

Defence Medical Services

RAF Boulmer Station Medical Centre

Quality Report

Longhoughton
Alnwick
Northumberland
NE66 3JF

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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, and information given to us from the provider and patients.

Ratings

Overall rating for this service	Requires improvement 
Are services safe?	Inadequate 
Are services effective?	Requires improvement 
Are services caring?	Good 
Are services responsive to people's needs?	Requires improvement 
Are services well-led?	Requires improvement 

Summary of findings

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at RAF Boulmer Station Medical Centre on 14 November 2017. Overall, the practice is rated as requires improvement. Our key findings across all the areas we inspected were as follows:

- Staff at the practice were patient focussed and worked hard to ensure patients' needs were met.
- There was a system in place for reporting and recording significant events. In all, there had been five significant events reported in the previous 12 months. However, we were aware of at least two clinical events that had not been reported.
- The assessment and management of risks involved in the contracting of part time NHS GPs to deliver services including aviation medicine, required improvement. For example, at the time of inspection only one of the three GPs who provided care at the practice was qualified in aviation medicine. We saw that this had an impact on patients' ability to see the right GP at the right time.
- There was insufficient time allocated for additional work GPs are expected to deliver, such as leadership, reporting on significant events, the review of patient notes, correcting Read coding errors on incoming patient notes, and linking conditions and prescribing in patient records, as well as clinical audit and general clinical oversight within the practice.
- There was a lack of comprehensive understanding of internal military systems which the contracted GPs were required to work within. GPs could not access some systems routinely required to do their work, for example, the Pathlinks system used to receive blood test results.
- We saw audits on diabetes care, asthma, cytology, hypertension and occupational health vaccinations. These were all nurse led audits. GPs providing services at the practice were not involved in quality improvement initiatives. This was due to insufficient facilitation time, afforded by the current service level agreement between GPs and Defence Medical Services.
- The lead on safeguarding was the practice nurse. However, this should have been a staff member with level three training in safeguarding of children and vulnerable adults.
- The practice manager was unaware of any Legionella risk assessment for the building.
- The practice did not provide access to a GP when it closed early on Wednesdays. There was no GP cover on Fridays from 16:00 and between 17:00 and 18:30 on weekdays. Patients were advised to use the local walk-in centre.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).
- Staff were aware of current evidence based guidance on clinical care.

- Results from the patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. We were not able to confirm that improvements were made as a result of investigation and analysis of complaints.
- Patients we spoke with said they found it easy to make an appointment with urgent appointments available the same day. However, some patients complained that sometimes the GP they had appointments with did not have the aviation medical training required to understand their clinical needs.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure in place. However, there was evidence that the current operating model at the practice did not fully meet the needs of staff or patients.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The Chief Inspector recommends:

- A comprehensive review of the current service level agreement in place between contracted GPs and Defence Medical Services, to ensure this provides sufficient expertise, clinical leadership, oversight and administrative time, which fully supports staff and patients of the practice. This should include access arrangements for patients up to 18:30 each week day. The rating of inadequate in the key question of safe, and ratings of requires improvement for the key questions of effective, well-led and responsive demonstrate the impact of the insufficiency of the current service level agreement.
- Review of the significant event reporting process to ensure contracted GPs report any incidents as and when they arise.
- Safeguarding leads at the practice should be trained to level three in safeguarding children and vulnerable adults.
- Provision of access for GPs to additional IT systems which are needed in their everyday work, such as the Pathlinks system.
- Sufficient resource should be allocated to support GPs to undertake clinical audits.
- An internal review of all patient records at RAF Boulmer to ensure these are effectively Read coded and that each patient record meets the standards set for patient record keeping by the General Medical Council. Where training is required for staff on Read coding, this should be made available.
- Assessment of the input and support provided by Regional Clinical Leads, who engage with contracted GPs at RAF Boulmer, to determine whether the needs of GPs who ordinarily work in the NHS, are being met.
- Provide access for the practice manager to a risk assessment on management of Legionella at the practice, and steps that should be taken to reduce this risk.
- Assess arrangements currently in place, whereby the practice manager rather than a GP attends station welfare meetings, to see if this meets the needs of patients and DPHC.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as inadequate for providing safe services.

- There was a system in place for reporting and recording significant events. However, GPs did not always report these. We were told that this was because they could not access the military system (ASER) for reporting significant events. We saw at least two clinical events that had not been reported.
- The current arrangements for delivery of GP services at the practice did not fully meet the needs of patients. Only one GP was qualified to deliver aviation medicine and occupational health services in relation to this.
- There were no GP led clinical audits being conducted, for example, on prescribing.
- Clinical meetings were rarely held at the practice; the practice nurse could recall two clinical meetings, which we saw were minuted. An action point from one of those meetings, held on 2 October 2017, was that more regular clinical meetings should be held between GPs and the PN in future.
- The staff member leading on safeguarding at the practice was insufficiently qualified for the role but had been responsible for this for a number of years.
- There was no deputy safeguarding lead appointed.
- The practice manager did not have access to a risk assessment on the management of Legionella, or to instructions on tasks to be performed to reduce this risk.
- There was no clinical waste pre-acceptance audit being conducted.
- There was no hepatitis B status record in place for clinical staff at the practice. No periodic checks were conducted on the professional registration of clinicians.
- The practice were unable to show copies of electrical safety certificates for the building.

