

Care Quality Commission

Inspection Evidence Table

Brockhurst Medical Centre (1-539431207)

Inspection date: 30 November 2020

Date of data download: 14 December 2020

Overall rating: Requires Improvement

We previously rated the practice as requires improvement overall due to a lack of governance processes to ensure safe care and treatment for patients. Following the receipt of information of concern, we undertook an inspection of Brockhurst Medical Centre on 21, 22 and 30 September 2020. As this was a focused inspection, we did not amend the overall rating of Requires Improvement, but we rated the key questions of Safe, Effective and Well Led as inadequate. We also placed urgent conditions on the provider's registration, requiring them to take urgent actions and report weekly to ourselves. As a result of information supplied through these weekly updates and upon the receipt of further information of concern, we carried out a remote access review of patient records on 23,24 and 25 of November followed by an urgent unannounced inspection on 30 November 2020. As this was also a focused inspection, we did not amend the overall rating from requires improvement, but we continued to rate the key questions of Safe, Effective and Well Led as inadequate. This was because:

- There was a lack of competent leadership, understanding of challenges and actions to keep patients safe.
- The practice did not have clear and effective processes for managing risks, meaning patients were at risk of harm.
- Care and treatment was not delivered in line with current legislation.
- Medication and long-term condition reviews had not been completed in an effective and timely manner.
- There was a risk that some patients were not receiving the care and treatment they needed.
- The practice did not have systems for the appropriate and safe use of medicines.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- We could not be assured that patient records accurately reflected the care and treatment received by patients.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Inadequate

We rated safe as inadequate because:

- Systems and processes were not in place to keep people safe.
- The information needed to plan safe care and treatment was not available.
- The practice did not have systems for the appropriate and safe use of medicines.

Risks to patients

There were gaps in systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	N
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	N
Explanation of any answers and additional evidence: <p>Following our last inspection on 30 September 2020, the provider made the decision to hand their contract to provide GP primary care services back to the commissioner (Fareham and Gosport Clinical Commissioning Group (CCG)). The CCG were supporting the practice with extra staff, which included a practice manager and an experienced GP (provided by the Local Medical Committee (LMC); a body which represents GPs) and the practice had employed other temporary staff to cover the period to the end of the contract on 9 January 2021. However, the advanced nurse practitioner (who was also a partner) had already left the practice and administrative staff (who would lose their jobs on the 9 January 2021) were leaving as they found other employment. This situation left the practice in a difficult staffing position which was being managed on a daily basis by the supporting practice manager.</p> <p>On the day of the inspection, we found the prescriptions clerk was covering reception which meant she was unable to carry out her role of processing prescription requests. She was also rostered to cover reception duties the following day. In the afternoon, the prescriptions clerk reported she had been able to process all the prescriptions received over the weekend both via paper and email. This meant despite covering other work, prescriptions were being covered in a timely manner. However, the prescriptions clerk was leaving the practice on 3 December 2020. A temporary prescriptions clerk had been recruited to start on 8 December 2020, meaning there was no dedicated member of staff to process prescription requests between 3 and 8 December 2020.</p> <p>We reviewed the rota for reception cover for the following week which showed that cover was still required on the morning of 8 December 2020. However, staff were leaving, often with short notice, and the acting practice manager reported it was extremely difficult to manage and a large proportion of their time was spent trying to source staff to cover administrative and reception roles and that the situation changed on a daily basis.</p> <p>The acting practice manager reported that a nearby practice had been supporting the practice, as a short term measure, by providing staff to help with processing referrals, scanning and coding.</p> <p>We reviewed the electronic document management system used to manage the flow of clinical data in and out of the practice, such as letters from secondary care, discharge summaries and blood test results. We found 60 documents which needed processing by a GP dating back to 28 October 2020. These included discharge summaries, administrative letters and rejected referrals. This showed GPs were not keeping up to date with the flow of clinical data coming into the practice. Patients were at risk of delayed treatment and care.</p> <p>During our remote review of patient records on 23, 25 and 26 November 2020 when we reviewed 92 patient records and our unannounced inspection on 30 November 2020 when we reviewed a further eight patient records, we found repeated examples of poor quality patient records with minimal detail recorded, making it difficult to determine what risk assessments had been carried out, what treatment</p>	

or management plan the patient was receiving and whether that treatment or management plan was appropriate to the condition being treated.

Information to deliver safe care and treatment

Staff did not have 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.	N
Referral letters contained specific information to allow appropriate and timely referrals.	N
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	N
There was a documented approach to the management of test results and this was managed in a timely manner.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	N

Explanation of any answers and additional evidence:

The information needed to plan and deliver effective care, treatment and support was not available.

