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>Overall rating for this service</th>
<th>Good</th>
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</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Good</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>Good</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 Army Foundation College (Harrogate) Medical Centre on 7 June 2017. Overall, the practice is rated as good. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. We did find some incidents reports had not been fully competed as required.
- The practice had defined and embedded systems to minimise risks to patient safety. However use of alerts on the electronic patient record system was not fully utilised by all staff.
- Staff were aware of current evidence based guidance.
- Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. Arrangements for some staff appraisals had not been formalised; this had been picked up the Senior Medical Officer (GP) in the short term but permanent arrangements required implementation.
- Results from patient feedback 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.
- Patients we spoke with said they found it easy to make an appointment with a GP 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.
- There was a clear leadership structure and staff felt supported by management.
- There was no full clinical team meeting held by the practice.
- 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:

- Ensure all staff have sufficient training and skills to enable them to use governance tools effectively. For example, the practice electronic patient records system.
- Review appraisal systems in place for contracted staff and ensure all contracted staff have appropriate background checks in place.
• Review training requirements for contracted staff, for example, in respect of completing significant event reports.
• Complete checking systems in place for security items for example, for prescription pads to ensure that tracking and recording systems are effective.
• Review cross practice communication requirements to check their effectiveness.
• Prioritise competency assessment of staff, for example, any medic who is working unsupervised and supplying medicines to patients.

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 requires improvement for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice.

- A number of significant events had been reported by nurses at the medical centre. These submissions had not been completed fully, which hindered the timely investigation of these incidents.

- All appropriate alerts were not being used on electronic patient records; staff had not been trained to utilise the full functionality of the electronic patient record system DMICP.

- Systems in place from the contractor working for Defence Primary Health Care (DPHC), EPS, were not effective in ensuring all nurses had undergone DBS checks to the required standard.

- Periodic audit of prescription pads was required to ensure security was fully effective.

- When things went wrong patients were informed as soon as practicable, received reasonable support, information and a written apology.

- Actions to improve processes to prevent the same thing happening again were put in place.

- The practice had systems, processes and practices to minimise risks to patient safety.

- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.

- The practice had adequate arrangements to respond to emergencies and major incidents.
### Are services effective?

The practice is rated as good for providing effective services.

- Staff were aware of current evidence based guidance and treated patients in accordance with this.
- A number of clinical audits had been undertaken by the practice. We reviewed two audits that were made up of at least two completed cycles. Both audits demonstrated quality improvement.
- The majority of staff had the skills and knowledge to deliver effective care and treatment. However, we found one staff member who had completed the training relevant to their role but who had not been signed off as competent. This staff member was providing treatment.
- There was evidence of appraisals and personal development plans for Defence Primary Health Care (DPHC) staff.
- We saw that nurses supplied by an external contractor had received appraisals but there were no formal arrangements in place for appraisal of the senior nurse (Matron). This had been identified and acted on by the Senior Medical Officer.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients’ needs.

### Are services caring?

The practice is rated as good for providing caring services.

- Feedback from patients showed they rated the practice highly for several aspects of care.
- Patients said they were treated 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, and maintained patient and information confidentiality.
- Patients we spoke with on the day of our inspection talked of the high level of confidence they had in the Senior Medical Officer (SMO) and civilian GP at the practice. We were given examples of how patients had been assisted in a timely return to duty, whilst receiving a very high standard of compassionate care.
Are services responsive?
The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet their needs. Clinicians and staff understood the impact of change of lifestyle on young people entering the armed forces. They offered pastoral support and advice to help patients overcome the physical challenges they faced as well as the mental and emotional challenges. This was referred to by patients we spoke to in a very positive way.

- The practice took account of the needs and preferences of patients; we saw Gillick competence used when clinicians asked patients about parental involvement in their treatment. This provided patients with the levels of privacy and confidentiality they expected.

- Access to physiotherapy for those with musculoskeletal injuries was rapid and responsive. Audit had been conducted on recovery times and results were highly positive.

- Patients we spoke with said they found it easy to make an appointment with a GP 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.

- A minor surgery clinic was delivered by the Senior Medical Officer.

- Information about how to complain was available and accessible to all.

Are services well-led?
The practice is rated as good for providing well-led services.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.

- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.

- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

- Staff had received inductions, annual performance reviews
and attended staff meetings.