Inadequate



Are services effective?

The practice is rated as requires improvement for providing effective services.

- At the time of our inspection and for a considerable period before this, only one of the three rotating GPs was qualified in aviation medicine. This had an impact on effective delivery of patient care and was reflected in patient comment cards.
- Review of patient records showed these were difficult to follow, with diagnoses not linked to prescribing and a lack of Read codes used to provide a meaningful care summary for any GP providing cover at the practice.
- Patients with long term conditions such as asthma and diabetes were well managed by the practice nurse.
- The call and recall of patients for cytology and other health screening initiatives was effective.
- We saw clinical audit by the practice nurse, prompted by their scope of duties. However, there was a lack of clinical audit by GPs, including prescribing audits.
- There were several areas of work in the practice that were not being effectively managed. For example, clinical governance, audit work, attendance at unit health committee meetings and welfare meetings, and effective housekeeping of clinical records. This work had not been fully considered in the service level agreement between contracted GPs and DMS.

Requires improvement



Are services caring?

The practice is rated as good for providing caring services.

- Comment cards, completed by patients before our inspection, demonstrated that patients felt practice staff treated them with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect. Staff had assessed the acoustics of the building and used a television and/or radio in the reception area to ensure that conversations could not be overheard. This helped maintain patient and information confidentiality.
- The practice had arranged transport for any patients who had chosen to receive secondary care outside of the immediate area, and who would struggle to get to these appointments using public transport.
- The practice staff also provided support and advice for carers

Good



<p>of patients with complex conditions, although these carers may not have been registered with the practice.</p> <ul style="list-style-type: none"> • There were four patients with declared carer responsibility currently registered with the practice. 	
<p>Are services responsive?</p> <p>The practice is rated as requires improvement for providing responsive services.</p> <ul style="list-style-type: none"> • Feedback on patient comment cards indicated that patients found it frustrating when they saw a GP who did not have training in aviation medicine, meaning their needs may not be met within that appointment. • We were told by the practice staff that home visits were not available and did not occur. • The practice did not provide access to a GP on the afternoons it closed early, or between 17:00 and 18:30. Patients were advised to use the local walk in centre and from 18:30, referred to NHS 111. • We were unable to confirm that following complaints, findings from investigations led to improvements in services, or were used to prevent similar incidents occurring in the future. • The practice did not have its own dispensary. Feedback from patients indicated that arrangements in place to have prescriptions fulfilled and delivered back to the practice worked well and was responsive to patient needs. • Patients were able to access the services of a female GP in the nearby town of Alnwick if required. Feedback in comment cards indicated that this was a responsive service, especially for patients who worked shifts. Patients were not subject to lengthy waits for appointments with a GP of their preferred gender. • We saw that the standard of nursing care, triage and onward referral was effective, responsive and of a high standard. For example, where patients had been identified as experiencing acute cardiac events and were transferred to hospital without delay. • The practice had good facilities and was equipped to treat patients and meet their needs. 	<p>Requires improvement </p>
<p>Are services well-led?</p> <p>The practice is rated as requires improvement for providing well-led services.</p> <ul style="list-style-type: none"> • Practice staff were committed to the vision of delivering safe and effective care for patients. Each understood their role in 	<p>Requires improvement </p>

achieving this but could identify the limitations placed upon them by the current operating model of healthcare delivery at the practice.

- In the delivery of day to day services, the practice was well led. However, the wider reaching managerial input and oversight required improvement.
- Areas of governance required attention both clinical and general. For example, audit work, attendance at unit health committee meetings and welfare meetings, and effective housekeeping of clinical records. This work had not been fully considered in the service level agreement between contracted GPs and DMS.
- A diary of regular meetings was in place which assisted communication between GPs and staff.
- Staff were performing duties that they had not had the appropriate training for. This had been the case for some time.
- Staff had raised the issue of the practice medic leaving the practice in December and the fact that this would leave the practice nurse as the only clinician in the building across key opening times. There was no plan in place to address this or to indicate how this would be managed.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. However some training had not been delivered in relation to buildings health and safety.
- The provider was aware of the requirements of the duty of candour. We saw evidence the practice complied with these requirements.

RAF Boulmer Station Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by a CQC inspector. The team included an Inspection Manager, a GP Specialist Advisor, a Practice Nurse Specialist Advisor and a Practice Manager Specialist Advisor.