During our review of 100 patient records during the period 23 to 30 November 2020, we found that some patient records used relevant templates and recorded appropriate detail. However, we found many examples, when templates were not used, of patient records which included scant detail regarding the patients' symptoms and conditions. We found examples of records being recorded retrospectively (sometimes as much as a week later) and also concurrently. For example, multiple patients recorded as having an appointment at the same time on the same day but recorded on the system a week later.

Records often showed consultations as having taken place over the telephone but included observations which could only have been observed in a face to face consultation. Therefore, it was difficult to be sure how the consultation had been conducted.

We found referrals to secondary care were often lacking in detail and were extremely brief. Some of these did not meet appropriate standards and had been rejected, as seen in the review of outstanding documents on the electronic records system.' We found referrals did not always meet patients' needs. For example, we saw a routine referral which should have been an urgent referral (based on the recorded needs of the patient) and another referral which did not follow the guidance of the secondary care consultant, meaning the patient was not referred to the right place. We also found that requests from secondary care for regular monitoring were not always complied with, meaning the patient was not monitored or managed in the way the consultant requested or anticipated. Some records included tests or treatments which patients said they had did not recall being completed and we also found evidence of delays of up to a year before diagnoses were recorded on patients' records.

A review of the document management system demonstrated that clinical documents relating to patients' care and treatment had been awaiting review by a GP for up to a month.

Overall, we found the patient's medical and prescribing history was not always apparent from the record, and decision-making in respect of those patients was not always clear. Patient records were not reliable for a clinician to review and understand a patient's medical and prescribing history. This put patients consistently at risk.

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2019 to 30/09/2020) (NHS Business Service Authority - NHSBSA)	1.12	0.74	0.82	Tending towards variation (negative)
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). (01/10/2019 to 30/09/2020) (NHSBSA)	8.6%	9.1%	8.8%	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 (01/04/2020 to 30/09/2020) (NHSBSA)	5.98	5.47	5.34	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2020 to 30/09/2020) (NHSBSA)	96.9‰	121.3‰	124.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2019 to 30/09/2020) (NHSBSA)	1.09	0.51	0.68	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	N
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N

Medicines management	Y/N/Partial
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.	N
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.	N
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	N
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	N
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	N
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	N
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection on 30 September, we found that medicines were not stored safely or securely and that fridges containing vaccines were overflowing and not appropriately monitored to ensure vaccines were stored within safe temperature parameters.</p> <p>During that inspection, we were told by the advanced nurse practitioner (ANP), there were plans in place to rent another vaccine fridge and in the meantime, vaccines were being stored by a local pharmacy.</p> <p>During our inspection on 30 November, we found that cupboards and fridges containing medicines and vaccines were appropriately locked. We saw records which showed that fridge temperatures had been regularly monitored and remained within safety limits. However, the practice had not obtained an extra vaccine fridge to store their overflow vaccines and these remained off the premises at a local pharmacy. The practice therefore had no control regarding the appropriate storage of these vaccines. They had not requested temperature record checks or taken any other steps to assure themselves that their vaccines were stored in an appropriate place within safe temperatures, to ensure the vaccines were safe to use. This meant the practice could not be assured that the vaccines were safe to use.</p> <p>The practice continued to use paper prescription requests and we saw that 116 of these requests had been delivered to the practice over the previous weekend, with a further 37 email requests. Although the prescriptions clerk reported that she had been able to keep up with the requests, she was placed under immense pressure due to the requirement to also cover reception duties due to the shortage of administrative staff. It was not clear how the practice would be able to cover repeat prescription requests in the coming days as there was a gap of several days between the prescription clerk leaving the practice and temporary cover for this role starting.</p> <p>During our inspection on 30 September, we found there were gaps in weekly checks made on emergency medicines and equipment. During this inspection on 30 November 2020, we continued to find deficiencies in emergency medicines and equipment. We found the defibrillator had been overdue servicing and calibration since 13 November 2020, meaning the provider could not be assured of the effectiveness of the equipment should it be required in an emergency situation. We found that defibrillator pads expired on 30 November (the day of the inspection) and the provider had not ordered new pads. A pair of dressing scissors, stored in the emergency equipment box, were also found to be out of date, meaning the practice could no longer be assured of their sterility.</p>	

Medicines management**Y/N/Partial**

A member of staff told us they checked emergency medicines and equipment every week, however they were unable to provide documentary evidence to support this. Records we observed during the inspection showed they had only been checked monthly (for October and November). The staff member told us that some emergency drugs were required, but there was a problem with requisition as the person responsible for requisitioning emergency medicines, the advanced nurse practitioner (ANP), had left the practice and had not passed responsibility onto another member of staff. However, during the inspection these were discovered in a separate cupboard. They were not stored in the emergency box with the other emergency medicines and the staff member responsible for checking the emergency medicines had not been made aware. This meant there was not an effective system for the ordering and monitoring of emergency medicines and equipment. In an emergency, patients might be at risk as staff were not aware of the location or existence of emergency medicines.

