
- All staff had received a disclosure and barring check (DBS).
- Processes had been strengthened for managing test results and communications from secondary care so recommended actions had been completed. However, blood test results were not always documented in the patient computer record.
- There was a process in place for the use of Patient Specific Directions (PSDs).
- The practice had started to make plans to form a PPG. There was a link on the practice website for patients to fill in a form expressing their interest. The practice had completed their own patient surveys.
- A system of staff appraisals and one-to-ones had been implemented. All job descriptions had been reviewed and a formal induction process was in place for new staff.
- The complaints policy had been reviewed. Complaints were handled in accordance with the recommended guidance.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Population group ratings

Older people	**Requires improvement**
People with long-term conditions	**Inadequate**
Families, children and young people	**Inadequate**
Working age people (including those recently retired and students)	**Inadequate**
People whose circumstances may make them vulnerable	**Inadequate**
People experiencing poor mental health (including people with dementia)	**Inadequate**

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector and included a GP specialist adviser.

Background to Lister House Surgery

Lister House Surgery provides a range of primary medical services to the residents of Luton. The practice has a registered manager in place. A registered manager is an individual registered with CQC to manage the regulated activities provided.

The practice provides primary medical services under a general medical services (GMS) contract from its location of 473 Dunstable Road, Luton, Bedfordshire, LU4 8DG. Online services can be accessed from the practice website www.listerhouseluton.co.uk

The practice has approximately 7100 patients. The practice population is of mixed ethnicity with an average age range. National data indicates the area is one of mid deprivation.

The practice is led by two male GP partners. They use three regular GP locums, one male and two female, to support the clinical team. The nursing team consists of a locum advanced nurse practitioner, a nurse practitioner, a practice nurse and a health care assistant, all female. There is a practice manager who leads a team of administrative and reception staff.

Lister House Surgery is open from 8.30am to 6.30pm Monday to Friday with the telephone lines open from 8am. The practice offers extended hours opening for pre-booked appointments on Saturdays from 8am to 12pm.

When the practice is closed out-of-hours services are provided by Herts Urgent Care and can be accessed via the NHS 111 service.

Why we carried out this inspection

We undertook a comprehensive inspection of Lister House Surgery on 18 and 19 June 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate. The full comprehensive report following the inspection on 18 and 19 June 2018 can be found by selecting the 'all reports' link for Lister House Surgery on our website at www.cqc.org.uk.

We issued warning notices to the provider and informed them they must become compliant within the law by 10 August 2018 for safe care and treatment and good governance.

We undertook a follow up focused inspection of Lister House Surgery on 22 August 2018. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

Inadequate

Are services safe?

Our findings

At our previous inspection on 18 and 19 June 2018, we rated the practice as inadequate for providing safe services as we identified significant concerns in respect of the systems and processes in place and the levels of risk associated with patient safety.

There had been some improvements made when we undertook a follow up inspection on 22 August 2018. However, there were still concerns in relation to patient safety.

Safety systems and processes

At the inspection in June 2018:

- We reviewed the safeguarding procedures in the practice and found the policies for safeguarding children and vulnerable adults had no review dates, they did not contain the identified safeguarding lead in the practice and the local authority contact details were dated 2015. At the August 2018 inspection the practice had reviewed the safeguarding policies and up to date local authority contact details were available. However, the practice safeguarding lead was not identified in the policy. All staff had access to the safeguarding policies on the practice computer system.
- The practice did not share information with the local health visitor with regards to children with multiple visits (frequent flyers) and non-attenders. At the August 2018 inspection we reviewed the patient computer records and found the practice now shared information with the local health visitor with regards to these patients.
- There was not an effective system to manage infection prevention and control (IPC). The IPC policy was overdue a review and IPC audits had not been completed. IPC training was not included in the induction of new staff. At the August 2018 inspection we were shown the updated IPC policy. However, we found the policy was not comprehensive and did not cover all areas of IPC. For example, the policy only contained a detailed cleaning schedule. There had been no IPC audits completed by the practice.
- The practice was unable to assure us that a Disclosure and Barring Service (DBS) check had been completed for a member of the nursing team. At the August 2018 inspection we were shown evidence that all staff employed by the practice had now received a DBS check. (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.)

Information to deliver safe care and treatment

At the inspection in June 2018:

- The approach to managing test results was not consistent. The most recent results received into the practice had been reviewed and acted upon but not all blood test results were documented in the patient computer records. At the August 2018 inspection we found that there had been no change to the way test results were managed. A review of the patient computer records showed that test results had not been documented.
- We found that actions identified in secondary care with regards to changes to patients prescribed medicines or treatment were not always completed. We reviewed two letters and found that one patient had not had their prescribed dose of medicine increased and another had not received a recommended review. At the August 2018 inspection we found that all actions identified in secondary care had now been acted on.

Appropriate and safe use of medicines

At the inspection in June 2018:

Inadequate

Are services safe?

- National guidance was not always followed when staff prescribed, administered or supplied medicines to patients and gave advice on medicines. The practice did not use Patient Specific Directions (PSDs) when the health care assistant administered vaccinations or injections. A PSD is the written instruction, signed by a doctor, dentist, or non-medical prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. At the August 2018 inspection we were informed by the practice that PSDs were now in use. Clinical staff were aware of the correct process to follow and the HCA had received a training update for the administration of vaccinations and injections.
- Members of the nursing team had completed medicine reviews that they were not qualified to do. At the August 2018 inspection we reviewed the patient computer record system and found that medicine reviews were now completed by a GP. The practice had recruited a locum advanced nurse practitioner who had the necessary training and qualification to complete medicine reviews.