Background to RAF Boulmer Station Medical Centre

RAF Boulmer Station Medical Centre is located near the town of Alnwick, Northumberland. The treatment facility offers care to forces personnel. Dependants and children of forces personnel are not served by the medical centre, but can register with practices in the nearby town of Alnwick.

The operating model for care delivery at RAF Boulmer is based on the contracted services of GPs from a local practice. Currently there is a rotation of three GPs who serve the practice. These GPs provide four morning clinics each week, Tuesday to Thursday at RAF Boulmer between 8:30 and 10:20. This is followed by occupational health medicals between 10.30 and 11.30. An emergency clinic is available at the NHS practice of the GPs each Monday, in Alnwick.

At the time of inspection, the patient list was approximately 600. Occupational health services are also provided to personnel and a number of reservists. At the time of inspection, the patient list was made up of Naval, Army and RAF staff, both male and female. Permanent staff ranged in age from 18 years to 65 years. GPs at the practice also deliver occupational health services for approximately 100 personnel from RAF Spadeadam in Cumbria. These patients travel to RAF Boulmer for these services.

In addition to routine GP services, the medical centre offers physiotherapy services and travel advice. Family planning advice is available from the NHS group practice in Alnwick, which provides the GPs that support the practice. Maternity and midwifery services are provided by this NHS practice and community teams, who hold clinics on a weekly basis.

At the time of our inspection, three local NHS GPs were contracted to provide care to patients on a rotational basis. Typically, there were eight hours of GP services for patients, and four hours of occupational healthcare provided each week. This was complemented by a practice nurse, who worked 30 hours per week and a full time RAF medic (the work of a military medic has greater scope than that of a health care assistant found in NHS GP practices). There was also a physiotherapist who worked three days each week. The medical centre was led by a full time practice manager, supported by two full time administrators and one full time receptionist.

The medical centre was open Monday, Tuesday and Thursday each week, between 08:00 and 17:00. On Wednesday the practice closed at 12:00 for staff training. The practice was open on Friday from 08:00 to 16:00. After these hours, and on Friday afternoons from 16:00, patients were advised to access the NHS walk in centre in Alnwick or to access NHS 111. Throughout this

report, RAF Boulmer Station Medical Centre will be referred to as 'the practice'.

Why we carried out this inspection

The Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

How we carried out this inspection

Before visiting, we reviewed a limited amount of information provided to us about the facility.

We carried out an announced visit on 14 November 2017. During our visit we:

- Spoke with a range of staff, including one GP, the practice manager, the practice nurse, and two administrative staff. We were able to speak with two patients who used the service.
- Reviewed comment cards completed by patients who shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.
- Carried out a visual check of the building and equipment provided to treat patients.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- We were aware of at least two clinical significant events that had not been reported. When we asked the practice GP about this, we were told they could not access the computerised reporting system (ASER).
- We were aware that one of the clinical events which was not reported was discussed at a meeting but no minutes had been kept of this meeting.
- The practice carried out a thorough analysis of the significant events that had been reported. Staff understood their roles in discussing, analysing and learning from incidents and events.

We reviewed safety records, incident reports and national patient safety alerts. We saw that there were regular practice meetings where these were discussed. We saw that learning from the reported significant events was shared to make sure action was taken to improve safety in the practice. Clinical meetings were not held frequently. We did see evidence of two clinical meetings held in October and November 2017 between the practice nurse and the lead GP.

When there were unintended or unexpected safety incidents, we were told patients received reasonable support, truthful information, and an apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had clearly defined systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding and this was the practice nurse. However, the practice nurse worked part time hours. There was no deputy appointed to cover the absence of the nurse due to part time hours, or for cover for planned leave. The nurse had received level two training in safeguarding of children and vulnerable adults. There were plans in place for the nurse to attend level three training in December 2017. However, we were aware that the nurse had been the safeguarding lead for some time, without the required training.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding. GPs were trained in child protection and safeguarding to level three; the practice nurse was trained to level two and other practice staff were trained to level one. The practice confirmed they would maintain an accurate and up to date register of patients subject to safeguarding arrangements and patients deemed to be 'at risk'. However there were no patients who fell into this group at the time of our inspection. Staff confirmed they would use the alert facility within DMICP (Defence Medical Information Capability Programme) to ensure that risks showed clearly when the medical record was opened.
- Notices in the waiting room and consultation rooms advised patients that chaperones were available if required. Staff who acted as chaperones were trained for the role, and had received a Disclosure and Barring Service (DBS) check (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). At the time of our inspection, the practice nurse and the medic were trained as chaperones. As the medic is due to leave the practice in December, requests for training for administrative staff have been submitted to DMS HQ.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice had an infection control policy and lead who had attended annual infection control refresher training. Infection control audits were carried out each month, for example, hand hygiene audits, audits on correct waste disposal and cleaning audits. However, the practice had not completed an annual waste pre-acceptance audit. This is an audit to check that all waste is segregated correctly, disposed of in the correct colour coded sacks and that bag numbers are correctly recorded in a waste log, ensuring all waste leaving the practice is traceable.
- All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. Spillage kits were available and clinical waste was stored appropriately and securely and was collected from the practice by an external contractor on a fortnightly basis.
- The arrangements for managing medicines at the practice, including emergency medicines and vaccinations, in the practice kept patients safe. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines.
- The practice had not carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. Practice staff told us that they were aware of patients who had been prescribed medicines that are no longer used in the NHS, or recommended for use by approved clinical guidance. This indicated that there are some patients who have passed through the practice whilst on training courses at RAF Boulmer, who may not be receiving treatment that is consistent with National Institute for Health and Care Excellence (NICE). We have reported this to DMS.
- We asked to see records of patients who were prescribed high risk medicines that require monitoring. Practice staff confirmed that there were no patients currently taking these medicines.
- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had a system for production of Patient Specific Directions and these were used appropriately.
- We were advised by the practice manager that all appropriate recruitment checks were in place for all staff working at the practice. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks

through the Disclosure and Barring Service. However, there were no periodic checks undertaken on professional registrations of the GPs and the practice nurse, to ensure they had maintained their registration, or to check that there were no restrictions on their licence to practice. We also noted that there was no active Hepatitis B register for staff, to ensure that those working with infected patients have sufficient immunity.

Monitoring risks to patients

Risks to patients were not sufficiently assessed and managed.

- There were some procedures in place for monitoring and managing risks to patient and staff safety. A health and safety policy was available and a poster was displayed in the practice office which identified local health and safety representatives.
- The practice had up to date fire risk assessments and carried out regular fire drills. The fire equipment was checked by an external contractor on a six monthly basis. Fire alarms were tested weekly and all electrical equipment was checked on a regular basis to ensure the equipment was safe to use.
- Clinical equipment was checked in line with Defence Medical Services policy to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection prevention and control.
- There was no risk assessment in place for the safe management of risk posed by legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice manager was conducting flushing exercises based on the advice from another practice. There were no water temperature checks in place and no guidance available to the practice manager on what temperatures should be achieved when running water from taps in the building.
- The practice building was owned by the Defence Infrastructural Organisation and, alongside services provided by the Station Quarter Master, we saw evidence to confirm the practice was taking the necessary action to manage the maintenance of the practice. The station was responsible for electrical safety of the building. We did not see the electrical safety certificate on the day of inspection and requested this was sent to us. The practice manager has been able to show us a works schedule for remedial works carried out but told us a new safety certificate had not been issued to them by the maintenance contractor. On documents sent to us by the practice, we can see the remedial works were carried out in 2016.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice had a record of the minimum number of GP sessions needed per week and used this to manage GP staffing levels. However, the current skill mix of the GPs providing services meant there was only one GP with a qualification in aviation medicine. This meant if this GP was absent for any reason, the needs of patients may not be met.
- The practice recognised the importance of managing sick chits (temporary sickness absence notes) to ensure the safety of patients and other military personnel. They had adopted a system to send copies of all sick chits to Chain of Command if a patient had been signed off from a certain task. This is important where the safety of the patient or their colleagues might be compromised where someone is temporarily unfit to perform a duty e.g. air traffic controllers. The clinical detail remained confidential between the GP and the patient, so adherence to Caldicott principles was maintained.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room and in the reception office.
- The practice had a defibrillator available on the premises and oxygen with adult masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. A copy of this plan was available on the practice computer system and additional copies were kept off the premises.

Are services effective? (for example, treatment is effective)

Requires improvement



Our findings

Effective needs assessment

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) and best practice guidelines.
- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- Clinical meetings were not held regularly. We viewed minutes from two recent meetings between the practice GP and the practice nurse held in October and November 2017. We noted that there was no contracted time for GPs who provided services to the the patients of RAF Boulmer, to hold meetings that included the nurse and medic on a regular basis. Peer review for the nurse was facilitated by regional nurse meetings.
- The Defence Primary Health Care (DPHC) Team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. The GP and nurse could refer to this and gave examples of updates they had acted on.

Management, monitoring and improving outcomes for people

The practice used information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provides a useful way of measuring this for DMS). Because the numbers of patients with long term conditions are often significantly lower at DPHC practices, we are not using NHS data as a comparator.

The practice provided the following patient outcomes data to us from their computer system on the day of the inspection:

- There were four patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. For three of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For two diabetic patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were 12 patients recorded as having high blood pressure. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. All had a record for their blood pressure in the past nine months. Of these patients with hypertension, 11 had a blood pressure reading of 150/90 or less.

