

# Care Quality Commission

## Inspection Evidence Table

### Merchiston Surgery (1-9883319722)

Inspection date: 11 October 2022

Date of data download: 10 October 2022

## Overall rating: Requires Improvement

Following our previous inspection in June 2022, the practice was rated as Requires Improvement overall.

We undertook a remote regulatory assessment on 11 October 2022 to follow up on the warning notice served to the provider following our inspection in June 2022 in relation to a breach of Regulation 12; safe care and treatment. We have not rated the practice at this remote assessment as this will be reviewed at a later date through inspection.

During this review, we found that the provider had made improvements. However further improvements were required in relation to embedding medicines management processes. In particular, ensuring safe care and treatment of patients with long-term conditions and patients prescribed high-risk medicines in line with national guidelines.

## Safe

## Rating: Not Rated

At our previous inspection in June 2022, we found there were shortfalls regarding medicines management which led to the issuing of a warning notice of regulation 12; safe care and treatment. In particular:

- The practice was unable to demonstrate the ongoing monitoring for patients prescribed high-risk medicines in line with national guidelines to ensure safe care and treatment.
- There was a lack of appropriate medicine reviews prior to prescribing.
- Processes to ensure regular intervals of clinical supervision to ensure prescribing competency of non-medical prescribers was not in place.
- There was a backlog of patient summarising records dated back to August 2021.

At this review, the practice had demonstrated improvements to the management of patients prescribed high-risk medicines, with an action plan of patients who had undertaken the appropriate blood monitoring and medicine reviews. The practice had updated medicine management processes with guidelines for staff regarding clinical search audits as a safety net mechanism for ensuring eligible patients were invited for appropriately timed reviews. However, we identified there were still shortfalls with ensuring all patients

had the required monitoring or safe treatment plan in place. New medicine management processes required embedding.

### Information to deliver safe care and treatment

#### Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• At the previous inspection in June 2022, we found there was a backlog of patient summarising which dated from August 2021. There was a risk that staff did not always have the correct and updated information required to deliver safe care and treatment.</li> <li>• During this assessment, we found that patient summarising records were kept up to date. The provider implemented additional administrative processes to ensure this was managed appropriately and maintained oversight of this area.</li> <li>• There was a documented approach to the management of test results. Clinicians were set tasks to review patient test results on the same day. "Buddy" arrangements were in place to ensure test results were reviewed by other clinicians for cover. We reviewed the system for incoming letters and patient results. We found a sample of historic duplication error result letters for patients who were seen by midwifery clinicians who worked for both the practice and for external healthcare providers. Although these were filed on the practice system correctly, this created a high number of correspondence in the inbox which may cause unnecessary administration risk leading to missed patient results.</li> </ul>	

### Appropriate and safe use of medicines

#### The practice had systems for the appropriate and safe use of medicines, including medicines optimization but this was not yet fully embedded.

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.66	0.74	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	11.8%	9.8%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	4.78	4.82	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	123.4‰	122.4‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.36	0.63	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	7.4‰	5.8‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y

Medicines management	Y/N/Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> <li>At the previous inspection in June 2022, we found there were shortfalls in medicine management which included;</li> <li>Clinical supervision for non-medical prescribers was recorded and oversight was provided by the practice's lead GP. However, supervision had been sporadically completed with no regular set intervals between each meeting.</li> <li>There was a lack of safety netting to identify outstanding monitoring and a risk that patients who were prescribed high-risk medicines did not receive safe care and treatment in relation to appropriate monitoring and clinical review prior to prescribing. In particular, patients who were prescribed Direct-Acting Oral Anticoagulants (DOAC), a type of medicine to thin the blood.</li> <li>We identified patients who were prescribed gabapentanoids, a controlled medicine used to treat partial seizures, who had not had a medicine review within the last 12 months, to ensure they were being prescribed the appropriate dose and whether it was appropriate for the patient to remain on the treatment.</li> </ul> <ul style="list-style-type: none"> <li>During this review undertaken in October 2002, we found:</li> <li>Clinical supervision records for non-medical prescribers were up to date and there was a plan in place for regular meetings.</li> <li>We undertook remote searches of the practice's clinical patient records system. We identified 467 patients who were prescribed Direct-Acting Oral Anticoagulants (DOAC), medicines which can prevent stroked by preventing blood clots, of which 96 patients had not received the appropriate monitoring. Of those patients, 72 had not had the appropriate blood monitoring in the previous 12 months. The remaining patients comprised of 18 patients who had not had a creatine clearance level calculation (CrCl) within the previous 12 months, 6 had never had this calculated. Patients prescribed DOACs require regular checks of their kidney function and calculation of their creatine clearance level (CrCl) to ensure they are being prescribed the appropriate dose, and confirm it was appropriate for the patient to remain on the treatment. There was a risk that these patients had not received the safe care and treatment required. The provider completed an action plan following this assessment to ensure the outstanding patients were managed appropriately through blood test monitoring, CrCl calculations and medicine reviews. This was completed by inviting patients for blood monitoring and CrCl calculations where possible by desktop review.</li> <li>The practice had worked through the backlog of patients who were prescribed gabpentanoids, medicines used to treat epilepsy, who had not received a medicine review within the previous 12 months. We identified significant improvements; our remote searches of the practice's clinical patients records system, showed that out of the 230 patients who were prescribed gabapentanoids, seven had not received a medicine review within the previous 12 months. Of those seven, five patients had failed to attend the medicine review appointment that was booked. There was an administration process where patients would be followed up subsequent to a failed attendance.</li> <li>During the clinical searches, we reviewed a sample of five patient consultation records to check the quality of medicine reviews. We saw evidence of all five recorded medicine reviews had been conducted with documented outcomes and addressed the required monitoring or changes to treatment required to ensure safe care and treatment.</li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>The provider shared an action plan of updated medicine management processes. This identified routine clinical search audits for those patients who required on-going monitoring would be undertaken. These would be reviewed by the pharmacy team with oversight of senior clinicians reported and discussed at quality meetings. Compliance to audit search outcomes would be monitored so that patients were safety netted and had the appropriate monitoring treatment plans in place. We saw evidence of updated standard operating procedures in relation to medicine management.</li> </ul>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the previous inspection in June 2022, we identified shortfalls in the management of safety alerts, in particular:</li> <li>Actions taken in response to a safety alert regarding to the dosage of Citalopram, a medicine used to treat depression, prescribed to patients aged 65 and over. Not all patients prescribed this medicine had been counselled and received a recent medicine review to protect them from potential harm relating to the safety alert.</li> <li>During this assessment undertaken in October 2022, we found that the management of safety alerts had been embedded and that patients affected by safety alerts were managed appropriately.</li> </ul>	

