Hetherington Group Practice

Quality 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 rating for this service	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hetherington Group Practice on 30 March 2016. The overall rating for the practice was good. However, we identified breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which led to the practice being rated as requires improvement for being well led.

Specifically:

- The systems for analysing significant events were not effective in that learning was not clearly documented or communicated to staff.
- Recruitment policies and processes were not effective in that there was no system in place for monitoring the professional registrations of clinical staff.
- The practice did not have a full supply of emergency medicines including rectal diazepam and diclofenac and there was no risk assessment in place to justify the absence of these medicines.

In addition to the breaches of legislation identified we found several areas where we suggested the provider should make improvements:

- Ensure complaints policy and responses comply with requirements of The Local Authority Social Services and NHS Complaints (England) Regulations 2009.
- Ensure that all staff have received required mandatory training including fire safety, information governance and infection control.
- Continue to review and monitor telephone and appointment access.
- Consider drafting a formal strategic business plan.
- Consider undertaking regular internal appraisals for salaried GPs and review the appraisal process for all staff.
- Review patients with mental health concerns and put strategies in place to ensure that their alcohol consumption is discussed and recorded.
- Continue to review patients to ensure that people with Coronary Heart Disease are identified.
- Review the process of internal audit, clearly documenting the action taken to improve outcomes and consider putting this information into a structured written format.

The full comprehensive report from the 30 March 2016 inspection can be found by selecting the 'all reports' link for Hetherington Group Practice on our website at www.cqc.org.uk.

This inspection was a desk-based focused review carried out on 13 February 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified

Summary of findings

in our previous inspection on 30 March 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

The practice rating for well led is now good. The practice remains rated good overall.

Our key findings in respect of the breaches of regulation were as follows:

- The practice had a full supply of emergency medicines.
- The practice had an effective system in place for documenting, discussing and learning from significant events.
- The practice had systems in place to monitor the professional registrations of clinical staff.

The practice had also taken action to address the areas where we suggested that improvement should be made:

- The practice detailed information about advocacy organisations patients could contact if they were unhappy with the practice's response in their complaint acknowledgement letter.
- The practice had systems in place to ensure that staff completed required training in accordance with current legislation and guidance.
- The practice had started drafting a business plan which had involved analysis of practice strengths, weaknesses, opportunities and threats.
- The practice told us that they had held two training sessions with patients to try and increase or improve access to online services thereby easing congestion on the practice's telephone appointment system. This was in response to a patient survey which indicated that patients were having difficulties using the online appointment system.
- We were provided with an appraisal schedule which indicated that all staff, including salaried GPs, had been appraised after our previous inspection.
- We saw that the practice was taking steps to improve outcomes for mental health patients. Reminders were sent to staff about the importance of undertaking health checks and the practice had planned a clinic for patients suffering from mental illness who resided at a local hostel. In addition the percentage of patients with mental illness who had their alcohol consumption recorded had increased from 63% in the 2014/15 Quality and Outcomes Framework (QOF) year to 72% in 2015/16. However, this was still below the national average of 89% and local performance of 73%. (QOF is a system intended to improve the quality of general practice and reward good practice)
- The practice provided us with evidence to show that the low prevalence of Coronary Heart Disease (CHD) amongst their patient list was in line with local averages. The document provided showed that, while nationally prevalence was 3.4%, the prevalence in south London was 1.97% and in Lambeth this was 1.3% which was similar to the practice prevalence rate of 1.2%. As CHD is generally a disease associated with older people, the lower prevalence was attributed to the practice population which has a higher proportion of younger patients than the national average.The practice informed us that they would continue to make efforts to ensure their CHD prevalence data was accurate by coding patients with this disease on receipt of information from newly registered patients and diagnostic information from secondary care. In addition one of the partners told us that they would undertake regular searches of patients on medicines that were indicative of CHD to ensure coding was accurate.
- The practice provided us with a review of abnormal potassium results. Although the practice identified a potential cause of the abnormal results it was not clear what action the practice had taken in response to their findings and there was no evidence of reviewing this action in order to see if improvements could be made.

Action the practice should take:

- Continue to work to improve the practice's vision and strategy.
- Continue to work on improving the quality of service provided including work to improve patient outcomes.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services well-led?

Good

The practice had improved systems and processes to report learning from significant events, handle emergencies and monitor the professional registrations of clinical staff:

- The practice provided us with seven significant events which demonstrated lessons and learning. For example there was an incident involving one patient being mistaken for another with the same name. In response to the incident the practice took action to ensure that reception staff verified the identity of patients who had the same name to ensure that the GP was referring to the correct patient's records. Alerts were placed on the system to ensure that patient identities were verified.
- The practice provided us with evidence that they had obtained supplies of both diclofenac and rectal diazepam to enable them to respond effectively in emergencies.
- The practice had a spreadsheet a system to monitor the professional registrations of all clinical staff.
- All staff had completed required training after our last inspection. The practice had purchased software which prompted staff to complete required training when this became due. The practice manager could use the system to oversee all staff and ensure that this was completed.
- The practice provided us with a copy of a potassium audit. Although this was clearly presented there was no evidence of quality improvement work stemming from the concern raised in the audit.

Hetherington Group Practice

Detailed findings

Background to Hetherington Group Practice

Hetherington Group Practice is part of Lambeth CCG and serves approximately 8600 patients. The practice is registered with the CQC for the following regulated activities Diagnostic and Screening Procedures, Family Planning, Maternity and Midwifery Services, Surgical Procedures

And Treatment of Disease, Disorder or Injury.