- The number of patients with long term physical or mental conditions, who smoke and whose notes contained a record that smoking cessation advice or referral to a specialist service had been offered within the previous 15 months was 13 which is 20% of the smoking patient population. The NHS target for this indicator is 90%.
- There were nine patients with a diagnosis of asthma. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. Of these, seven had received an asthma review in the preceding 12 months which included an assessment of asthma control using the three RCP questions.
- There were 21 patients with a new diagnosis of depression in last 12 months. All had been reviewed within 10 to 35 days of the date of diagnosis.
- Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that instance of audiometric hearing assessment was in line with DPHC practices regionally and nationally. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data from July 2017 showed :
 - 100% of patients had a record of audiometric assessment, compared to 100% regionally and 99% for DPHC nationally.
 - 94% of patients' audiometric assessments were in date (within the last two years) compared to 94% regionally and 86% for DPHC nationally.
- There was some evidence of quality improvement. The audits conducted in the practice were done by the practice nurse. The lack of administration time afforded to GPs under the current service level agreement, meant that GPs were not involved in quality improvement work at the practice.
- Audits undertaken to date were relevant to the needs of registered patients. All audits were made up of the first cycle only, as the nurse had only commenced work at the practice in January 2017. However, QOF results showed improvements had been made since first audit cycles.
- We reviewed an audit on care of diabetic patients in line with NICE guidance. At the time of conducting the audit, in May 2017, there were three diabetic patients registered with the practice. Results showed:
 - 33% of patients (one out of three) had an HbA1c (glycated haemoglobin) of 59 or less
 - 66% of patients (two out of three) had received retinopathy screening in the past 12 months.
 - 33% (one out of three) had blood pressure readings of 140/90 or less.
 - 33% (one out of three) had a cholesterol measurement of 5mmol/l or less.
 - 0% (none) of the patients had received a foot assessment in the past 12 months.

All the results for this audit are below the NHS targets. Recommendations were made and the audit will be repeated annually. However, from the QOF results shared with us by the practice, we could see that care for this patient group had improved since the audit. Patients requiring foot checks are receiving these at Alnwick Medical Group Practice as the equipment for performing these was not available at RAF Boulmer.

We reviewed an audit on cytology. This audit was conducted in 2017 but did not indicate the

month it was carried out in. This showed the practice delivered cytology to 98% of patients within the correct time frame, that 100% of results came back to the practice within two weeks and that 100% of patients were informed of the result in two weeks.

We reviewed an audit on asthma conducted in June 2017. There were 11 patients on the practice asthma register. The audit showed:

- 57% of patients had received an asthma review that included the three Royal College of Physicians (RCP) questions.
- 91% of patients had a record of their smoking status in the preceding 12 months.
- 91% of patients received a maximum of one inhaler per month on average.

Recommendations were made, including that the asthma template within the practice patient record system (DMICP) must be used at asthma reviews to ensure all necessary checks take place, and that asthma reviews should include a medication review. We could see from QOF data that there had been improvements in asthma care, with 78% of patients having received an asthma review which included the three RCP questions. The audit is due to be repeated next year.

We reviewed an audit on vaccinations delivered. This measured the percentage of patients registered with the practice, who were up to date with vaccinations in line with occupational health requirements. Results showed:

- For three of the five vaccinations recommended, the practice had exceeded the target of 90%, achieving 96% in each of the three required vaccinations.
- For Hepatitis B vaccination, results showed 68% of patients were fully vaccinated, 28% were partially vaccinated; 96% of patients had some level of Hepatitis B vaccination, against a target of 90%.
- For MMR vaccination, 67% of patients were vaccinated against a target of 90%.

The practice explained that MMR results were lower because this is now included in the basic vaccination requirements. A significant number of patients aged between 30 and 40 were not given this vaccination at school and there was no catch up programme for recruits when they started their career in the military, as there is now.

- There were no prescribing audits or audits on the use of antibiotics.
- Monitoring exercises were in place to check that standard operating procedures continued to meet the needs of the practice and its patients.
- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. When we reviewed the CAF we saw that any areas requiring further action or updating were being managed effectively. We also noted that the practice had used this self-assessment tool in a way which aided the effective management of areas that needed attention.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment. However, GP hours allocated to provide patient care, required review. There was insufficient time allocated for GPs to complete other clinical leadership work and essential administrative tasks.

We also found:

- The practice had an induction programme for all newly appointed staff. However, this was work in progress. There was no end to end process in place to capture completion of training and the practice training data base does not have the facility to record a completed staff induction, in this current format. We saw that the induction included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and Caldicott accountability. Staff had access to and made use of e-learning training modules and in-house training.
- Staff had all received mandatory training in subjects such as fire, basic life support and infection control. In addition staff had received role-specific training. For example, the infection control lead had attended a relevant course and all clinicians had been trained around the application of Gillick competence (Gillick is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge). Staff who acted as chaperones had received training. The RAF medic was trained in chaperone duties but was due to leave the base in December 2017.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training including an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes. Personnel requiring this vaccination would be required to travel to another practice.
- The nurse maintained their own continual professional development. The practice manager organised mandatory training and the practice nurse managed their own nursing update training. We were told there was no issue with being released for courses and or updates.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information was shared between services, with patients' consent, using a shared care record.
- From the sample of anonymised patient notes we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services. However, review of patient records showed these were difficult to follow. Summary templates had not always been used which meant that it was difficult for clinicians to see when a diagnosis had been agreed and to see a history of clinical events. Read coding had been applied inconsistently in some records, making clinical searches inaccurate. This was evidenced from records of patients transferring into the practice from other DMS practices, rather than notes that had been completed by the GPs providing services at RAF Boulmer. The contracted GPs did not have protected time to address the shortfalls in patient records.
- When we checked, there was no backlog in summarising notes.
- Reports were usually received from the OOH service within 48 hours of a patient having

