The Bermuda Practice Partnership

Inspection 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 location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

In light of the current Covid-19, The Care Quality Commissions (CQC) has looked at ways to fulfil our regulatory obligations, respond to risk and reduce the burden placed on practices, by minimising the time inspection teams spend on site.

In order to seek assurances around potential risks to patients, we carried out a GP Focused Inspection Pilot (GPFIP) of The Bermuda Practice Partnership between 12 December 2020 and the 15 December 2020 to follow up on information of concern raised to CQC.

This report covers our findings in relation to those concerns. The inspection consisted of remote interviews and reviews of clinical records which were conducted with the consent of the provider. We focussed our inspection on the following key questions; Safe, Effective and Well-Led. We did not inspect the Caring or Responsive key questions as part of this inspection.

We have not rated the practice during this inspection as we did not visit the Provider.

We based our judgement of the quality of care at this service on a combination of:

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

We found that:

- The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.
- The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation
- The delivery of care and treatment was exposing patients to the risk of harm. This included evidence of actual or potential actual harm for patients.
- 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.
- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- Responsibilities and roles were unclear and the overall governance arrangements were ineffective.

The areas where the provider **must** make improvements are:

- Ensure that care and treatment is provided in a safe way.
- Ensure patients are protected from abuse and improper treatment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Following our remote GP focused inspection pilot undertaken on 12, 13 and 15 December 2020, we issued the provider with an urgent notice of decision to impose conditions on the registration.

In line with CQC enforcement procedures, the provider is expected to implement actions to address all the issues raised within agreed timescales. The service will be kept under review and if needed could be escalated to further urgent enforcement action.

Details of our findings and the evidence supporting our ratings are set out in the evidence tables.

Overall summary

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of General Practice

Population group ratings

Older people	**Inspected but not rated**
People with long-term conditions	**Inspected but not rated**
Families, children and young people	**Inspected but not rated**
Working age people (including those recently retired and students)	**Inspected but not rated**
People whose circumstances may make them vulnerable	**Inspected but not rated**
People experiencing poor mental health (including people with dementia)	**Inspected but not rated**

Our inspection team

Our inspection team was led by a CQC lead inspector and included a GP specialist advisor and a member of the CQC medicines team.

Background to The Bermuda Practice Partnership

The Bermuda Practice Partnership is located at Shakespeare House Health Centre in Popley, Basingstoke, Hampshire, RG24 9DT. The practice has a branch site located at Fort Hill, Winklebury Centre, Winklebury Way, Basingstoke, RG3 8BJ. The Bermuda Practice Partnership is part of the NHS North Hampshire Clinical Commissioning Group (CCG).

The practice has approximately 14,000 registered patients and is registered with CQC to deliver the Regulated Activities; diagnostic and screening procedures, surgical procedures, maternity and midwifery services, family planning and treatment of disease, disorder or injury.

There are two GP partners, both of which are male, and three female salaried GPs. The practice is supported by two practice nurses, a healthcare assistant, a pharmacist and an administrative team led by a practice manager.

The practice opening hours are Monday to Friday 8.00am to 6.30pm at the Shakespeare House site, with the Forthill surgery open on Wednesday afternoons only. Outside of these times patients are directed to contact the out-of-hours service by using the NHS 111 number

The National General Practice Profile states that 87.8% of the practice population are from a white ethnicity. Information published by Public Health England, rates the level of deprivation within the practice population group as six, on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

This section is primarily information for the provider

Enforcement actions

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA (RA) Regulations 2014 Service users must be protected from abuse and improper treatment** **On 18 December 2020 we imposed urgent conditions on the registration of The Bermuda Practice Partnership in respect of the above regulation.** **How the regulation was not being met** **The registered person did not have systems and processes in place that operated effectively to prevent abuse of service users. In particular:** • Safeguarding systems, processes and practices were had not always been developed, implemented and communicated to staff. • Not all staff, including clinicians were trained in safeguarding adults and children, to appropriate levels for their role. **This was in breach of Regulation 13 (1)&(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Termination of pregnancies	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Service users must be protected from abuse and improper treatment** **On 18 December 2020 we imposed urgent conditions on the registration of The Bermuda Practice Partnership in respect of the above regulation.** **How the regulation was not being met**

This section is primarily information for the provider

Enforcement actions

The practice had not ensured that systems and processes had been established and operated effectively to assess, monitor and improve the quality and safety of the services provided. In particular;

- There was a lack of strong stable leadership.
- Governance processes were not in place to ensure patients and staff were safe and to meet the requirements of the Health and Social Care Act 2008. This included:
  - Appropriate recording of consultation, recall, monitor and reviewing of patients.
  - Safe prescribing systems including the implementation of safety alerts.
  - Systems to ensure learning from significant events.
  - Systems to ensure patients were safeguarded from abuse.
  - Appropriate training for staff.
- The practice did not always act on appropriate and accurate information.

This was in breach of Regulation 17 (1)&(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures Maternity and midwifery services Family planning services Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment On 18 December 2020 we imposed urgent conditions on the registration of The Bermuda Practice Partnership in respect of the above regulation. Care and treatment must be provided in a safe way for service users **How the regulation was not being met:** The provider had failed to ensure the proper and safe management of medicines; Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular;

This section is primarily information for the provider

Enforcement actions

- The delivery of care and treatment was exposing patients to the risk of harm. This included actual or potential actual harm for patients.
- Consultations had not always been undertaken in accordance with national guidance.

The registered provider had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular;

- There was limited monitoring of outcomes of care and treatment including but limited to patients with long term and/or chronic conditions.
- There were not effective systems and processes in place to ensure robust record keeping in accordance with national guidance.

The provider had failed to ensure the proper and safe management of medicines. In particular;

- The provider did not have an effective system in place to ensure patient safety alerts and alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA) were always acted on appropriately.
- The provider did not have effective arrangements in place to provide assurance that medicine reviews were completed appropriately, or that prescribing was in line with nationally recognised guidelines.

This was in breach of Regulation 12 (1)&(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.