Dr Amos Ramon

Quality Report

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Date of inspection visit: 23 November 2017
Date of publication: 15/01/2018

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Amos Ramon-The New Coningsby Surgery on 27 October 2015.

Breaches of Regulation 17 (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance were found.

Overall the practice was rated as 'Requires Improvement.' Specifically we found it to be requires improvement in safe and effective key questions and good in the caring, responsive and well-led key questions.

This inspection was an announced focused inspection carried out on 23 November 2017 to check that they had followed their action plan and to confirm they now met their legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 27 October 2015. This report covers our findings in relation to those requirements and also additional issues that arose during the course of that inspection.

You can read the last comprehensive inspection report from October 2015 by selecting the 'all reports' link for Dr Amos Ramon on our website at www.cqc.co.uk

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Overall the practice is now rated as 'Requires Improvement'

Our key findings were as follows:

- Relevant staff had now completed their required infection prevention and control training.
- Clinical audits had been completed.
- Policies in relation to the safe storage of medicines requiring refrigeration had been implemented.
- Learning from significant events had been cascaded to staff.
- The whistle blowing policy had been updated.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Have systems and processes in place that operate effectively to prevent abuse of patients.
- Care and treatment of patients must be appropriate and meet their needs.
- Ensure that patients diagnosed with long term health conditions are reviewed regularly.

Summary of findings

- Ensure there are systems or processes that enable the registered person to assess, monitor and improve the quality and safety of the services being provided.

In addition the provider should:

- Should seek to provide a shared computer drive to enable all staff to access policies, protocols and meeting minutes. A shared drive would ensure consistency and provide assurance that all staff were referring to the latest relevant documents.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Have systems and processes in place that operate effectively to prevent abuse of patients.
- Care and treatment of patients must be appropriate and meet their needs.
- Ensure that patients diagnosed with long term health conditions are reviewed regularly.
- Ensure there are systems or processes that enable the registered person to assess, monitor and improve the quality and safety of the services being provided.

Action the service SHOULD take to improve

- Should seek to provide a shared computer drive to enable all staff to access policies, protocols and meeting minutes. A shared drive would ensure consistency and provide assurance that all staff were referring to the latest relevant documents.

Dr Amos Ramon

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a practice manager specialist advisor and an additional CQC inspector.

Background to Dr Amos Ramon

Dr Amos Ramon- The New Coningsby Surgery provides primary medical care for approximately 7,900 patients living in Coningsby and the neighbouring villages.

The service is provided under a General Medical Services contract with Lincolnshire East Clinical Commissioning Group.

It is a dispensing practice to approximately 3,500 eligible patients.

The area is less deprived than the national average, but there are isolated pockets of deprivation particularly in some of the outlying rural communities.

The village has a large Royal Air Force base, RAF Coningsby. Many of the service personnel's dependents, particularly mothers and children are patients of the practice. The practice serves a community with a higher than national average of patients over the age of 65.

The practice is owned by a male GP and is additionally staffed by three salaried GPs of whom two are female. The whole time equivalent of GPs is 2.9. There is one nurse practitioner, three nurses and one health care assistant. They are supported by dispensers, receptionists and administration staff. A clinical pharmacist is employed for one day a week.

The practice is open between 8am and 6.30pm Monday to Friday, excepting Thursday when the surgery is open until 8pm. Appointments are from 8.30am to 1pm and 1.30pm to 6.30pm daily, excepting Thursday when appointments are available until 8pm.

When the surgery is closed GP out-of- hours services are provided by Lincolnshire Community Health Services NHS Trust which is accessed via NHS111

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Why we carried out this inspection

We undertook a comprehensive inspection of Dr Amos Ramon The New Coningsby Surgery on 27 October 2015 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement. The full comprehensive report following the inspection can be found by selecting the 'all reports' link for Dr Amos Ramon

We undertook a follow up focused inspection of Dr Amos Ramon, The New Coningsby Surgery on 23 November 2017. 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.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 27 October 2015 , we rated the practice as requires improvement for providing safe services as the arrangements in respect of safeguarding, the safe storage of medicines requiring refrigeration and learning from significant events were not adequate.

When we undertook a follow up inspection on 23 November 2017 we found the practice had made changes, but further improvement was necessary. The practice remains as requires improvement for providing safe services**.**

Safe track record and learning

At our inspection on 27 October 2015 we found here was an open and transparent approach and a system in place for reporting and recording significant events. However we found that there was limited evidence of learning from such events being cascaded to staff. At this inspection we found that significant events were a standing agenda items at practice meetings where learning from them was discussed. There was also formal audit process for reviewing and re-visiting significant events.

Overview of safety systems and process

At our previous inspection we could not be assured that the arrangements for managing medicines, including drugs and vaccinations, always kept people safe as the practice did not have a cold chain policy. At this inspection we saw that there was a cold chain policy in place which was kept adjacent to the refrigerators. Staff we spoke with understood the policy and what action they needed to take in the event of a breach of the cold chain.

Our previous inspection had highlighted the need for the practice to review their processes to ensure that patients including children subject to safeguarding concerns were appropriately identified on patient records and that they were discussed at safeguarding meetings.