accessed treatment. These reports were scanned on to DMICP and alerts sent to a doctor to ensure they were read and appropriate follow up instigated if necessary. The reviewing doctor coded problems/conditions as necessary on DMICP. Patients seen by the out of hours service (OOH) were required to present to the practice, if practicable, the next day for review.

Consent to care and treatment

- At RAF Boulmer, we saw staff sought patients' consent to care and treatment in line with legislation and guidance.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.
- When providing care and treatment for younger recruits, some of whom may be aged under 18 years, staff carried out assessments of capacity to consent in line with relevant guidance.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- All new patients were asked to complete a proforma on arrival. The practice nurse followed up any areas of concern, such as raised blood pressure.
- The practice offered basic sexual health advice including the issue of free condoms and referred on to local clinics in the community for more comprehensive services including family planning.
- Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs.
- All patients over 50 who had not had cholesterol check in the past five years were called in to be tested. Flu vaccinations had been offered to all patients deemed to be at risk.
- The number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 50 out of 51 eligible women. This represented an achievement of 98%. The NHS target was 80%.
- There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The data below from July 2017 provides vaccination data for patients using this practice:

- 100% of patients were recorded as being up to date with vaccination against diphtheria compared to 100% regionally and 100% for DPHC nationally.
- 100% of patients were recorded as being up to date with vaccination against polio compared to 100% regionally and 100% for DPHC nationally.
- 98% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 99% regionally and 99% for DPHC nationally.
- 99% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 98% regionally and 99% nationally.
- 100% of patients were recorded as being up to date with vaccination against Tetanus, compared to 100% regionally and 100% for DPHC nationally.
- 72% of patients were recorded as being up to date with vaccination against Typhoid, compared to 86% regionally and 91% for DPHC nationally.

The Typhoid vaccine has a lower uptake than other vaccinations. Current guidance state DMS practices should offer the Typhoid vaccination to personnel before deployment and not to routinely vaccinate the whole population.

Good



Are services caring?

Our findings

Kindness, dignity, respect and compassion

- During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Staff had assessed the acoustics of the building and used a television and/or radio in the reception area to ensure that conversations could not be overheard. Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- At the time of inspection, the practice could offer patients the services of either a female or a male GP. Those patients wishing to see a female GP could do this at the practice in Alnwick town. This will change when a female GP returns from a period of leave, who will offer regular access at the practice at RAF Boulmer. For any intimate examinations that were to be performed by a GP of the opposite gender, a chaperone was available. Arrangements were in place for women to access a family planning clinic in the community.
- There was an accessible toilet in the waiting area. A room was available for baby changing and/or breastfeeding.
- We were able to speak with two patients. They told us they were satisfied with the care provided by the practice and said they were able to get an appointment when needed.
- Patients commented in feedback provided on CQC comment cards that they felt involved in decision making about the care and treatment they received. They commented that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Results from the practice's Patient Experience Survey showed patients felt they were treated with compassion, dignity and respect. For example:
 - 64% of patients said the practice was good at listening to any compliments, comments or complaints; 25% of respondents said this question was not applicable to them 9% of patients did not answer this question.
 - 80% of patients said they felt involved in decisions about their care and treatment; 13% of patients said this question was not applicable to them; 9% of patients did not answer this question.

We did not receive any comparator data to help interpret the above patient survey results. However the views of patients expressed on CQC comment cards and those from patients we spoke with, aligned with the views above.

The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities. The information also signposted learning centres, for patients who may want to increase their fluency in English.

Care planning and involvement in decisions about care and treatment

- The Choose and Book service was used to support patient choice as appropriate (Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).
- The practice had arranged transport to and from hospital appointments for any patients who had opted to have treatment at a centre outside of the immediate area and would struggle using public transport.
- Data received from the patient experience survey, conducted between July and October 2017 showed patients responded positively to questions about their care and treatment. For example:
 - 87% of patients said if their friends, family or colleagues were able to use the medical centre at RAF Boulmer, they would recommend it to them.
- The data presented by the practice was not benchmarked against regional and national averages for DMS, or against the previous year's performance.
- The practice provided a service to patients from different countries and some of these patients did not have English as a first language. Staff told us that interpreter services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in reception and a computer was also available to access health information.

