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

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td>Overall rating for this service</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services safe?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services caring?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Requires improvement</td>
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</tbody>
</table>
Summary of findings

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at St Athan Medical Treatment Facility on 16 May 2017. Overall, The practice is rated as Requires Improvement. Our key findings across all the areas we inspected were as follows:

- Systems and processes to keep patients safe were in place at the practice.
- There was an open approach to patient safety and a system in place for reporting and recording significant events.
- The review of one significant event was not carried out in a timely manner.
- Although significant events were analysed following investigation, there was no annual review of events to check for themes or re-occurring events.
- Staff were aware of current evidence based guidance; staff had received the training required to provide them with the skills and knowledge to deliver safe care and treatment.
- There was some evidence of quality improvement in patient treatment; the practice conducted a continuous cycle of clinical audit. However, we found audit was not specifically targeted to areas identified locally as requiring improvement.
- Data showed patient outcomes in some areas were less favourable compared to the national average. For example, in cytology and in management of hypertension.
- Most governance systems were effective. However, we did find areas for improvement:
  - A small number of blood test results had not been reviewed by clinicians since receipt in April. These were addressed on the day of our visit.
  - We also found some backlog in note summarising; there was no effective plan in place to address this.
  - There was a large number of former patients’ paper, clinical notes held at the practice. There was no plan in place to manage the movement of these records. These notes had not been summarised whilst patients had been registered with the practice.
  - The infection control lead had not received additional training specific to their role. Staff were awaiting placement on specific courses which had not been sourced.
  - There was no contract in place for the disposal of clinical waste. It was not clear whether the existing month by month removal of clinical waste covered pharmaceutical waste.
  - We were advised that we would be provided with further data on the day of our inspection. The practice provided services for some dependants and children of
military personnel. Data on the delivery of childhood immunisations and vaccinations was not available to us on the day of inspection. When we did receive information on childhood vaccinations, post inspection, it was not broken down to demonstrate which children had received particular vaccinations and which were due to be vaccinated.

- Patients were positive about their interactions with staff and said they were treated with compassion, dignity and respect.
- We received 12 completed patient comment cards. All expressed positive views of the service. Patients commented on good access to GPs and nurses, and that staff were supportive.
- The practice investigated and acted on complaints received.
- The practice had good facilities and was equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff worked well as a team.
- 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:

- All staff to receive the training required to carry out their duties effectively. This includes training specific to staff roles, such as infection control leads.
- Maximise the functionality of DMICP in order that the practice can run clinical searches, provide assurance around patient recall systems and produce accurate performance data.
- A contract for disposal of clinical waste to be in place.
- Systems to be in place to ensure all test results have been picked up from mailboxes of clinicians.
- Definitive registers of patients to be in place, such as safeguarding registers and registers for patients on high risk medicines.
- Any backlog in note summarising to be treated as a priority to reduce risk to patients.
- All clerical notes to be archived in the central depository, to facilitate timely access for receiving practices of those patients transferring out of the practice and/or out of service.
- Clinical audit and improvement programmes to focus on areas which will have most impact for the practice’s patient population.
- The doctor’s grab bag to be locked or have a tamper evident seal when controlled drugs are stored in the bag.
- Governance arrangements including the management of data systems to be in place to allow accurate collection of data which can be used to effectively manage quality and performance at the practice.

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

**The five questions we ask and what we found**

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
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<tbody>
<tr>
<td><strong>Are services safe?</strong></td>
<td>Requires improvement</td>
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<tr>
<td>The practice is rated as requires improvement for providing safe services.</td>
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<tr>
<td>- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong reviews and investigations were carried out.</td>
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<tr>
<td>- The review of some significant events was not as timely as could be. There was no review of significant events annually to check for trends or common themes.</td>
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<tr>
<td>- Risks to patients were assessed and systems to address these risks were in place.</td>
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<tr>
<td>- We did note the practice did not keep patient registers to assist clinicians for example, safeguarding registers or registers of patients on high risk medicines.</td>
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<tr>
<td>- There were a number of previous patients’ clerical records, which had not been summarised. This represented risk.</td>
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<tr>
<td>- Shared care was in place for those patients on high risk medicines.</td>
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<td>- Clinicians’ adherence to the Defence Primary Health Care (DPHC) Tri Service Formulary was 52%, down from 73% in the previous quarter. There was no work in place to discover why this was or a plan on how this could be improved.</td>
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<td>- There were no annual GMC registration checks in place.</td>
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<tr>
<td>- Emergency medicines and equipment were available and ready for use however we noted that the doctors’ grab bag contained controlled medicines but did not have a tamper evidence seal in place.</td>
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<tr>
<td>- Staffing levels were sufficient for the numbers of patients registered with the practice.</td>
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**Are services effective?**

The practice is rated as requires improvement for providing
There was no contract in place for the disposal of sharps and clinical waste, or for the disposal of unused medicines. This was being managed by the practice manager on a monthly basis. It was unclear how effective this arrangement was.