At this inspection we looked at the process and found that patients subject to safeguarding concerns were now identified with an icon on the patient record. However, the contact numbers available to staff to report safeguarding concerns were out of date and no longer relevant. When we raised this correct numbers were immediately made available.

A salaried GP was the safeguarding lead. They had received the appropriate training but we could not be assured that people were kept safe. For example we asked about the process for following up on children who did not attend appointments in secondary care. Did not attend appointment letters were directed to individual clinicians but we could not find any evidence that they were followed up. There was no effective system to monitor such cases and the safeguarding lead had no oversight of them.

In addition we asked about GPs attending safeguarding meetings. Attendance at the meetings or the sending of a report were not prioritised which may have led to relevant safeguarding information not being passed on to the local authority. They generally only gave apologies for their absence. They said they had been to a small number, adding that they were part time so don't have time to attend them all. They said they may speak to the health visitor and they may go.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 27 October 2015, we rated the practice as requires improvement for providing effective services as the arrangements in respect of clinical audits and staff training in infection prevention and control needed improving.

These arrangements had significantly improved when we undertook a follow up inspection on 23 November 2017. However we had concerns that patients diagnosed with long term health conditions were not receiving the appropriate levels of care. The practice is rated as requires improvement for providing effective services.

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 for the year 2016/17 were 68% of the total number of points available compared with the clinical commissioning group and national average of 96%.

The overall exception reporting rate was 6% compared to the CCG and national averages of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

The QOF achievement for 2016/17 in respect of asthma was 51% which was 45% lower than both the CCG and national average. For the current year 2017/18 131 out of 528 reviews (24.8%) had been completed. The practice explained that since December 2016 few had been completed as a key member of staff who had been responsible for many of the reviews for asthma and chronic pulmonary obstructive disease had been absent from work owing to serious injury and had not been replaced. In addition this member of staff had responsibility for coding for QOF purposes.

Results for other groups of patients with long term conditions were significantly lower than national and CCG averages with the exception of atrial fibrillation, chronic kidney disease, epilepsy, palliative care and learning disability.

The practice produced an action plan that was dated 21 November 2017 which addressed the very low QOF achievement and to ensure that patients diagnosed with long term conditions were recalled for review.

However we were not assured that the plan was viable or achievable given that no extra resources were being made available to address the issues.

At the last inspection we found there to be limited evidence of clinical audit aimed at helping to improve outcomes for patients.

At this inspection we found that the practice had improved significantly in its clinical audit. We were provided with evidence of a number of audits including patients in receipt of quinolones, gestational diabetes, patients over 65 years of age on aspirin who were also receiving a proton pump inhibitor, gout, end of life and minor surgery. Three of these audits were full cycle audits and demonstrated improved outcomes for patients. For example the audit in respect of patients over 65 years of age on aspirin who were also receiving a proton pump inhibitor showed a clear improvement from 51% to 87%.

Effective staffing

At our inspection on 27 October 2015 we found there was no record that some members of staff, including six clinical members of staff had completed infection prevention and control training.

At this inspection we saw that all members of staff had completed the required training and that the practice management had clear oversight of when that training needed to be refreshed.

Are services well-led?

Requires improvement

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

Our findings

Leadership capacity and capability

The former practice manager who was also the lead for QOF and long term conditions reviews had been absent from the practice since December 2016 and had only the week before our inspection stated they were not returning to work. The failure to recognise the key roles they undertook had resulted in low QOF attainment and some patients not receiving the reviews of their treatment and medication.

The current non clinical management team recognised that they had been ill-equipped to fill the void as they were not fully aware of what needed to be done.

Staff we spoke with told us that clinical leadership had been patchy and put this down to a proposed merger with other practices. The merger was not now going ahead.

The inspection team acknowledged the efforts and desire of the management team to improve the service but have reservations that this can be achieved without additional clinical input and more resources.

Vision and strategy

The staff we spoke with were positive and stated that in their view things would improve with more and improved clinical input and patient care would be enhanced.

We saw the plans for a modernisation and major extension to the surgery.

Governance arrangements

We found that the practice did not have access to a shared computer drive and as a consequence there was no assurance that staff were accessing the most recent and relevant polices and protocols. Staff were reliant upon paper copies of such documents. In addition we saw that policies were attached to the on-line training system but when we asked staff to access the documents they were unable to do so as once read and the training module completed they became inaccessible.

The practice manager informed us that they were not aware that a shared drive was available and told us they would follow it up with their IT provider immediately.

Notes of some meetings for example multi- disciplinary meetings were lacking in detail.

Managing risks, issues and performance

The practice did not have in place effective systems to monitor performance and improve outcomes for patients. QOF attainment had been significantly below both CCG and national averages. For example:

2014/2015 85% compared to the national average of 94%

2015/2016 88% compared to the national average of 95%

2016/2017 68% compared to the national average of 96%

The practice could not produce any evidence to demonstrate how they had monitored or reacted to the significantly lower performance over this period.

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 were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person did not have systems and processes in place that operated effectively to prevent abuse of service users.** **Regulation 13(1) and (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.** **The registered person did not have in place an effective system to ensure that patients diagnosed with long term conditions were recalled and reviewed.** **Regulation 17(1) and (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**