Patient and carer support to cope emotionally with treatment

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw that information that was relevant to the patient demographic and prominently displayed and accessible. For example, we saw posters which explained how to use a condom safely, on symptoms that may suggest a sexual health screening appointment would be useful, on access to contraception and on the importance of completing any prescribed course of treatment.
- The practice proactively identified patients who were also carers. Four patients had been identified as having caring responsibilities. Where patients identified themselves as carers, a code was added to their records in order to make them identifiable and so that extra support or healthcare could be offered as required.
- Patient information leaflets and notices were available in the patient waiting area which informed patients how to access a number of support groups and organisations.
- The practice had provided support to a carer of a patient of the practice, although the carer was not a registered patient at the practice. This support consisted of signposting to other

organisations, but also listening to carer and liaison with other organisations to ensure they received all the help required to enable them to continue caring for their family member.

Are services responsive to people's needs? (for example, to feedback)

Requires improvement



Our findings

Responding to and meeting people's needs

The Senior Medical Officer, practice manager and staff understood the patient population profile of the practice. However, the structure of clinical care provision did not always meet the needs of patients at the practice.

- A wide range of clinics were available to service personnel, for example, minor surgery services, physiotherapy, health checks and travel advice.
- There was no access to a female GP at RAF Boulmer. Patients wishing to see a female GP could book an appointment at the civilian practice in Alnwick town. This situation will be addressed when a female GP on long term leave, returns to work at the practice. Pre and post-natal clinics are held at the civilian practice in Alnwick on a weekly basis where health visitors are also based.
- Patients could access physiotherapy services at the practice.
- Patients were able to receive travel vaccines when required. Patients requiring a Yellow Fever vaccine were required to travel to the civilian practice at Alnwick.
- Patients could have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse. Patients requiring them could book a double GP appointment of 30 minutes.
- We saw that the standard of nursing care, triage and onward referral was effective, responsive and of a high standard. For example, where patients had been identified as experiencing an acute cardiac event, staff responded without delay.
- Same day appointments were not always available for those patients who needed to be seen quickly. GPs were only contracted to provide eight hours of GP care each week and four hours of occupational health care each week.
- There were accessible facilities which included interpreter services when required. Transport for patients to hospital appointments was available if needed.
- Eye care and spectacles vouchers were available to service personnel from the medical centre.

Access to the service

- The practice was open Monday to Thursday from 08:00 to 17:00 and on Friday from 08:00 to 16:00. The practice was closed on Wednesday afternoon for staff training.
- GP clinics were held at the practice on Tuesday, Wednesday, Thursday and Friday, from 08:30 to 10:20. The doctors supporting the practice at RAF Boulmer, held a clinic at their own practice

in Alnwick on Monday morning, for urgent appointments, between 11:00 and 12:00. Patients were asked to speak to staff in the medical centre who would make these appointments for them, and were requested not to contact the practice in Alnwick directly.

- GPs provided occupational health services from 10:30 to 11.30 on Tuesday, Wednesday, Thursday and Friday at RAF Boulmer medical centre.
- Outside of practice opening hours, patients were diverted to the local walk in centre in Alnwick or, after 18:30, to the NHS 111 service. Patient information provided to us on the day, which we checked following inspection, confirmed that there were no local out of hours or shoulder cover arrangements in place.
- Results from the practice patient experience survey showed that overall patient satisfaction levels with access to care and treatment was good. For example:
 - 93% of patients said they were able to obtain a suitable appointment when they needed one.
- Patients told us on the day of the inspection that they were able to get appointments when they needed them. However, patients' comments on CQC comment cards demonstrated that some patients felt frustrated when they arrived for an appointment and found the GP they were booked to see could not advise them as they were not qualified in aviation medicine. For some time, the Senior Medical Officer has been the only GP supporting the practice, who is qualified in aviation medicine.
- Although the practice did not have its own dispensary, feedback from patients and staff indicated that the arrangements in place to have prescriptions fulfilled by a local pharmacy and delivered back to the practice, worked well for patients.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Defence Primary Health Care had an established policy and the practice adhered to this.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.
- We spoke with two patients who told us that they felt comfortable and knew how to complain if the need arose. They confirmed that military rank would not be a barrier to them raising issues with the practice.
- There had been two complaints raised in the twelve months prior to inspection. We saw that there were processes in place to share learning from complaints. However, we were aware of one complaint that was correctly recorded and dealt with effectively, but minutes recording actions to prevent the same thing happening again were not kept, or shared with staff more widely.
- Complaints were audited through the Common Assurance Framework (CAF). This was used to focus on improvements to the service and to ensure that designated standards were being met on the handling of complaints. However, we found some complaint follow-up actions had not been fully recorded. As a result, these would not be subject to the overview provided by the CAF. We were unable to confirm that following complaints, findings from investigations led to improvements in services, or were used to prevent similar incidents occurring in the future.

Are services well-led?