Data shared with us before inspection showed patient health care could be improved, for example, in relation to cytology and management of hypertension.

There was evidence that clinical audit was driving some improvement in patient outcomes. However, the practice was working to a clinical audit plan which did not necessarily reflect the needs of the patients of the practice.

The system in place for checking that all blood tests had been reviewed required attention. We saw that three sets of blood tests from April had not been reviewed. These were dealt with by the practice on the day of our inspection.

Staff worked well with multidisciplinary teams. We saw positive examples of physio-therapist involvement at the earliest stages to aid recovery of patients with musculoskeletal injuries.

Although information required was eventually supplied by the practice, there was evidence that this information could not be accessed quickly. For example, data on childhood immunisations, broken down by immunisation type and age of children.

Are services caring?
The practice is rated as good for providing caring services.

- Feedback from patient comment cards was positive
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Nurses were flexible when required and worked at weekends to ensure all personnel patients’ needs were addressed before any deployment.
**Are services responsive?**

The practice is rated as good for providing responsive services.

- The practice offered a range of services to meet the needs of personnel and their dependants; referral links to providers of additional services were in place and worked effectively.
- Patients commented they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and accessible to all patients. We saw that complaints raised had been investigated and addressed, and that learning from those complaints was shared with staff and other stakeholders.

**Are services well-led?**

The practice is rated as requires improvement for providing well-led services.

- The practice had a vision to deliver quality care and promote good outcomes for patients.
- There was a clear leadership structure and staff said they felt supported by management.
- An overarching governance framework supported the delivery of good quality care. However, we saw areas of governance that required improvement. There was a staff member for whom security vetting checks were outstanding; there was no annual review of significant events to check for any re-occurring themes or incidents. The review of some incidents was not as timely or as detailed as could be.
- The practice had approximately 1,720 patients. Our inspection showed that there was a backlog in note summarising. This was made up of 37 civilian records and 20 personnel records. A large number of former patients’ notes were being held at the practice; these had not been summarised by the practice. There was no plan in place to ring-fence staff time to address this backlog.
- The practice did not keep defined patient registers, for the purpose of effective risk management, for example, a safeguarding register, or a register of patients taking high risk medicines that require monitoring. Even though patient numbers on these registers would be small, this would reflect best practice.
• We saw that medics were not signed off to deliver any treatment, but had been trained to conduct preliminary examinations, triage clinics and record these in the electronic patient notes. No priority plans were in place to assess competence to deliver basic treatment which may have eased pressures on the health centre.

• An emergency grab bag held controlled medicines but was not security sealed to prevent unauthorised use.

• There were areas of staff training that needed addressing, for example, appropriate training for infection control leads.

• The Acting Senior Medical Officer (a military GP) and civilian GPs were aware of the requirements of the duty of candour.

• The GPs encouraged a culture of honesty. The practice had systems to receive details of notifiable safety incidents and sharing the information with staff, ensuring appropriate action was taken.

• The practice had carried out a patient survey. We saw that results were collated and shared with practice staff and were available to patients.
Our inspection team

Our inspection team was led by a CQC inspector. The team included a second CQC inspector, a CQC medicines inspector, a GP specialist adviser, and a practice manager specialist adviser.

Background to St Athan Medical Treatment Facility

St Athan Medical Treatment Facility is located in the rural Vale of Glamorgan. The treatment facility treats both forces personnel and some dependants and children. At the time of inspection, the patient list was approximately 1,700. Occupational health services are also provided to personnel and a number of reservists.

In addition to routine GP services, the treatment facility offers minor surgical procedures, physiotherapy services and travel advice. Family planning advice is available, with referral onwards to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams, who hold clinics at the practice on a weekly basis. Childhood immunisations and vaccinations are also offered by the treatment facility. All facilities are at ground floor level. Most of the treatment facility is fully accessible; should patients require assistance with the doors at the front of the facility they can ask staff for help.