Patient records did not demonstrate that appropriate prescribing and medication reviews were taking place. During our inspection on 30 September, we found medication reviews were not used to monitor prescribing and this meant patients were put at risk. During our review of 100 patient records during the period 23-30 November 2020, we continued to find multiple examples of medication reviews recorded as an administrative review. This meant that a box had been 'ticked' to indicate a medication review had taken place, but there was no evidence it had included a discussion with the patient or consideration of the type and number of medicines prescribed. Information provided by the practice and extracted from the patient record system showed 1,331 patients had not received a medication review in the last 12 months. Substantial numbers of patients had either not received a medication review or had received a medication review which did not adequately demonstrate they were receiving medicines in line with their assessed needs. This meant that patients were put at risk.

In addition, we found prescribing was not in line with national and local guidance. We found examples of patients being prescribed medicines which were not in line with the patient's recorded symptoms and condition. Furthermore, we found that antibiotics were not prescribed in line with national guidance and that some patients may have received antibiotics which they didn't need, and some may have received a type of antibiotic which was not appropriate to treat their condition. Inappropriate antibiotic prescribing is reflected in the above indicators in that the practice had higher antibiotic prescribing than the CCG and England average per unit.

Effective

Rating: Inadequate

We rated effective as inadequate because:

- Care and treatment was not delivered in line with current legislation, evidence-based guidance or best practice.
- Medication and long term condition reviews had not been completed in an effective and timely manner.
- There was a risk that some patients were not receiving the care and treatment they needed.

Effective needs assessment, care and treatment

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

	Y/N/Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	N
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N
Explanation of any answers and additional evidence: During our inspection, we remotely accessed and reviewed 100 patient records. We found patient records were not regularly reviewed and updated and lacked detail which made it difficult to understand the care and treatment patients had received. For example, we found that medication reviews were not completed every 12 months to ensure that medicines remained appropriate and safe for patient use. We found that monitoring of long term conditions was not up to date and patients had not been given information about how to manage their own condition, for example, information about diet and lifestyle. We found examples of inappropriate prescribing and patient diagnoses which had not been followed up on or monitored. We found that patient referrals had not been made appropriately, clinical tests such as blood tests had not been completed in line with requirements or not completed at all and some had findings which had not been followed up. We also found that administrative requests, affecting patient care, made by staff members to a GP had often not been responded to and we could find no evidence from reviewing patient records that these requests had been carried out. Where we had concerns about patient care and treatment, we referred these to the Clinical Commissioning Group for follow up.	

Helping patients to live healthier lives

Staff were not consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	N
Patients had access to appropriate health assessments and checks.	N
Explanation of any answers and additional evidence: During our inspection we found repeated evidence of patient monitoring and reviews not taking place. We found 138 patients with asthma overdue their review, 193 diabetic reviews were overdue, and 179 cancer care reviews were overdue. These were examples of the types of chronic care reviews which had not been kept up to date to ensure patients' conditions were monitored. During the inspection, patients received diabetes reviews by a specialist team brought in to help the practice meet the conditions laid down by the Care Quality Commission. Patients reported that they previously had no insight into their condition and had not been given advice or guidance on how to manage their condition themselves.	

Well-led

Rating: Inadequate

We rated well-led as inadequate because:

- There was not a strong stable leadership in the practice.
- A lack of governance processes led to gaps in care planning and staff and patient safety.
- A lack of systems and processes meant that the practice did not operate in an effective manner and there was no assurance around planning, delivery and sustainability of the practice as a whole.

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	N
Explanation of any answers and additional evidence: During our inspection on 30 September 2020, we found the practice did not have a stable or strong leadership and that the current partners had not understood the challenges to the practice or taken steps to address them, leaving patients at risk of an unsafe service. On the day of this inspection, the registered manager and lead GP partner (the same person) was not present in the practice and told us they were too ill to speak with us. The advanced nurse practitioner (ANP) had left the practice to work elsewhere but remained a partner and therefore responsible for the leadership of the practice. Staff reported that the ANP visited the practice two afternoons a week but requested to take part in basic nursing tasks rather than undertake a leadership role. Following our previous inspection, the partners had made a decision to terminate their contract to supply NHS primary care to their patients. We continued to monitor the progress of the practice, laying down key requirements to keep patients safe, until the practice closed. However, we found continued concerns about patient care and treatment and a continued lack of systems and processes to keep patients safe. For example, we continued to find concerns regarding the storage of medicines and the management and monitoring of emergency medicines and equipment. We found a complete lack of competent leadership in the practice leading to a risk of patient harm.	

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)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 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 CCG 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 CCG 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.
- **PHE:** Public Health England.
- **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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- $\%$ = per thousand.