Dr Mannath Ramachandran

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 safe?	Good
Are services effective?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of this practice on 18 November 2015.

The practice was rated as requires improvement for providing safe and effective services and requires improvement overall. We issued the provider with a requirement notice for improvement.

After the comprehensive inspection, the practice wrote to us outlining what they would do to meet legal requirements in relation to: the monitoring and responding to national patient safety alert and medicines alerts; monitoring of patients prescribed medicines that require regular review. We had also identified a need for improvement with the proactive identification of children who might be at risk and with the clinical performance with regards to patients with a long term condition.

We undertook this focused inspection to ensure that the practice had made the necessary improvements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dr Mannath Ramachandran on our website at www.cqc.org.uk

We carried out a desk based review of Dr Mannath Ramachandran on 10 August 2016. This means we asked the practice to provide us with evidence that they were meeting the legal requirements, but we did not visit the premises. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was a system in place to monitor and review patients prescribed high risk medicines.
- There was a system in place to review and action any patient safety or medicines alerts received by the practice.
- There was a system to identify and support children who may be at risk.
- The practice had improved their performance in relation to the management and monitoring of patients with a long term condition.

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 safe?

Good

The practice is rated as good for providing safe services.

- There was a system in place for in place to monitor and review patients prescribed high risk medicines.
- There was a system in place to review and action any patient safety and medicines alerts received by the practice.
- The practice had systems, processes and practices in place to keep children safe and safeguarded from abuse.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) published in 2015 to 2016 showed patient outcomes for diabetes were at or above average compared to the local and national average.
- Since our previous inspection all diabetic patients had been invited to attend for a review of their medicinal condition.
- Overall exception reporting was higher than local and national average however staff were receiving training to ensure they coded patients correctly.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

- All staff had received safeguarding training.
- Patients prescribed high risk medicines, such as Warfarin, were being reviewed and monitored according to best practice guidelines.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Registers were in place for patients with long term conditions and their conditions were regularly monitored.
- Performance data for patients with diabetes was in line with or higher than national averages for the period 2015 to 2016.
- Patients prescribed high risk medicines, such as Methotrexate, were being reviewed and monitored according to best practice guidelines

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- All staff had received appropriate training in safeguarding children and young persons.

Working age people (including those recently retired and students)

Good

We did not need to inspect this population group as part of this inspection.

People whose circumstances may make them vulnerable

Good

We did not need to inspect this population group as part of this inspection.

People experiencing poor mental health (including people with dementia)

Good

We did not need to inspect this population group as part of this inspection.

Summary of findings

What people who use the service say

As this inspection was completed as a desk based review of compliance and the areas for review were not related to patient satisfaction or feedback, we did not speak to any patients for their views on the service.

Dr Mannath Ramachandran

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector.

Background to Dr Mannath Ramachandran

Dr Mannath Ramachandran is located in Tilbury, Essex. The practice has a general medical services (GMS) contract with the NHS. There are approximately 2700 patients registered at the practice. The practice is registered with the Care Quality Commission as a sole provider.

There is one lead GP registered. The GP is supported by a practice nurse, a practice manager and three members of reception and administration staff all working a variety of full and part-time hours. The practice is open Monday to Friday between 8.30am and 6.30pm each weekday and closed Thursday afternoons and at weekends.

During closing time, including Thursday afternoons, patients are directed to the out of hour's service provided by South Essex Emergency Doctors Service. GP surgeries run in the mornings between 9.30am and 11.30am on Mondays, Wednesdays and Thursdays and in the afternoon between 4pm and 6pm on Tuesdays and Fridays.

Why we carried out this inspection

We undertook an announced desk based review of Dr Mannath Ramachandran on 10 August 2016. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 18 November 2015 had been made. We inspected the practice against two of the five questions we ask about services: is the service safe and effective, the rating for these reflects against all the population groups although we did not specifically inspect the population groups as part of the desk based review. This is because the service was not meeting some legal requirements.

How we carried out this inspection

We asked the provider to send us evidence to prove that they were now meeting the legal requirements that we had found they were not meeting as part of our previous inspection.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record and learning

The practice told us that had set up a system for medicine and patient safety alerts. When the medicine alerts were received by the practice they were brought to the attention of all clinical staff. Staff were required to either sign that they had seen them or email to acknowledge having read the alert that was sent to them. A record of this was kept by the practice. We saw copies of staff meetings that evidenced that action was being taken.

We reviewed minutes of meetings where patient safety and medicine alerts were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, we found that one set of meeting minutes referenced an action point to inform a member of clinical staff not to prescribe a particular medicine and gave the alternatives that should be prescribed instead.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. The child safeguarding policy clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The practice sent us evidence to show what action they would take when a child did not attend for either a hospital appointment or routine immunisation. We saw meeting minutes which referenced the system for multi-disciplinary communication regarding any child related safeguarding concerns.
- The arrangements for the monitoring of patients prescribed high risk medicines, kept patients safe. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. For example, the practice had instigated a system of three monthly searches or audits to review which patients were on medicines considered as high risk. These patients were then called in for review. The practice had also audited whether patients were reviewed. We viewed the results of these audits for patients on Methotrexate and Warfarin. We saw that there were few numbers of patients where reviews had not taken place depending on the medicine and period of audit. We found this audit to be effective and identified those patients that had not been reviewed. The practice had put an action plan in place to ensure that when they re-audited this they would have 100% of patients reviewed in line with guidance. All patients had been taken off repeat prescriptions for these medicines.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results, from 2015 to 2016, indicated that the practice achieved 99% of the total number of points available compared with the CCG average of 94% and the national average of 95%.

- The practice had an 18% exception reporting rate overall which was higher than the CCG average of 8% and lower than the national average of 10%. (The QOF includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.)
- Performance for diabetes related indicators was in line with or higher than the CCG and national average. For example, the percentage of patients with a record of an annual foot examination and risk classification was 95% compared to the CCG average of 87% and the national average of 88%. Exception reporting for this indicator was 11% which was higher than the CCG average of 5% and in line with national average of 8%.

We saw evidence from practice meeting minutes that staff were receiving training with regards to appropriate coding of patients in order to ensure that exception reporting had been appropriately recorded.