The Bermuda Practice Partnership

Quality Report

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Bermuda Practice Partnership on 5 July 2016. The overall rating for the practice was requires improvement. We carried out a follow up focused inspection on 20 April 2017 to assess if the practice met the legal requirements in relation to the breaches in regulation previously identified. Whilst some improvements had been made, the overall rating for the practice remained requires improvement as the practice had not met all the legal requirements. The full comprehensive and follow up report on the July 2016 and April 2017 inspections can be found by selecting the 'all reports' link for The Bermuda Practice Partnership on our website at www.cqc.org.uk.

This inspection was a focused follow up carried out on 16 November 2017 to confirm that the practice met the legal requirements in relation to the breaches in regulations that we identified at our previous inspection on 20 April 2017. This report covers our findings in relation to those requirements and any additional improvements made since our last inspection.

Overall the practice is now rated as requires improvement.

Our key findings were as follows:

- The practice's systems did not ensure that policies and procedures were always followed.
- Not all patient group directions were countersigned by an authorised person; not all single use equipment available was in date and cytotoxic drugs were not disposed of in the correct containers.
- Vaccines were in date, however staff did not always follow procedures to document that stock rotation had been completed. For example, the checklist documenting the expiry dates of medicines had not been updated once stock had been changed.
- The practice had emergency equipment and medicines on site which were kept in a room with a coded keypad on the door however not all staff were aware of the code and so would not be able to easily access the equipment or medicines in the event of an emergency
- The practice's cleaning schedule checklist was not completed which meant the practice could not evidence that the cleaning schedules had been completed.
- There were comprehensive risk assessments in relation to safety issues such as fire and legionnaires disease. However, a fire risk assessment had been undertaken in May 2017 and there were still actions which had not been addressed.
- There was an improved oversight of the governance for training to ensure all staff had training at the right time. Staff had all received training for their roles and mandatory training was now included on the practice's induction checklist for new starters.

Summary of findings

- The practice had launched a self-care internet and mobile application solution which aimed to help patients better manage long-term conditions and encourage healthy lifestyles by providing easily accessible information.

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

Importantly, the provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

In addition the provider should:

- Review the processes for the care of patients with long-term conditions.

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

The Bermuda Practice Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included two CQC inspectors, and a GP specialist adviser.

Background to The Bermuda Practice Partnership

The Bermuda Practice Partnership is located at Shakespeare Road, Basingstoke, Hampshire, RG24 9DT. The practice is based in Popley which is a suburb of Basingstoke. The practice provides services under an Alternative Provider Medical Services contract and is part of the NHS North Hampshire Clinical Commissioning Group (CCG). The practice is most commonly known to patients as the Bermuda and Marlow practice. The premises are leased through NHS property services.

The practice has a branch surgery in Winklebury, Basingstoke which is open once a week.

The practice has approximately 13,400 registered patients. The practice population has a slightly higher than average working age population with 70% of patients in paid or full time education in comparison to the national average of 62%. The practice is based in an area considered to be of average deprivation. The practice population is predominantly White British. Approximately 1% of the practice population is Nepalese.

The practice has three GP partners and a GP registrar. All three GP partners are male and work full time. The GPs are supported by a nursing team consisting of three advanced nurse practitioners and two practice nurses. The practice also has a health care assistant and a phlebotomist. The clinical team are supported by a management team including a practice manager, secretarial and administrative/reception staff. The practice has recently become a training practice for qualified doctors training to become GPs.

The practice reception and telephone lines are open between 8.30am and 6.30pm Monday to Friday. Extended hours appointments are offered on a pre-bookable basis from 8am to 11am on one Saturday per month and on Monday and Tuesday evenings until 7.30pm. Morning appointments with a GP are available between 8.30am and 11am and afternoon appointments are available from 3pm to 5pm daily.

The Bermuda Practice Partnership had opted out of providing out-of-hours services to their own patients and patients are requested to contact the out-of-hours GP via the NHS 111 service.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 20 April 2017, we rated the practice as requires improvement for providing safe services as the practice failed to provide assurances that staff had the knowledge and understanding to keep patients safe. Specifically, not all staff had received safeguarding training for children or adults and not all staff had received basic life support training.

