

Milton Surgery

Quality Report

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Milton

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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

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	3

Detailed findings from this inspection

Our inspection team	4
Background to Milton Surgery	4
Why we carried out this inspection	4
How we carried out this inspection	4
Detailed findings	5

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Milton Surgery on 27 April 2016. At this time we noted that systems and processes were not established and operated effectively to ensure that clinicians were overseeing and checking changes to patients' prescriptions. After the comprehensive inspection, the practice wrote to us to say what they would do to meet legal requirements in relation to ensuring effective processes were in place.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements.

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?

At the last inspection on 27 April 2016 we found that:

- Patients were not fully protected against the risks associated with the management of medicines because there were not appropriate arrangements in place for the safe dispensing of medicines. Prescriptions were reviewed and signed by GPs before they were given to the patient. However, following discharge from hospital, dispensers made changes to patients' medicines which were not satisfactorily checked by GPs to ensure safety.

Our focused inspection on 3 January 2017 found that:

- The practice had implemented a clear policy and audit system to ensure that medication changes made as a result of correspondence from secondary care providers were accurate and had been authorised by a GP.

This report should be read in conjunction with the full inspection report from 27 April 2016.

Good



Milton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

This desk based review was completed by a CQC lead inspector.

Background to Milton Surgery

Milton Surgery is a well-established GP practice that has operated in the area for many years. It serves approximately 4,950 registered patients and has a general medical services contract with NHS Cambridgeshire and Peterborough CCG. It is located in an affluent area of Cambridgeshire.

According to information taken from Public Health England, the patient population has a slightly higher than average number of patients aged 30-54 years, and a lower than average number of patients 10-29 years, compared to the practice average across England.

The practice team consists of two GP partners, a salaried GP, two nurses, a health care assistant and a phlebotomist. They are supported by dispensary and administrative staff.

The opening times for the surgery are Monday to Friday from 8am to 6pm. The dispensary is open from 8am to 12pm Monday to Friday.

Why we carried out this inspection

As a result of the last inspection on 27 April 2016 we had concerns and issued a requirement notice in respect of safe care and treatment. This was because the practice had not ensured that patients who were prescribed medicines that required specific monitoring were reviewed in line with national prescribing guidance.

How we carried out this inspection

We spoke with the practice manager and reviewed the information received from the practice.

We have not revisited Milton Surgery as part of this review because the practice were able to demonstrate they were meeting the standards without the need for a visit.

We carried out a desk-based review on 3 January 2017.

Are services safe?

Our findings

We found improvements were needed in relation to safe care and treatment at our last inspection on 27 April 2016.

- Patients were not fully protected against the risks associated with the management of medicines because there were not appropriate arrangements in place for the safe dispensing of medicines. Prescriptions were reviewed and signed by GPs before they were given to the patient. However, following discharge from hospital, dispensers made changes to patients' medicines which were not satisfactorily checked by GPs to ensure safety.

The provider sent us an action plan informing us about the action they would take to ensure that patients were safe.

Our focused inspection on 3 January 2017 found that the practice had implemented an effective system to ensure that medication changes made as a result of correspondence from secondary care providers were accurate and had been authorised by a GP.

- The provider sent us a clear policy detailing the process to be implemented when medication changes were required. We also received a completed log of monthly spot checks to ensure that this process had been embedded into practice. The findings of the spot checks showed that GPs maintained clinical oversight and made amendments to required medication changes rather than the dispensary team.