- The provider was aware of the requirements of the duty of candour. In examples we reviewed we saw evidence the practice complied with these requirements.

- The clinicians at the practice encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.

- The practice proactively sought feedback from staff and patients.

- There was a focus on continuous learning and improvement at all levels.

- The civilian GP and SMO, who were skilled in specialist areas used their expertise to offer additional services 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, a practice nurse specialist adviser and a practice manager specialist adviser.

Background to Army Foundation College (Harrogate) Medical Centre

The Army Foundation College (Harrogate) Medical Centre (referred to in this report as the practice), is located in the grounds of the Army Foundation College, in rural North Yorkshire, near the town of Harrogate. The practice is run by Defence Primary Health Care, in a joint finance initiative facility, where nurses and physiotherapy staff are supplied by the partner (referred to as the contractor) in the joint finance initiative. Some administrative staff are also supplied by the contractor. The practice building is managed and maintained by contractor staff. The Senior Medical Officer (SMO) who is a member of the armed forces, oversees clinical care.

The practice provides primary medical services to new army recruits aged 16 - 18 years, as well as to permanent staff members of the armed forces, based at the College, and their dependents. At the time of inspection, the practice patient register numbered approximately 1,700 patients, with approximately 1,000 of these being 16-18 year old new recruits to the army. The practice also provides occupational health services for up to 1,000 reserve members of the armed forces.

The practice runs primary health care clinics alongside its commitment to the Army Foundation College Training Programme which includes, amongst other things platoons coming in for vaccination parades, initial medical assessments, blood grouping and provides permanent staff health protection clinics. Surgical procedures can also be provided. The mission of Defence Primary Health Care (DPHC) is “to deliver a unified, safe, efficient and accountable primary health care service for entitled personnel in order to maximise their health and deliver fit personnel for operations.”

The practice staff are a mix of DPHC staff and contractor staff. In summary: The Senior Medical Officer (SMO) oversees all clinical care, supported by a civilian GP. There are also two medics who work at the practice who are overseen by the SMO. (The work of a military medic has greater scope than that of a health care assistant found in NHS GP practices).

The practice is complemented by a team of three physiotherapists employed by the contractor. The nursing team is made up of approximately 14 practice nurses, who work a variety of shifts to provide daily cover between Monday and Friday of each week. All nurses are employed by the contractor. The practice has a 20 bed overnight observation facility, located on the upper floor of the practice. This is run by the nurses supplied by the contractor. All nursing duties are overseen by a nursing Matron employed by the contractor. A medical facilities manager, employed by the
contractor, is based at the practice and works alongside the practice manager, who is a member of military staff. There are two further contractor staff who work in reception and clerical areas.

The practice has a dispensary which is open from 8am to 11.00am on Monday, Tuesday and Thursday of each week, and between 8am and 12.30 on Wednesday of each week. The dispensary was open all day on Friday, except during the lunch period of 12.30pm to 1.30pm. The dispensary is operated by a member of military staff. Any medicines that are not immediately available within the dispensary can be collected on prescription from Lloyds Pharmacy, who have a contract to dispense medicines for DPHC sites.

The practice is open from Monday to Friday, between 7.30am and 4.30pm. The Senior Medical Officer and civilian GP were available for emergency referrals between 4.30pm and 6.30pm. Outside of these times, patients were referred to NHS 111 or local out of hour’s services. The nearest accident and emergency unit is located at Harrogate District Hospital, which is approximately three miles from 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice.

We carried out can announced inspection on 7 June 2017. During the inspection, we:

- Spoke with a range of staff including the Senior Medical Officer, a civilian GP, a medic, a member of physiotherapy staff, the nursing Matron and members of nursing staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and bedding down unit.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Inspected the clinical facilities in the practice.
- Looked at information the practice used to deliver care and treatment.

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 for reporting and recording significant events. Staff told us they would inform the Senior Medical Officer (GP) of any incidents and there was a recording form available on the practice computer system. The incident recording form supported the recording of notifiable incidents under 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).

From the sample of four documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of significant events. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, as a result of an incident involving a patient leaving camp to attend an outpatient appointment, the role of escorting patients to and from secondary care appointments was reviewed.