At the time of our inspection, the facility had three full time GPs, three practice nurses, a pharmacy technician who worked in the practice dispensary, and one practice medic. (The work of a military medic has greater scope than that of a health care assistant found in NHS GP practices). The facility was led by a practice manager, supported by a deputy and a number of administrative staff. The facility also had an officer providing primary care rehabilitation services via physiotherapy and exercise training.

The facility was open from Monday to Friday each week, between 8am and 5pm. The centre was closed on Wednesday and Friday afternoons. On Monday, Tuesday and Thursday of each week between 5pm and 6.30pm, telephone advice was available from the centre medic. After these hours, and on Wednesday and Friday afternoons, patients were diverted to out of hour’s services provided by Cardiff and Vale of Glamorgan Health Board. Throughout this report, St Athan Medical Treatment Facility will be referred to as ‘the practice’.

Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services
during inspection, we will report them by making a recommendation for action to the Surgeon General’s office.

We carried out a comprehensive inspection of this service. St Athan Medical Treatment Facility had not been inspected by the CQC previously.

How we carried out this inspection

Before visiting, we reviewed a limited amount of information were given about the facility.

We carried out can announced inspection on 16 May 2017. During the inspection, we:

- Spoke with a range of staff, including three GPs, the practice manager, deputy practice manager, pharmacy technician, two practice nurses, two medics, a physiotherapist and two administrative staff. We were able to speak with one patient who used the service.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 there was a clear process for reporting and recording incidents. A recording form was available on the practice computer system. Staff said there was an open culture and added they were supported through this reporting process. We did see that the review of some incidents was not as timely as they could be or as detailed, to provide genuine learning points for all involved. Also, significant events were not reviewed annually to check for any re-occurring themes or trends.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, clinicians at the centre had raised an alert following successive examples of syringe needles coming away from the barrel of a syringe during treatment. This was escalated and reported to the Medicines and Healthcare Products Regulatory Agency so that the possibility of defective batches of syringes could be investigated and recalled if necessary. In respect of wider safety issues, the facility had reported incidents of patients using the wrong entrance to the car park at the centre, which had resulted in a 'near miss' traffic accident. As a result, changes were made to the car park and signage.

Overview of safety systems and processes

St Athan Medical Treatment Facility (referred to as the practice) had systems, processes and practices in place to minimise risks to patient safety.

- 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 a GP who worked full time at the practice. Effective deputising arrangements were in place.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level three.

- A notice in the waiting room 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).

- We noted the practice did not keep a formal register of patients subject to safeguarding
arrangements, or of those deemed to be ‘at risk’. When we discussed this we found GPs’
tended to share this information with concerned colleagues within the practice and relied on
their own knowledge to deal with these patients.

- Where paper records of former patients of the practice had not been summarised, there was
  also the risk that some of those patients may have required safeguarding markers to be placed
  on their electronic records, which had been previously missed. Issues such as these can place
  vulnerable children and adults at risk.

We observed the premises to be clean and tidy.

- There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead, who had
  received basic level infection control training. However there was no evidence of any further,
  specific training to enable them to discharge their responsibilities as an infection control lead.
- All areas (including clinical) had only a daily clean. GPs and nurses were responsible for wiping
  down items such as the examination bed with alcohol wipes and each performed a deep clean
  on their own consulting rooms every six months. Due to the lack of specific training the nurse
  was unable to say whether the deep cleans performed met the requirements of the “Health and
  Social Care Act Code of Practice on the prevention and control of infections and related
  guidance”. We noted that surgical procedures were delivered at the practice.
- Gloves, aprons, hand soap and gel were seen around the practice and stored appropriately.
- Hand washing and sharps injury posters were in all clinical areas.
- The main cleaning cupboard was secured. COSHH information on all products was available
  and staff could identify this.
- Clinical waste was being removed on a monthly basis, along with pharmaceutical waste; there
  was no annual contract in place to manage this, including for the disposal of sharps. It was
  unclear how effective this arrangement was for Defence Medical Services.

There were arrangements in place for managing medicines, including emergency medicines and
vaccines (including obtaining, prescribing, recording, handling, storing, security and disposal).

- Alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) were received
  in the practice by the pharmacy technician, who circulated these to all staff. The practice
  maintained a register of the alerts and actions taken.
- There were processes for handling repeat prescriptions which included the review of high risk
  medicines. Although there were a very small number of patients on high risk medicines, there
  were no formal registers for these patients. When we asked GPs about this, we found they
  searched for patients using a medicine search facility. We explained that having a register, by
  appropriate read code is a safe and effective way of enabling quick retrieval of this information.
- Repeat prescriptions were signed before being dispensed to patients and there was a reliable
  process to ensure this occurred.
- We saw evidence of audits to ensure prescribing was in line with best practice guidelines. We
  reviewed an audit of antibiotic prescribing for the practice which was made up of two completed
  cycles. This showed 100% adherence to antibiotic prescribing guidelines.
- We were also shown audits aimed at driving high standards of care and follow-up of patients.
  For example, we saw the first complete cycle of an audit to review delivery of sexual health
  screening within the practice. This was due to be repeated in 12 months time (approximately
September 2018).

- Blank prescription forms and pads were securely stored throughout the practice. There were systems in place to monitor their use. However, there was no annual audit to ensure that all prescriptions were accounted for.

- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. These were up to date and had been reviewed recently.

- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures to manage them safely. There were also arrangements for the destruction of controlled drugs.

- Records showed fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature.

- 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. We did note that the doctor’s grab bag contained controlled drugs; the bag did not have a lock or tamper proof seal in place, to prevent or deter inappropriate access to these medicines.

- Medicines were effectively managed within the dispensary at the centre. The pharmacy technician on the day of inspection told us they performed a date check on stock each month.

- We saw that all stock ordered and received was entered into a computer record, to aid effective maintenance of stock levels and ordering.

- Where medicines prescribed were not held in stock, patients could send their prescription to a community pharmacy to be fulfilled. We were not aware of any instances where patients had experienced delays receiving their medicines.

- Recruitment checks were in place for all staff. We did note that once MOD GPs had started at the practice, there was no annual check on their GMC registration. Following inspection the practice commented that they rely on the annual appraisal process for GPs, which includes a GMC check. This does not provide sufficient assurance for practices and it is expected that practices have their own governance and assurance checks in place. Annual checks were in place for nurses’ professional registrations.

**Monitoring risks to patients**

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.

- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff should help patients vacate the premises.

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.

- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients’ needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.
• When we reviewed the management of call and recall of patients, we found this was well managed.

**Arrangements to deal with emergencies and major incidents**

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

- All clinical rooms had an alarm which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available.
- The centre had a defibrillator available on the premises and oxygen with adult and children’s masks.
- 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 stored securely. We pointed out that a lock or tamper evident seal should be on the doctor’s grab bag in the practice as controlled medicines were available in the bag.
- The centre had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. We saw that this had been tested recently when an IT failure occurred lasting more than 24 hours for the centre.
Are services effective?  
(for example, treatment is effective)

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) 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.
- Peer review between GPs monitored that these guidelines were followed.
- The Defence Primary Health Care (DPHC) service also produced a newsletter that was circulated to clinicians providing further information and a summary of other safety updates. GPs we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.

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. The system is used to measure some aspects of performance in 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 provided a useful way of measuring this for DMS).

We reviewed QOF performance of the practice. QOF results from 2016-2017, which were benchmarked against NHS targets for the year 2011/12 showed:

- The number of women aged 25-49 and 50-64 whose notes recorded that a cervical smear had been performed in the last 3-5 years was 116, out of 182 eligible women. This represented an achievement of 64%. The NHS target was 80%.

There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. Patients failing to respond to the initial call for screening were sent reminder letters by the practice.

An internal quality assurance tool, the Common Assurance Framework (CAF) was used to monitor safety and performance. When we reviewed the CAF we saw that any areas requiring further action or updating were being managed. However, the confirmed involvement of external agencies with the practice’s major incident plan had yet to be addressed. Training required for implementation of the plan had yet to be delivered.
From data provided, some groups of patients were particularly small, such as those requiring blood pressure monitoring due to diabetes. Data from QOF performance for six key indicators, up to February 2017 has been benchmarked against the NHS targets set for 2011/12, shows:

- The number of patients with diabetes whose last measured total cholesterol (within the preceding 15 months) was 5mmol/l or less was one. This equates to 100% achievement, which is above the NHS target of 70%.

- The number of patients with diabetes in whom the last blood pressure reading (measured in the last 15 months) was 150/90 or less was one. This equates to 100% achievement, which is above the NHS target of 70%.