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

Requires improvement



Our findings

Vision and strategy

- The practice had a vision to deliver high quality care and promote good outcomes for patients. However, the strategy to deliver this required some review.
- Consistent, safe and effective care was vision for the practice. This was evidenced by the commitment of all staff delivering services at the practice.
- The practice had a mission statement: “DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care service for entitled personnel to maximise their health and to deliver personnel medically fit for operations.”
- Staff we spoke with throughout the day could identify this mission statement, which was displayed in the waiting areas and staff knew and understood the values and behaviours required to support this. The practice had a supporting business plan which reflected the values and these were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of quality care. There was a clear staffing structure and staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. Some of these lead responsibilities required review. As examples, the nurse was the lead on safeguarding but was not fully qualified for this role. All clinical audit was being performed by the nurse, covering the scope of her work. GPs were not involved in quality improvement work due to the lack of administration time afforded under the current service level agreement. Although it was the responsibility of all staff to report and record significant events, we were aware of at least two events that had not been reported by GPs. When we asked why this was, we were told GPs could not access the reporting system. Information provided to us by DMS indicates that all staff providing care in a military setting have access to the electronic reporting system (ASER). Findings from our inspection showed that GPs do not have sufficient administration time to allow them to complete this additional paperwork, during their contracted hours at the practice.

Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.

The practice manager used the Common Assurance Framework (CAF) as a governance tool. Practice meetings were held regularly and were used as an additional governance communication tool. Learning needs were discussed at practice meetings and appropriate training was requested and delivered through this forum. The meetings were also used for forward planning, for example, to ensure patient needs were met during busy clinic times and periods of staff sickness. However, the practice had been working with only one GP who was qualified to deliver aviation medicine,

which impacted on patients.

A programme of clinical and internal audit was used to monitor quality and to make improvements. We saw that the practice used their audit work to identify learning and action points. For example, the practice nurse had conducted several audits within the scope of her work, which had resulted in improvements in care to asthma patients and those with diabetes.

There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, these did not take account of the unique operating arrangements at RAF Boulmer. Also, there was no evidence available that plans were in place to mitigate the pending loss of the medic from the practice in December 2017.

Leadership and culture

On the day of inspection the leaders in the practice demonstrated they had the experience, and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Everything we saw on the inspection day, and communications with the practice following the inspection, supported this. We saw that leaders recognised the challenges they faced in delivering a high quality service to all patients at RAF Boulmer. Although there was a clear leadership structure and staff felt supported by management, the Senior Medical Officer (SMO) at the practice was not sufficiently empowered or supported to deliver all tasks and responsibilities required of them. The SMO reported to a regional clinical director, who they had met approximately three times in the two years they had been working at RAF Boulmer. We were told the practice has received support when they had previously struggled to provide a full programme of care. We saw the SMO had access to telephone support from clinicians at RAF Leeming and at Catterick Garrison. However, the structure of the care provision did not fully take account of additional duties required of an SMO, which could not be delegated to other staff at the practice. There was no plan in place to increase GP hours at the practice to facilitate this work. There were very limited examples of clinical meetings between the practice nurse and the GPs. The SMO told us it was their intention to address this when more time became available. There were some systems that the GP could not access, which hindered the flow of work and added to the administrative burden. The practice manager (representing the SMO) attended Unit Health Committee meetings, where the downgrading of patients was discussed. Clinical staff did not have adequate time available to review and improve patient records and to address problems with Read coding.

Staff told us the practice leaders were approachable and took the time to listen to all members of staff. All staff were involved in discussions about how to run and develop the practice, but recognised that the current model of care delivery imposed limitations. We particularly noted the positive input of the practice nurse and the practice manager, who had both been in post for less than 12 months. Both were highly supportive of the SMO and visiting GPs.

Staff told us the practice held regular meetings. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. Minutes were comprehensive and were available for practice staff to view. However in instances where complaints had been discussed in meetings between the practice manager and the SMO, no minutes had been kept.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included training for all staff on communicating with patients about notifiable safety incidents. The GPs and practice manager encouraged a culture of openness and honesty. We found that the practice had systems

to ensure that when things went wrong with care and treatment, the practice gave affected people reasonable support, information and a verbal and written apology.

Seeking and acting on feedback from patients, and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through surveys and from any individual patient feedback received.
- The practice did not have a patient participation group, but relied on a comments box which was available for patients to make their views known.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.
- Staff told us they felt involved and engaged to improve how the practice was run but recognised the limitations it had to work within.
- Completed CQC comment cards from patients supported our findings, that there was an open door policy when it came to patient input and feedback.

Continuous improvement

- The practice did focus on continuous learning and improvement, but this work was limited considerably by the terms of the current service level agreement with GPs. The practice nurse conducted audits within the scope of her work, shared findings and implemented actions that improved outcomes for patients.
- The SMO had identified areas for improvement but was limited by contractual arrangements in driving this improvement.
- The practice staff worked hard to ensure that systems in place were fit for purpose, for example, reviewing how correspondence was managed so that the SMO had access to this when working from a laptop at the civilian practice in Alnwick.