Arrangements for staff training had some improvement when we undertook a focused follow up inspection on 16 November 2017.However improvements are still needed. The practice remains rated requires improvement for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments with the assistance of external companies or NHS property services.
- The practice's cleaning schedule checklist was not completed as recommended which meant the practice could not evidence that the cleaning schedules had been completed
- Policies were reviewed and were accessible to all staff electronically through their shared drive.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken for all staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse.
- The practice worked with other agencies to support patients and protect them from neglect and abuse.
- Staff spoken to during the inspection demonstrated knowledge of how to identify and report safeguarding concerns. However, at the time of inspection not all staff had received up-to-date safeguarding and safety training to an appropriate level for their role and in line with the practice's safeguarding policy. Specifically not all clinical staff had safeguarding childrens training to the correct level however this was rectified on 20 November 2017. The practice provided us with evidence that the remaining clinical staff had completed safeguarding training to level 2. These certificates were dated 20 November 2017.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- Whilst the practice had an infection prevention and control (IPC) policy, we found that this was not always followed. For example, we found items of single use equipment including needles and syringes, which were out of date, one of which had expired in 2011. We also identified three sets of sharps boxes which had not been signed or dated and that not all staff were disposing of medicines and equipment in line with policy. Additionally cytotoxic drugs were not disposed of in the correct containers.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. However the practice was also unable to evidence the most recent portable appliance testing (PAT) certificates where needed, this was completed within two working days of the inspection.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

Requires improvement

Are services safe?

- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice did not always have reliable systems for appropriate and safe handling of medicines.

- The practice had emergency equipment and medicines on site which were kept in a room with a coded keypad on the door and we were told that all staff knew the code. However, during the course of the inspection we saw that not all staff were aware of the code and so would not be able to easily access the equipment or medicines in the event of an emergency.
- The systems for managing medicines, including vaccines did not always minimise risk. We saw that whilst vaccines were in date, staff did not always follow procedures to document that stock rotation had been completed. For example, the checklist documenting the expiry dates of medicines had not been updated once stock had been changed. The checklist showed that expiry dates for several medicines had passed. However, further checks of the medicines provided evidence that these had been replaced with in date stock. Additionally, the practice could not evidence regular oxygen level checks to ensure this was at an appropriate level. We also found a local anaesthetic medicine which was not stored securely.
- The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) However, we found that three PGDs which were used by the nursing team had not been countersigned by an authorised person.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

There were comprehensive risk assessments in relation to safety issues such as fire and legionnaires disease. However, a fire risk assessment had been undertaken in May 2017 and there were still outstanding actions which had not been addressed. The building was owned by NHS property services and they held responsibility for undertaking tasks relating to the actions from the risk assessment. The practice couldn't evidence to us that they had raised these actions in a timely manner with NHS property services or chased up the non-responses. The practice manager has since asked for a review to be completed.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. Since our inspection in April 2017, there had been 15 significant events. We saw evidence that these had been discussed at team meetings and trends analysed. A summary of significant events for the year was on the meeting room wall for all staff to view.
- There was a system for receiving and acting on safety alerts. Medicines and Healthcare products Regulatory Agency (MHRA) alerts were sent through sporadically to the practice manager who would bring them to the next clinical meeting. It would be discussed and then filed with other historical alerts. One of the GP partners was responsible for running any resulting searches and completed a six monthly review of previous alerts received.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 20 April 2017, we rated the practice as requires improvement for providing effective services as the practice could not evidence that all staff had received training appropriate to their role. Specifically two members of staff were missing safeguarding children training, 19 members of staff were missing safeguarding adults training and three members of staff were missing basic life support training.

This had improved when we undertook a focused follow up inspection on 16 November 2017. The practice is now rated as good for providing effective services.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- In the six weeks preceding the inspection the practice had created and launched a self-care internet and mobile application solution which aimed to help patients better manage long-term conditions and encourage healthy lifestyles by providing easily accessible information. This had been introduced to enable clinicians to send patients or carers self-help information or information about clinical services straight to their mobile phone following a consultation.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The percentage of patients with Chronic Obstructive Pulmonary Disease (COPD) who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness in the preceding 12 months was 89% compared to the clinical commissioning group (CCG) average of 92% and national average of 90%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 77%, which was in line with the 80% coverage target for the national screening programme.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

People experiencing poor mental health (including people with dementia):

- 98% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the CCG and national average of 84%.

Good

Are services effective?

(for example, treatment is effective)

- 88% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the CCG average of 89% and national average of 91%.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. We reviewed evidence that the practice had conducted appropriate prescribing audits which had led to a reduced number of antibiotics being prescribed. We also saw the practice were undertaking reviews for both expected and unexpected deaths in order to determine if anything could have been done differently.