When reviewing significant events, we saw that these had been reported by staff at all levels. We saw that a number of events had been reported by nurses at the practice. However, as the on-line forms had not been fully completed, this delayed the investigation of the significant event. We also noted that there were no arrangements in place at the practice to review significant events annually to check for any themes or reoccurring incidents. We have made recommendations to the practice in relation to these matters.

Overview of safety systems and processes

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. The Senior Medical Officer was the lead for safeguarding; all staff we spoke with were aware of this and how they could and should raise any concerns. The Senior Medical Officer attended internal safeguarding meetings when required and could demonstrate good working links with other agencies who would be contacted if any patient was discharged from the military training establishment. Effective deputising arrangements were in place.

- 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'
shared this information with concerned colleagues within the practice but did not have sufficient working knowledge of the electronic patient records system (DMICP) to add alerts and create appropriate registers. We highlighted this as a training need which was noted and acknowledged by the GPs at the practice.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. The Senior Medical Officer and civilian GP were trained to child protection or child safeguarding level three. All nurses were trained to safeguarding level two as a minimum. When we reviewed training records we saw that the training of one nurse was due for renewal (this member of staff was on long term leave) and one other staff member was awaiting training.

- A notice in the waiting room advised patients that chaperones were available if required. All 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). As part of the practice’s preparation for inspection, it was found that the contract company that supplied nursing staff was not providing enhanced DBS clearance for all nurses; seven out of 14 nurses were found to have standard clearance rather than the required enhanced level clearance required by the practice.

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There were cleaning schedules in place and monitoring systems ensured that the standard of cleaning in place met infection control standards.

- The practice matron was the infection prevention and control (IPC) clinical lead. The medical facilities manager, who liaised with the practice matron, had effective links with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

- 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.

- There were effective arrangements in place for removal of clinical and pharmaceutical waste.

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).

- There were processes for handling repeat prescriptions. Any repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred.

- The practice carried out regular medicines audits, with the support of the regional medicines management team, to ensure prescribing was in line with best practice guidelines for safe prescribing.

- Blank prescription forms and pads were securely stored and there were systems to monitor their use. However, there was no formal annual review of prescription usage to ensure systems in place were effective.

- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

- The practice had a dispensary on site. The Senior Medical Officer was responsible for the
dispensary and all members of staff involved in dispensing medicines had received appropriate training and had undertook continuing professional learning and development.

- The practice held stocks of controlled drugs (medicines that required extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements for the destruction of controlled drugs.
- The practice held and managed stocks of medicines appropriately, including those that required refrigeration. Records kept by the practice showed fridge and room temperature checks were carried out which ensured medicines were stored in accordance with manufacturer’s instructions. Staff demonstrated they understood procedures in place to deal with a fridge failure and steps to take if any stock had to be disposed of.
- Nursing staff managed medicines administration safely on the 20 bed ward on the practice site. The prescribing GP wrote a prescription chart for patients and all medicines had a patient label with administration instructions. The nurses encouraged patients to self-administer their medicines and there was a risk assessment in place to support this.
- The practice had access to emergency medicines and equipment in the medical centre and on the ward. We saw that this was checked regularly and suitable for use.

We reviewed personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. This was the case for all staff employed by both Defence Primary Health Care (DPHC) and Ministry of Defence. However, in the case of the nurses supplied by a contractor working with DPHC, in preparation for our inspection, it came to light that seven of the nurses had not undergone an enhanced DBS check. When this was brought to light, it was addressed immediately by the practice manager.

### 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 was tested regularly.
- 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. We saw that overnight there were at least two nurses on duty on the overnight ward based at the practice.

### Staff recruitment

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 carried personal
alarms.

- All staff received annual basic life support training and there were emergency medicines available and ready for use.

- The practice had a defibrillator available on the premises and oxygen with appropriate 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 we asked knew of their location. All the medicines we checked were in date and stored securely.

- The practice had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.
Are services effective?
(for example, treatment is effective)

Good

Our findings

Effective needs assessment

Clinicians we spoke to on the day of our inspection demonstrated their knowledge and awareness 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 in place 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.
- The Senior Medical Officer and civilian GP monitored that these guidelines were followed through audits and random sample checks of patient records.
- 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.

