Alconbury & Brampton Surgeries

Quality Report

The Surgery
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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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of this practice on 24 November 2015.

During the initial inspection we found areas where improvements should be made:

- The practice should improve the way it manages patients on medicines that require regular blood testing and monitoring.
- The practice should improve the way it implements and reviews action taken in light of The Medicines and Healthcare Products Regulatory Agency (MHRA) alerts to ensure patient safety.
- The practice should improve the security of prescription forms throughout the practice in line with national guidance (NHS Protect Security of Prescription Forms Guidance).
- The practice should ensure that it records any action it takes in response to the non-attendance of a child at a hospital appointment in the child's notes.

The practice told us these issues would be addressed and provided us with evidence to show they had taken the action to address the concerns.

We undertook a focussed follow up inspection on 30 November 2016 to make a judgement about whether their actions had addressed the areas highlighted.

The overall rating for the practice is good. You can read our previous report by selecting the 'all reports' link for on our website at www.cqc.org.uk

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

At the last inspection on 24 November 2015 we found that:

- The practice should improve the way it manages patients on medicines that require regular blood testing and monitoring.
- The practice should improve the way it implements and reviews action taken in light of MHRA alerts to ensure patient safety.
- The practice should improve the security of prescription forms throughout the practice in line with national guidance (NHS Protect Security of Prescription Forms Guidance).
- The practice should ensure that it records any action it takes in response to the non-attendance of a child at a hospital appointment in the child's notes.

Our focused inspection on 30 November 2016 found that:

The practice is rated as good for providing safe services.

- The practice had safe and effective systems in place and had implemented more efficient processes to ensure patients that required regular blood testing and monitoring were identified and managed.
- The practice had effective systems and processes to manage MHRA alerts. Patient Safety Alerts were logged, shared and searches were completed to ensure changes were adequately recorded on the relevant patient care records.
- The practice had improved the security of prescription forms throughout the practice in line with national guidance (NHS Protect Security of Prescription Forms Guidance). Printers which held prescription forms were locked and the reception staff continued to log and track the prescriptions as before.
- The practice had reviewed the systems and processes to ensure they had recorded actions taken in response to the non-attendance of a child at a hospital appointment in the child's notes. Any children with two or more non-attendances were followed up by the patients named GP and where appropriate, were discussed at safeguarding meetings. The practice completed searches of the relevant clinical computer system read codes.

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Detailed findings

Our inspection team

Our inspection team was led by:

This focussed follow up inspection was completed by a CQC inspector and a GP specialist advisor.

Background to Alconbury & Brampton Surgeries

Alconbury and Brampton Surgeries are well-established GP surgeries that have operated in the area for many years. They serve approximately 9,600 registered patients and have a general medical services contract with NHS Cambridgeshire and Peterborough CCG. The practice is based on two sites, one in Alconbury and the other close by in Brampton. It is located in an affluent area of Cambridgeshire and has very low rates of deprivation. According to information taken from Public Health England, the patient population has a higher than average number of patients aged 40-85 years, and a lower than average number of patients 15-39 years compared to the practice average across England. The clinical team consist of a partnership of four GPs, two salaried GPs, three practice nurses, and three health care assistants. The administrative team is led by the practice manager and consists of a management assistant, three medical secretaries, nine receptionists and five dispensers.

Why we carried out this inspection

As a result of the last inspection on 24 November 2015 we found areas where improvements should be made.

How we carried out this inspection

We reviewed the information received from the practice, spoke with the practice manager and two GP partners and requested additional information from the practice.

We visited Alconbury Surgery as part of this inspection however we did not need to visit Brampton Surgery. The practice were able to demonstrate they were meeting the required standards.

We carried out a focussed follow up inspection on 30 November 2016.

Good

Are services safe?