Where appropriate, clinicians took part in local and national improvement initiatives. The practice had signed up to an NHS England initiative in order to improve uptake of cervical screening. They had submitted an action plan to show how they intended to achieve improvements and had agreed to take part in targeted workshops. The lead nurse had also encouraged uptake of screening by sending information to patients through their internet and mobile application. There were information leaflets on cervical screening in English, Polish and Nepalese. Also patients were reminded of screening being due on other occasions they attended the practice to see the lead nurse. Through these processes, the practice had increased uptake of cervical screening to 80%.

The most recent published Quality Outcome Framework (QOF) results were 94.6% of the total number of points available compared with the CCG average of 96.8% and national average of 95.5%. The overall exception reporting rate was 15.5% compared with a national average of 9.9%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice exception rate for patients with diabetes, on the register, in whom the last blood pressure reading was within range at 140/80 in the last 12 months, was 28% which was higher than the CCG average of 13% and national average of 9%..The practice had not identified how improvement in the exception reporting of patients with long term conditions could be improved.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice had conducted a clinical audit as part of a CCG initiative which looked at antibiotic prescribing. This had led to an overall reduction in the amount of antibiotics prescribed by the practice.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when

Good

Are services effective?

(for example, treatment is effective)

they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.

- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 20 April 2017, we rated the practice as requires improvement for providing a well-led service. This was because there were shortfalls around the governance of staff training as not all staff had completed training appropriate to their role.

Whilst this had improved at our inspection on 16 November 2017, the practice is still rated as requires improvement for providing a well-led service.

Whilst the practice had improved on their training record since our previous inspection in April 2017, systems for ensuring staff followed processes and procedures were not fully embedded.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services.
- Leaders at all levels were visible and approachable.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The practice planned its services to meet the needs of the practice population.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients. However there were areas of improvement needed such as for patient with long term conditions and to ensure that staff followed procedures at all times to meet the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. We saw evidence that complaints were investigated and where appropriate, apology letters were sent to patients.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so.
- There were processes for providing staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. The practice was part of the violent patients scheme and to protect staff a system alert was created and these patients would automatically be booked in with a GP when they requested an appointment.
- The practice actively promoted equality and diversity and staff had received equality and diversity training.
- There were positive relationships between staff and teams.

Governance arrangements

Responsibilities, roles and systems of accountability to support good governance and management were not always clear.

- Structures, processes and systems to support good governance and management were not fully embedded resulting in some shortfalls for safe practice. There were a number of areas identified by the inspection that had not been identified by the practice governance and leadership.

Are services well-led?

Requires improvement

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

- Staff were clear on their roles and accountabilities; however not all clinical staff had level 2 training prior to inspection in respect of safeguarding children and infection prevention and control procedures were not followed.
- Practice leaders had not assured themselves that established policies, procedures and activities to ensure safety were operating as intended. For example, not all patient group directions were countersigned by an authorised person; not all single use equipment available was in date and cytotoxic drugs were not disposed of in the correct containers.

The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

Managing risks, issues and performance

There were processes for managing risks, issues and performance but these were not fully embedded and there was not always an effective process to identify, monitor and address current and future risks including risks to patient safety.

- There were comprehensive risk assessments in relation to safety issues such as fire and legionnaires disease. However, a fire risk assessment had been undertaken in May 2017 and there were still actions which had not been addressed.
- The practice infection prevention and control policy stated that spot checks would be carried out and discussed at clinical meetings. Whilst we received verbal assurances that these had been actioned, there was no record of this and staff were unaware that they should be discussed at clinical meetings in line with policy.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. However there was limited evidence of action to change practice to improve quality. There was not a comprehensive action plan to improve exception reporting for patients with long term conditions.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services. The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement within the practice. The practice had created and launched a self-care internet and mobile solution which aimed to help patients better manage long-term conditions and encourage healthy lifestyles by providing easily accessible information. This enabled clinicians to send patients or carers self-help information or information about clinical services straight to their mobile following a consultation. This had been launched approximately six weeks prior to inspection and the practice therefore did not have any outcome measures to demonstrate the impact this had. The practice aimed to use this service to promote self-help material around mental health with the hope that this would ease demand on Child and Adolescent Mental Health Services (CAMHS). The practice was in early consultation with CAMHS to see how to further develop this and run a pilot.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** **The registered person did not do all that was reasonably practicable to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.** **They had not ensured:** • Practice policies such as for infection control were followed. • Single use equipment was in date and appropriate for use. • All patient group directions were countersigned by an authorised person. • Cytotoxic drugs were disposed of in the correct containers. • The actions were completed following comprehensive risk assessments in relation to safety issues such as fire. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.