## Effective

## Rating: Not Rated

At our previous inspection in June 2022, we found that there were a lack of systems and processes in place for the monitoring patients with long-term conditions which led to the issuing of a warning notice for the identified breach of regulation 12; safe care and treatment.

During this remote assessment, we found that whilst the practice had made improvements to the management of patient treatment plans, there remained a risk to some patients of not receiving safe care and treatment in relation to the on-going monitoring in line with national guidelines.

*QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.*

### Effective needs assessment, care and treatment

**Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>At the previous inspection in June 2022, we identified five patients as having a potential missed diagnosis of diabetes. There was a potential risk to patients experiencing symptoms relating to diabetes.</li></ul>	

- During this assessment, we found there were systems and processes for managing patients with diabetes and pre-diabetes. We reviewed a sample of four pre-diabetic patients, of which, all the patients had been informed about their condition, were coded on the clinical system correctly and the appropriate on-going blood monitoring had taken place.
- GPs referred patients to secondary care and used two-week wait pathways where appropriate. A two week wait pathway is where the cause of a patients presenting condition may be in relation to cancer.
- Patients were given advice on what to do if their condition deteriorated, for example, call backs or contact with the out of hours service. Communications between the out of hours service was highlighted as effective and proactive when we spoke with senior clinical staff, including the transfer of discharge notifications and changes to patient's prescribed medicine.

## Effective care for the practice population

### Findings

- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. The practice told us that they were in the process of recruiting a designated mental health practitioner.

## Management of people with long term conditions

### Findings

- At the previous inspection in June 2022, we found a lack of systems and processes in place for the monitoring of patients with long-term conditions. In particular;
- Patients with hypothyroidism, (a condition which results in low activity of the thyroid gland), who had not received the appropriate thyroid function (TFT/TSH) blood monitoring within the last 18 months.
- Patients with chronic kidney disease (CKD) stage 3, 4 or 5 who had not had the appropriate consultation review including blood monitoring, urea and electrolytes (U&E) within the last nine months.
- During this assessment in October 2022, we found:
- During the remote searches of the practice's clinical patient records system, we identified 473 patients with hypothyroidism, of which 37 of those patients had not received the appropriate thyroid function blood monitoring within the last 18 months. Although the practice had made improvements in patient recall and medicine management processes, there remained a risk that patients had not received safe care and treatment. Following this assessment, the provider shared an action plan which showed that 31 out of the 37 patients had either had their blood monitoring reviews or were booked in for an appointment.

- We found that patients with chronic kidney disease (CKD) stages 3, 4 or 5 were managed appropriately either through the on-going blood monitoring and structured annual reviews or by secondary care providers.
- We identified 1873 patients on the asthma register, of which, 47 patients who had been prescribed two or more courses of rescue steroids in the last 12 months. We reviewed a sample of five patient records, and found three patients had not been followed up appropriately within one week of presenting with acute exacerbations. These patients were not always followed up in line with national guidance to ensure they received appropriate care. We found that four out of the five patients had their annual asthma review with care plans in place. Following this assessment, the provider had shared an action plan which showed that 32 of the 47 patients had either had their asthma review completed, booked for an appointment, were under secondary care or steroids had not been prescribed for asthma. Leaders we spoke with told us that national guidelines were shared amongst clinical staff for learning and that asthma management was incorporated into the regular audit searches completed as part of updated standard operating procedures. The provider had recently recruited an asthma specialist nurse to assist with the completion of annual asthma reviews and to improve the management of this area.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.



## Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a SICBL average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a SICBL average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- $\%$  = per thousand.