- The number of patients with hypertension in whom there is a record of their blood pressure in the past nine months was 14. The total meeting the NHS target was 11 patients. This equates to an achievement rate of 79%, compared to the NHS target of 90%.

- The number of patients with hypertension in whom the last blood pressure (measured in the previous nine months) was 150/90 or less was 8, which equates to an achievement rate of 57%, compared to the NHS target of 70%.

- 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, (where available) had been offered within the previous 15 months was six, which represents an achievement rate of 86%, compared to the NHS target of 90%.

We saw that numbers of patients given in data, did not include figures on those patients excepted from checks or screening. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The QOF data collection was not performed by the practice. This was done centrally by Defence Statistics. There was no evidence that this was checked within the practice to ensure any exceptions were appropriate.

There was some evidence of quality improvement including clinical audit. We reviewed two audits, one in relation to antibiotic prescribing which had two completed cycles. The audit showed that improvement was needed by recording Fever Pain scores in consultations. One re-occurring prescribing factor found in the audit was that treatment durations were longer than recommended guidelines. The audit was effective in that it brought this to the attention of clinicians.

We reviewed recent improvements in patient transfer in and out, which included picking up any longstanding medical and /or welfare issues for patients that had not been addressed by the previous practice. This was done in a patient screening clinic was appeared to be working effectively.

**Effective staffing**

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and
Staff had all received mandatory training in subjects such as fire, basic life support and infection control. However, the centre could not demonstrate how they ensured role-specific training for relevant staff. For example, for those who were leads in infection control.

Staff were trained to chaperone and only clinical staff performed these duties.

Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and discussion at practice meetings. We were aware that medics at the centre did not administer any treatment. Training for medics to do this was available and following a period working with a nurse and an assessment of competency, they could work alone delivering vaccinations and immunisations. Many of the difficulties experienced by staff at the centre were caused by short notice deployment of personnel, when large numbers of personnel required vaccinations and immunisations before mobilizing. The relatively small amount of work required to ensure medics have this training would reduce pressure on nursing staff at peak periods of activity.

The medical centre was Yellow Fever registered and the practice nurse was up to date with training for this.

The nurses maintained their own continual professional development. The practice manager organised mandatory training and the practice nurses managed their own nursing update training. We were told there was no issue with being released for courses and or updates.

The medic assessed “fresh cases”. There was planning in place to facilitate some peer review to discuss decisions the medic may have pursued with basic triaged cases.

Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

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 clinic patient record system and their intranet system.

- This included risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. However, this could not be done electronically through the portal used by the local Health Board in Cardiff and Glamorgan. All referrals had to be faxed and posted; systems in place at the practice included telephone follow-up of faxes to ensure they had been received. There is no choose and book system in place in Wales.
- We spoke with the administrator who undertook the booking of follow on appointments for patients including those that were required to have appointments made within two weeks of seeing their GP. There was a good system in place which enabled the patient to have their appointment made immediately after seeing their GP. There were also failsafe checks after the appointment by the administrator to ensure the patient had attended their appointment and a
follow up letter had been received.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients’ needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. There were pre and post-natal clinics facilitated by the practice on a weekly basis.

A clinical psychologist visited every two weeks and held a half day clinic at the practice each fortnight. We were made aware by the Acting Senior Medical Officer at the practice that this provision had recently reduced. The Acting Senior Medical Officer expressed their concern on the impact this may have on patients who are deployable personnel.

**Consent to care and treatment**

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.
- We saw formal consent forms used by clinicians who performed surgical procedures.

**Supporting patients to live healthier lives**

We asked the practice for information on their performance in respect of childhood immunisations. We received this information post inspection. This was not broken down by type of immunisation. Information provided showed that the practice had 108 children eligible for vaccinations. Eight of these patients required follow-up. The practice identified patients who may be in need of extra support and signposted those to relevant services. For example:

- The practice offered basic sexual health advice including the issue of free condoms, but referred on to local clinics in the community for more comprehensive services including family planning.
- The practice completed an obesity audit. As a result a health promotion day has been scheduled for June 2017.
- The practice held roadshows to promote good health within their local community. This included a visit to the local primary school and a ‘healthy day’ planned for the summer, with outside agencies visiting the practice to work together to give advice and information on topics such as healthy eating and weight management.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and breast cancer checks. A monthly search was undertaken for any patients aged 50-64 years who would be entitled to breast screening and an appointment sent to them. The practice engaged with national screening programmes such as bowel cancer screening, if any patients registered were eligible for this.
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.
- 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.
- The practice could not offer the services of a female GP. Arrangements were in place for women to access a family planning clinic in the community.
- The practice identified a local practice for women to visit to see a female GP. This was monitored by the practice manager. If demand for a female GP rose, the practice manager could contact Regional Headquarters to ascertain whether a female GP could visit to conduct a clinic at the practice.
- For any intimate examinations that were to be performed by a male GP at the practice, a chaperone was always available.
- There was an accessible toilet in the waiting area.
- A room was available for baby changing and/or breastfeeding.

We received 12 comment cards, which were all positive about the standard of care received. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

We were able to speak with one patient. They told us they were satisfied with the care provided by the practice and said they were able to get an appointment when needed.

We asked the practice for a copy of their most recent patient experience survey. Information provided showed the practice performed well in most areas, but improvement was required in others. Those areas were in relation to GP call backs, routine appointment availability, timeliness of appointments when patients had arrived at the practice and awareness around the complaints procedure. The data presented by the practice was not benchmarked against regional and national averages for DMS, or against the previous year's performance.

We did note that the practice had received seven written ‘thank you’s’ in response to care and
treatment provided by the nursing team.

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**

Patients commented on CQC comment cards that they felt listened to and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

The practice provided facilities to help patients be involved in decisions about their care:

- The practice sometimes dealt with patients from different countries, some of whom 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. Reception staff knew which patients may require literature in alternative languages and could make other formats available for these patients.

**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 support groups and organisations.
Are services responsive to people’s needs?  
(for example, to feedback)

Our findings

Responding to and meeting people’s needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- A wide range of clinics were available to service personnel and their dependants, for example, minor surgery services (GP and consultant led), physiotherapy, health checks, travel advice, well woman clinics and family planning advice. Pre and post-natal clinics were held at the practice every week. Patients were able to receive travel vaccines when required. The practice was a Yellow Fever centre and nurses had received all training to support this.

- Patients were able to have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse. Those requiring them could book a double GP appointment of 30 minutes.

- Same day appointments were available for those patients with medical problems that required it.

- Physiotherapists were employed within the practice, and there was a hydrotherapy pool available to personnel patients. All referrals to this service were made by the GPs and the average waiting time for an appointment was less than one week.

- There were accessible facilities, which included interpreter services when required.

- Eye care and spectacles vouchers were available to service personnel from the medical centre.

We were told that a recent patient survey had highlighted an issue with the waiting times for routine appointments with a GP. In response to this the practice had introduced duty doctor clinics which meant patients would be seen within 48 hours. The practice had also taken the decision to convert the last available appointment with the GPs each day, into three five minute telephone consultation slots, which had proved to be popular with patients requiring GP advice.

Access to the service

The practice was open from Monday to Friday, between the hours of 8am and 5pm. The practice was closed on Wednesday and Friday afternoons and accepted emergency cases only. The practice closed for lunch each day from 12pm to 1pm. The practice did offer home visits to patients who could not attend the practice due to their medical condition, although all patients were encouraged to travel to the practice if at all possible.

When the practice closed on Monday, Tuesday and Thursday, telephone advice was available.
from the medic between 5pm and 6.30pm. After this patients were diverted to the service provided by Cardiff and the Vale Health Board. Details of this was posted on the outer doors of the centre and in the practice leaflet.

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.
- There had been five complaints raised since January 2017. We saw that there were processes in place to share learning from complaints. Complaints were audited through the Common Assessment 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.
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 quality care and promote good outcomes for patients.

- The practice did not have a mission statement that all staff identified with. However, staff we spoke with told us of their commitment to the care of patients and the provision of high quality care.
- The practice had supporting business plans in place and progress against this was monitored through a series of meetings.