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 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 with 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 diabetes, in whom the last blood pressure reading (measured in the last 15 months) was 140/80 or less, was one. This equates to 100% achievement, which is above the NHS target of 60%.
- The number of patients with hypertension was two. Of these, there was a record of one patient’s blood pressure in the past nine months. The total meeting the NHS target was one
The number of patients with hypertension (two) in whom the last blood pressure (measured in the previous nine months) was 150/90 or less was one. This equates to an achievement rate of 50%, 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 seven. This equates to an achievement rate of 100% compared to the NHS target of 90%.

There was evidence of quality improvement including clinical audit:

- There had been two clinical audits commenced in the last two years, one of these was a completed audit where the improvements made were implemented and monitored.
- Monitoring exercises were in place to check that standard operating procedures continued to meet the needs of the practice and its patients.
- Findings were used by the practice to improve services. For example, recent action taken as a result included ‘follow-up slips’ which were issued to junior soldiers, to present to reception so that any condition or injury was followed up in a timely manner and the likelihood of this being overlooked, reduced.

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 honestly, which aided the effective management of areas that needed attention.

Information about patients’ outcomes was used to make improvements. For example, the Senior Medical Officer used their background in minor surgery to reduce the number of junior soldier training days lost, by providing minor surgery clinics. These were used to deal with skin lesions, ingrown toe-nails and wart removal, which would otherwise have to be referred to an NHS clinic in Harrogate, for which there was a waiting time for appointments.

**Effective staffing**

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment. However, when reviewing records and interviewing practice staff we found one medic was delivering treatment to patients, without the necessary competency assessment following formal training.

- 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 confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for nurses and GPs on consent and Gillick competence. We did note that one staff member required safeguarding training and that this was being addressed by the practice.
- 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 nurses meetings.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. We found all but one staff member had received an appraisal within the last 12 months. The external contractor did not have any formal arrangements in place for the appraisal of the practice matron. The Senior Medical Officer had volunteered to pick up this duty but formal arrangements were needed for future appraisals.

- There was no full clinical team meeting held at the practice which included nurses and medics. When interviewing nursing staff they said they thought this could improve communication across the practice.

- Where any competency checks for medics were outstanding, further attention was needed to ensure this was picked up as a priority, following medics training.

- 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 or updates.

- 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.

- As a result of the above, the practice maintained and delivered effective clinics. Nurses triaged patients attending sick parade each day, referring cases to the GPs as necessary. GPs referred patients to physiotherapists, who assessed patients and formulated a course of treatment to meet the patient’s needs.

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.

- 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, or when discharging junior soldiers from the armed forces due to medical reasons.

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. Information was shared between services, with patients’ consent, using a shared care record. We saw that parents or guardians were involved in the care of patients between 16-18, only with the consent of the patient.

The practice ensured that all relevant information on patients was recorded and highlighted to the civilian GP and Senior Medical Officer. The method for receiving incoming patient notes was highly effective; a full copy of the patient medical record, current and historic, was requested and
sent to the practice before new recruits arrived at the college. This was reviewed and summarised. We noted there was no backlog in patient summarising. Any significant illness or surgery was highlighted appropriately.

The practice were aware of those patients who were joining the armed forces after being in care or foster homes. This information was noted by clinicians. However the practice did not fully utilise the computerised patient medical record system, to place appropriate markers on the records of those patients that may be vulnerable. This would alert any visiting GP, or receiving practice, of these potentially vulnerable patients.

**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.
- When providing care and treatment for army recruits, many of whom are aged between 16-18 years, and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- 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.
- The process for seeking consent was monitored.
- We saw that any parental or guardian involvement in patients’ care or treatment was with the consent of the patient.

**Supporting patients to live healthier lives**

The practice did not have any dependents or children of recruits registered with the practice.

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example those requiring advice on their diet, smoking and alcohol cessation. The practice also gave sexual health advice, offered free condoms and referred to a sexual health clinic when required. Advice on prevention of musculoskeletal injury was also available from physiotherapy staff at the practice, as well as the GPs providing services.

We reviewed QOF performance of the practice. Results 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 24, out of 30 eligible women. This represented an achievement of 80%. 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.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. 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.