Lessons learned and improvements made

At the inspection in June 2018:

- The GPs and staff did not understand their duty to raise concerns and report incidents and near misses. We found that no significant events had been identified or reported on for two years. At the August 2018 inspection we saw that significant events were now identified by all staff groups.
- There were no systems for reviewing and investigating when things went wrong. The practice did not hold any clinical or staff meetings where significant events would be discussed, reviewed and lessons learnt from the event identified to improve safety in the practice. The practice had now introduced clinical and staff meetings. A review of the minutes of the meetings held showed that significant events were now discussed and reviewed with lessons learnt identified.
- The practice did not act on and learn from external safety events as well as patient and medicine safety alerts. At the August 2018 inspection the practice had a process in place to act on alerts. A review of the patient computer records indicated that alerts received had been acted on.

Please refer to the evidence tables for further information.

Inadequate

Are services responsive to people's needs?

Our findings

At our previous inspection on 18 and 19 June 2018, we rated the practice as inadequate for providing responsive services as the arrangements in respect of recording, investigating and learning from complaints needed improving.

These arrangements had improved when we undertook a follow up inspection on 22 August 2018.

Listening and learning from concerns and complaints

At the inspection in June 2018:

- Information in the complaints leaflet and on the practice website regarding the complaints lead was not correct. At the inspection in August 2018 the complaints leaflet and policy had been reviewed and updated and identified the practice manager as the lead for managing complaints. There was a procedure available for staff to follow when a patient wished to make a complaint. The complaints policy was available on the practice website.
- The complaints policy and procedures documented recommended timeframes and actions to take in line with recognised guidance but the practice did not follow the policy for the management of all complaints. At the inspection in August 2018 we observed that the recommended guidance was now followed.
- The practice did not complete an analysis of complaints to identify any trends. There were no meetings held to share learning or discussions with staff. At the August 2018 inspection the practice had a complaints log to help the practice identify any trends in complaints made. The practice had started a programme of clinical and practice meetings and a review of the meeting minutes showed that complaints, and learning from them, were discussed with staff.

Please refer to the evidence tables for further information.

Inadequate

Are services well-led?

Our findings

At our previous inspection on 18 and 19 June 2018, we rated the practice as inadequate for providing well-led services as we found significant concerns in the leadership and governance of the practice.

There had been some improvements made when we undertook a follow up inspection on 22 August 2018. However, there were still concerns in relation to leadership in the practice.

Leadership capacity and capability

At the inspection in June 2018*:*

- Leaders were not aware of issues and priorities relating to the quality and future of services. They did not understand the challenges and no actions had been taken to address them. Following the inspection, the practice recruited a new practice manager and developed an action plan to ensure they made the necessary changes within the practice.
- Staff reported that they did not always feel supported by the leaders in the practice. At the August 2018 inspection staff reported that they felt more supported following the recruitment of the new practice manager. All staff, apart from the deputy practice manager, had received an appraisal which included a review of performance development. The practice informed us they planned to hold monthly one to one meetings with staff to review their continuous development.

Governance arrangements

At the inspection in June 2018*:*

- Policies and procedures in place were not specific to the practice and many were overdue a review. Key policies including Whistleblowing and Business Continuity were missing. At the August 2018 inspection we saw that all the practice policies and procedures were undergoing a review. The practice had in place policies for Whistleblowing and Business Continuity.

Managing risks, issues and performance

At the inspection in June 2018*:*

- There was not an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. At the August 2018 inspection the practice had completed some but not all of the necessary risk assessments required to ensure patient safety. They had not completed the recommended actions as a result of the risk assessments.
- The practice did not have processes to manage current and future performance. Practice leaders did not have oversight of safety alerts, incidents, and complaints. At the August 2018 inspection the practice had reviewed its processes and clinical meetings were scheduled to review safety alerts, incidents and complaints.
- The practice did not have plans in place for major incidents. There was no business continuity plan. At the August 2018 inspection the practice had a business continuity plan. We were informed a copy of the plan was kept off site.

Engagement with patients, the public, staff and external partners

At the inspection in June 2018:

- The practice did not have a patient participation group (PPG) to represent the views of patient in the practice. At the August 2018 inspection the practice had started to make plans to form a PPG. There was a link on the practice website for patients to fill in a form expressing their interest.
- The NHS Friends and Family Test (FFT) responses were not collated, analysed or published. The practice had now devised their own survey that reflected the FFT.

Inadequate

Are services well-led?

- There was a lack of staff engagement due to the absence of one-to-ones, appraisals and staff meetings. At the August 2018 inspection we saw evidence that staff had received an appraisal since the previous inspection. A schedule of staff meetings and one-to-ones had been put in place.

The practice continued to work with the local clinical commissioning group (CCG) to secure stability for the future of the practice.

Please refer to the evidence tables for further information.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The system for checking the monitoring of medicines that required review was not evident. Regulation 12 Health and Social Care Act

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There were significant concerns in the leadership and governance of the practice. There were some gaps in the management of policies. For example, the complaints policy did not contain the recommended timeframe for an initial acknowledgement of complaints received and the practices safeguarding lead was not named in the safeguarding policy. Identified actions had not been taken following the Fire Safety and Legionella risk assessments. There were no up to date risk assessments in place for the control of substances hazardous to health (COSHH) and Infection Prevention and Control. Regulation 17 Health and Social Care Act