Governance arrangements

On the day of our inspection, we found the practice did have governance arrangements in place to support the delivery of good quality care, but some of these were not embedded. For example:

- An understanding of the performance of the practice was maintained and shared with staff. The presentation of some data required improvement to provide meaning for all staff. There was some evidence post inspection that the practice staff could not access and interpret data in ways required to address any performance issues.
- Clinical audits we reviewed did demonstrate quality improvement. For example, an antibiotic audit had identified that all clinicians were not recording the Fever Pain Score before prescribing. The audit also identified re-occurring themes, for example, treatment being given for longer than defined by recognised guidance. This was a good, well-structured audit with repeated cycles. The practice was working to an audit programme that did not reflect the needs of the patients of the practice. For example, the audit programme we were shown was around QOF targets. The numbers of patients that fell into some of these categories was very small, so audit was not as meaningful.
- A plan to increase prescribing adherence by the practice clinicians to the Tri Service Formulary was not in place and could not be described by the practice.
- There were arrangements in place for identifying, recording and managing risks and issues, and for implementing mitigating actions. However, we noted that guidance on the summarising and archiving of medical records had been given in February 2017, yet the practice had retained up to approximately 500 sets of paper medical records, of former patients of the practice. None of these had been summarised by the clinic, and none had been sent to the central depository for paper patient records.
- Contractual arrangements provided insufficient cover for removal of sharps, clinical and pharmaceutical waste from the practice. This was being conducted on a month by month basis.
It was unclear whether pharmaceutical waste was included in this arrangement, or how effective this arrangement was for Defence Medical Services.

- Our findings on inspection indicated that the DMS Common Assurance Framework (CAF) was being used effectively as a self-assessment tool by practice managers.

- We found three sets of blood tests from April 2017 that had not been actioned, in an email inbox; these were dealt with on the day of our inspection. Governance around checking that all results are dealt with required attention.

Systems were in place to monitor medicines, equipment and safety alerts sent by the Medicines & Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS).

We saw evidence from minutes of meetings that time was allowed for lessons to be learned and shared following significant events and complaints. For example, following an interruption to the electrical supply of fridges at the practice, the pharmacy technician had made a business case for data loggers to be installed to ensure that fridge temperatures did not move outside of the required range over weekend and bank holiday periods. This was successful and fridge temperatures were now monitored continuously. However, we noted that some investigations into significant events were not initiated by the practice but by DMS HQ. Also, the detail contained in some significant event records was insufficient to provide genuine learning points.

**Leadership and culture**

We found on the day of inspection the GPs and management of the practice prioritised safe, high quality and compassionate care. Leadership arrangements were effective enough to ensure safe care. However, a number of governance issues required review. There was a lack of progress chasing some issues.

- There was no annual review of significant events to check for re-occurring themes or trends. The analysis of some events was not as timely or as detailed as it could be.

- A backlog in patient note summarising in relation to current patients had not been identified as a priority task; clinicians were summarising. There were no plans in place to train other staff members to undertake this task.

- There were no defined registers within the practice, for example, safeguarding registers and registers of patients on high risk medicines that require monitoring. Although numbers concerned were small, this arrangement would reflect best practice and aid any incoming locum GP if regular GPs were unavailable.

- An emergency grab bag contained controlled drugs but did not have a tamper evident seal in place.

- Infection control training for the infection control lead required implementation. We were advised by the practice that this was due to lack of funding for training infection control leads. However, we were made aware by DMS that funding is available from different sources to support this training and practices can bid for this funding.

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). The practice manager encouraged a culture of openness and honesty. Where things had gone wrong the practice gave affected people reasonable support, truthful information and a verbal and written apology. There was a clear leadership structure and staff felt supported by management.
The practice held and minuted a range of multi-disciplinary meetings including meetings with health visitors.

Staff told us the practice held regular team meetings.

Pharmacy update was a standing order on the monthly agenda for the practice team meeting.

Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.

Staff said they felt respected, valued and supported.

Seeking and acting on feedback from patients, and staff

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

- Patients through the patient experience survey.
- Through complaints and compliments received.
- There was no formal staff survey undertaken although feedback from staff was gained generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues.

Continuous improvement

The medical facility was a training practice but was not hosting any GP registrars at the time of our inspection. The practice had a series of governance meetings in place to monitor performance.

When we put questions to the practice for example, on lower levels of adherence to the Defence Primary Health Care Tri-Service Formulary, these could not be answered. There were no clear ideas on how results in this and other areas could be improved. Although the practice used the Common Assessment Framework to identify areas for improvement, the practice did not recognise the availability of other reports and information that could be used as drivers for improvement. An anti-biotic prescribing audit reported on in January 2017 had identified that clinicians were prescribing courses of antibiotic treatment for longer than guidance recommends. There was no evidence of local review of this by clinicians before a wider audit meeting which was planned.