All patients received a full health check when registering with the practice. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Part of the new patient health check included checks on immunisations received and arrangements made for immunisations to delivered. The World Health Organisation (WHO) sets a target of 95% vaccination against diphtheria, tetanus, whooping cough and polio and measles, mumps and rubella. Vaccination data as of 1 March 2017 for the practice showed:

- 73% of patients were in date for WHO target vaccines, compared to 76% for DPHC practices in the North of England and 75% for DPHC nationally.
- 100% of patients had a record of diphtheria vaccination, which was in line with the achievement for DPHC practices in Northern England and with DPHC nationally.
- 100% of patients had a record of Hepatitis A vaccination, compared to 98.5% for DPHC practices in the North of England and 99% for DPHC nationally.
- 99% of patients had a record of Hepatitis B vaccination, compared to 99.5% for DPHC practices in the North of England and 99% for DPHC nationally.
- 100% of patients had a record of polio vaccination, compared to 100% for DPHC practices in the North of England and 99% for DPHC nationally.
- 100% of patients had a record of Tetanus vaccination, compared to 100% for DPHC practices in the North of England and 100% for DPHC nationally.
- 98% of patients had a record of Typhoid vaccination compared to 87% for DPHC practices in the North of England and 100% for DPHC nationally.
- 99% of patients had a record of Yellow Fever vaccination, compared to 97% for DPHC practices in the North of England and 97.5% for DPHC nationally.
- 80.5% of patients had a record of vaccination for Measels, Mumps and Rubella (MMR) combined, compared with 82.5% for DPHC practices in the North of England and 73% for DPHC nationally.

(NOTE: The MMR combined vaccination became available in 1988. Personnel who have only received the single vaccinations that were available prior to this have not been included in this metric and may therefore contribute to the lower percentage for this statistic).
Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very 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.
- Patients could be treated by a clinician of the same sex.

We received 36 patient Care Quality Commission comment cards. Of these, 33 were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Three comment cards referred to longer than expected waiting times when arriving for pre-booked appointments.

We spoke with two patients. They told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. Both patients commented on the level of caring from GPs, particularly the Senior Medical Officer, who had worked hard to address causal factors of patients’ conditions.

Results from the latest Defence Medical Services Patient Experience Survey, for Army Foundation College Harrogate, showed patients felt they were treated with compassion, dignity and respect. For example:

- 97% of patients said the practice was good at listening to any compliments, comments or complaints.
- 91% of patients said they felt involved in decisions about their care.
- 94.5% of patients said they had confidence that their medical treatment and records would be treated confidentially.
- 97.3% of patients said they would be happy to be treated by the same health care professional again.
- 97.3% of patients said they were treated with dignity and respect throughout their treatment at
97.1% of patients said the health professional they saw was good at listening to them.

88.8% of patients said health professional they saw was good at explaining their condition and treatment to them.

100% of patients said if family, friends and colleagues could use the practice, they would recommend it to them.

96% of patients said they found the receptionists at the practice listened to them.

We did not receive any comparator data from Defence Medical Services to set out alongside the above data. However the views of patients expressed on CQC comment cards and those from patients we spoke with, aligned with the views above.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us 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.

The clinicians and staff at the practice, under the leadership of the Senior Medical Officer, demonstrated that they recognised at all times that the junior soldiers they provided care and treatment for, could be making and taking decisions about treatment themselves for the first time. Staff demonstrated how they gauged the level of understanding of patients, avoided overly technical explanations of diagnoses and treatment and encouraged and empowered young patients to make decisions based on sound guidance and clinical facts. When we spoke with patients they told us the GPs took the time for example, to explain why an injury may be slow to heal and what they could do to improve the healing process. We saw this type of engagement and involvement across all treatment and in handover between GPs, nurses and physiotherapy staff.

The young patients at the practice were treated in an age-appropriate way and recognised as individuals.

Results from the practice patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Particularly, patients we spoke with and from feedback on CQC comment cards, showed that patients valued the insight of GPs and physiotherapy staff into how their condition impacted on their ability to perform the duties and training required of them each day. For example:

- 85% of patients said the last health professional they saw was good at considering the impact of their condition on patient ability to continue training and related duties.
- 77% of patients said the last health professional they saw was good at providing or arranging treatment for them.
- 85% of patients said the last health professional they saw was polite.

The practice did not have any patients for whom English was a second language. We did see that:

- Information leaflets were available in easy read format.
- Junior soldiers were escorted to and from hospital appointments.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a
national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Visits to these appointments would be accompanied.

**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 age appropriate and relevant to the patient demographic was 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 acted in a compassionate way toward any patient that had to be discharged from the college on health grounds. We saw that the practice reassured these patients and signposted to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions.