The practice population is in the fourth most deprived decile on the index of multiple deprivation. The practice has a significantly higher proportion of working age people. The practice has a slightly lower than the national average proportion of older people and children.

The practice is run by three male partners and five salaried GPs of mixed gender. The practice is a training practice and currently has two trainee GPs. There are six nurses; two of which do work exclusively in the community.

The practice is open between 8 am and 6.30 pm Monday to Friday except Tuesdays when the practice stays open till 8 pm. The practice is also open on Saturdays 9 am till 12 pm. Appointments are available 8 am and 12 pm and 3 pm till 6 pm Monday to Friday except Tuesdays when surgery commences at 9 am till 12 pm and then resumes from 5 pm till 8 pm. The practice offers 47 sessions per week with booked and emergency appointments five days per week. Only pre booked appointments are available between 9 am and 12 pm on Saturdays.

Hetherington Group Practice operates from 18 Hetherington Road, Clapham, London, SW4 7NU in purpose built premises which are rented from NHS Property Services. The service is accessible for people with mobility difficulties. The practice is based over three floors and there is a lift. We were told that patients with mobility difficulties tended to be seen on the ground floor only.

Practice patients are directed to contact the local out of hours provider when the surgery is closed.

The practice operates under a Personal Medical Services (PMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These are: Childhood Vaccination and Immunisation Scheme, Extended Hours Access, Facilitating Timely Diagnosis and Support for People with Dementia, Improving Patient Online Access, Influenza and Pneumococcal Immunisations, Learning Disabilities, Minor Surgery, Rotavirus and Shingles Immunisations and Unplanned Admissions.

The practice is part of a GP federation.

Why we carried out this inspection

We carried out a focused inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

We carried out a desk-based focused inspection of Hetherington Group Practice on 13 February 2017. From reviewing the evidence provided by the practice we found that:

- The practice had a full supply of emergency medicines.
- The practice had an effective system in place for documenting, discussing and learning from significant events.
- The practice had systems in place to monitor the professional registrations of clinical staff.

In addition to addressing the breaches of regulation the practice had taken action to address most of the areas where we suggested they should make improvements.

Are services well-led?

Good

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

Our findings

At our previous inspection on 30 March 2016, we rated the practice as requires improvement for providing well-led services as there were deficiencies in governance which amounted to breaches of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance. Specifically:

- The practice's arrangements to respond to emergencies were not effective as they did not have a supply of diclofenac or rectal diazepam and there was no risk assessment to justify their absence.
- The systems for analysing significant events were not effective in that learning was not clearly documented or communicated to staff.
- Recruitment policies and processes did not ensure that patients were kept safe as there was no system in place for monitoring the professional registrations of clinical staff.

In addition we specified a number of areas where the practice should make improvements as:

- The practice did not have a documented business plan to support the implementation of the practice strategy.
- Systems for ensuring staff had completed all essential training did not operate effectively as not all staff had received fire safety, information governance and infection control training.
- It was evident that the practice had systems for monitoring performance and improving quality. However, it was not clear from looking at documented quality improvement reports and audits what action had caused the improvement in quality.

We issued a requirement notice in respect of these breaches and found that governance arrangements had improved when we undertook a follow up inspection of the service on 13 February 2017. The practice is now rated as good for being well-led.

Vision and strategy

The practice provided us with a copy of a business plan which analysed practice strengths, weaknesses, opportunities and threats; though there was no reference to proposed action to be taken in response to this analysis. The plan also referred to business areas including finances, staffing and premises.

Governance arrangements

- The practice had effective systems and processes in place to respond to emergencies. Since our last inspection visit the practice had purchased rectal diazepam (administered in response to an epileptic fit) and diclofenac (pain medication).
- The practice had improved the systems and processes in place for documenting and communicating learning arising from significant events. The practice provided us with seven significant events which had been raised since our last inspection. These were reported using an electronic reporting system to enable learning to be shared both within the practice and with external agencies who were involved in the care of practice patients. The practice provided evidence that two meetings had been held to discuss significant events since out last inspection. We saw evidence of improvements made. For example there was an incident involving one patient being mistaken for another with the same name. In response to the incident the practice took action to ensure that reception staff verified the identity of patients who had the same name to ensure that the GP was referring to the correct patient's records. Alerts were placed on the system to ensure that patient identities were verified.
- The practice had made improvements to their recruitment monitoring processes. We were provided with a copy of a spreadsheet which listed all clinical members of staff and the dates that their professional registrations were due to expire. All registrations were showing as being up to date. The practice manager informed us that they would use an alert on their email calendar which would prompt them to check the registration the day it expired.
- The practice provided us with copies of all missing essential training certificates after our inspection in March 2016. The practice used online training software which notified both staff and the practice manager when training for individual staff members became due. This ensured that training updates where completed as and when required.

Are services well-led?

Good

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

- The practice provided us with a copy of an audit of potassium results. The practice had identified a number of raised results which had no clear clinical cause. The first audit compared results in November 2014 and 2015 and the second compared results in March 2015 and March 2016. The number of results with raised potassium levels was lower in both years in March than it was in both years in November. The practice concluded that the variation was caused by seasonal change as excessive cooling of a blood sample can cause the level of potassium present in a sample to increase. The audit stated that the practice continued to monitor the situation and raised their findings with the CCG and laboratory in an effort to reduce additional blood testing where abnormal results were found. Though the information was clearly documented there was no evidence of specific action taken in response to the practice findings which had been subsequently measured and demonstrated improvement.