Our findings

We found improvements should be made at our last inspection on 24 November 2015, we found that:

- The practice should improve the way it manages patients on medicines that require regular blood testing and monitoring. We reviewed how the practice managed patients who took medicines that required specific blood monitoring. We found that the monitoring for patients on disease modifying anti-rheumatic drugs and lithium were in line with recommendations. However we found 12 of 389 patients who were prescribed levothyroxine had not received a thyroid function test in the previous 18 months. We also found 39 of 985 patients on ARB and ACE inhibitors had no coded entry for creatinine checks in the last 18 months. Although some of these patients might have had their results monitored in hospital, we found no record of hospital renal screening having been completed on some of the records.
- The practice should improve the way it implements and reviews action taken in light of MHRA alerts to ensure patient safety. Whilst the practice did have procedures in place to deal with MHRA alerts, on occasion they placed too much weight on the clinical opinion of local specialists with regard to risks, as opposed to implementing nationally accepted safety guidance alerts. Four patients had been prescribed simvastatin (a medicine used to treat high cholesterol) in combination with other medicines that increased risk to patient safety. 13 patients had been prescribed more than 30 domperidone (a medicine used to relieve feelings of sickness) in the past year, all had an alert on their records however it was not clear that this had been responded to in all cases. 27 patients had been prescribed clopidogrel (a medicine to help reduce the risk of heart attack and stroke) in combination with omeprazole/esomeprazole (a medicine to reduce the amount of acid in your stomach). This combination could reduce the efficacy of clopidogrel and could lead patients to a possible risk of clotting in cardiac stents or increased cardiovascular risk.
- The practice should improve the security of prescription forms throughout the practice in line with national guidance (NHS Protect Security of Prescription Forms Guidance). Both blank prescription forms for use in printers and those for hand written prescriptions were logged and tracked through the practice but were not stored securely in all areas.
- The practice should ensure that it records any action it takes in response to the non-attendance of a child at a hospital appointment in the child's notes. We looked at the records for 14 patients under the age of 16 years who, in the previous 12 months, had not attended their hospital appointment. We found that although there was a record in their clinical notes that they had not attended the appointment, often there was no further record of how the practice had followed this up.

The provider informed us about the actions they had taken to address the issues raised. Our focused follow up inspection on 30 November 2016 found that the practice had implemented and embedded clearly defined systems, processes and practices.

The practice is rated as good for providing safe services.

- The practice had safe and effective systems in place and had implemented more efficient processes to ensure patients that required regular blood testing and monitoring were identified and managed. The practice carried out monthly clinical computer system searches for patients on specific medicines. We checked that patients who were prescribed Levothyroxine (a medicine used to treat low thyroid activity) had received a thyroid function test in the last 12 months. There were seven patients out of the 401 who were overdue which equated to 98% of patients which had received the appropriate test. We looked at patients who were on ACE inhibitors (medicines that are used to treat high blood pressure) to check whether patients had received a creatinine level blood test. There were six patients out of 993 who had not received the appropriate test, four of those were children where it was contraindicated on instruction by the patients' consultant. This equated to 99% of patients who had received the appropriate test. All patients that flagged up on their searches were contacted either by letter or telephone to encourage attendance to the practice.
- The practice had robust systems and processes to manage MHRA alerts. Patient Safety Alerts were logged, shared and searches were completed to ensure changes were adequately effected on the relevant patient care records. We checked a recent MHRA alert for Etoricoxib

Good

Are services safe?

(a non-steroidal anti-inflammatory drug) to ensure changes had been made and the four patients prescribed the medicine had their records reviewed and the appropriate changes made following consultations with the rheumatologist by the practice's GPs. We checked the three medication searches conducted at the previous inspection for improvement and found that all patients had been assessed and clinical justifications recorded on the patient records where changes had not been effected.

- The practice had improved the security of prescription forms throughout the practice in line with national guidance (NHS Protect Security of Prescription Forms Guidance). Printers which held prescription forms were locked and the reception staff continued to log and track the prescriptions as before.
- The practice had reviewed the systems and processes to ensure they had recorded actions taken in response to the non-attendance of a child at a hospital appointment in the child's notes. The practice completed searches of the relevant clinical computer system read code and any children with two or more non-attendances were followed up by the patients named GP. Where appropriate, these were discussed at safeguarding meetings. We saw evidence of minutes from meetings and all GPs and practice nurses had received additional face to face safeguarding level three training in addition to the e-learning training already completed. The practice had a safeguarding children lead GP and a safeguarding children lead nurse.