The GPs at the practice demonstrated that they knew each cohort well but did not place formal markers on patients records in relation to those patients who may be vulnerable, for example, those entering the army from local authority or foster care, or those being discharged who had no family to return to on leaving the army. This information could be lost when passing a discharged patient’s details onto the receiving NHS practice.
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. The practice register was predominantly made up of younger people. In summary, approximately 1,010 patients were aged 16-17 years; 128 patients were aged 18-25 years; 133 patients were aged 26-30 years; 75 patients were aged 31-35 years and 33 patients were aged 36-40 years. The rest of the patient register, which was 46 patients were aged between 41 and 65 years.

- The practice had a dispensary on site, which was open daily.
- Physiotherapy clinics were available to all patients referred by the GPs. These ran daily, Monday to Thursday from 8.30am to 4.30pm and on Friday from 8.30am to 4pm.
- Occupational medicals were available by appointment, for example, for driving, diving or boxing medicals.
- Same day appointments were available for those patients with medical problems that require same day consultation.
- A chaperone service was available to all patients and posters advertising this were placed prominently around the practice.
- Minor surgical procedures were available at the practice following consultation and agreement to treatment by the Senior Medical Officer.
- Patients were instructed by reception staff and through the practice leaflet to book a double appointment with GPs if they had more than one problem to discuss.
- The practice had a 20 bed overnight unit, manned by nurses and overseen by the Senior Medical Officer and civilian GP. This was mainly used to enable the practice to monitor patients overnight and to isolate patients with viral illness, such as vomiting and diarrhea.

A variety of clinic services and health campaigns were available, based on the need for service personnel to be fit, healthy and ready to be deployed or to be moved to phase two of training. These included, but were not limited to smoking cessation, breast awareness, testicular awareness, cervical screening awareness, mental health and stress awareness, alcohol advice, non-freezing cold injury and heat injury presentations, foot care, sexual health, chlamydia screening, contraception services and condom distribution and injury prevention.
Access to the service

- The practice was open from Monday to Friday from 7.30am to 4.30pm, with sick parade at 7.30am each morning before clinics started at 8.30am.

- The practice provided three GP clinics each day, 8.30am to 10.00am, 10.30am to 12.30pm, and 2pm to 4pm. Nurse clinics were available each morning and afternoon from 10.15am to 12.30pm and from 1.30pm to 4pm each day.

- After these hours, telephone cover was provided by one of the GPs between 4.30pm to 6.30pm. Outside of these hours, patients were diverted to the NHS 111 service.

- The practice leaflet gave clear directions on local accident and emergency unit access. The nearest accident and emergency department was located at Harrogate District Hospital.

Results from the Defence Medical Services Patient Experience Survey showed that overall patient satisfaction with access to care and treatment good. For example:

- 91% of patients said reception staff at the practice were good at making patients feel at ease.
- 96% of patients said reception staff listened to them.

When patients were asked about their access to and experience of Primary Care Receiving Facilities and Exercise Rehabilitation Instructors, feedback was positive. For example:

- Of patients asked, 91% said their experience of physiotherapy at the practice was either good or very good.
- Of patients asked, 97% said their experience with Exercise Rehabilitation Instructors was either good or very good.
- Of patients asked 88% said they would recommend the Primary Care Receiving Facilities (PCRF) to a friend or family.
- Of Patients asked, 85% said their overall experience of the PCRF was either good or very good;
- And, 94% of patients asked said they felt the PCRF had listened to their comments.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess whether a visit to a patient in accommodation within the college was clinically necessary; and the urgency of the need for medical attention.

Listening and learning from concerns and complaints

- Defence Primary Health Care had an established policy for receiving and handling complaints and the practice adhered to this.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. The practice leaflet set out how patients could make a complaint. Notices in the reception and waiting areas also gave clear information on how a complaint could be made. There had not been any complaints received by the practice in the last two years.
- We did see evidence that where GPs had made an error, apologies and explanations were
offered to patients and were appropriate, GPs spoke with the parent or guardian of the patient with the permission of the patient.
Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Good

Our findings

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

- 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 clear strategy and supporting business plans which reflected the vision and values and these were regularly monitored.

Governance arrangements
The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. It was particularly noted that nurses operated within the scope of their duties, which were clearly set out in their job descriptions.
- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.
- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. Practice meetings were held although there appeared to be no guarantee these would be monthly. From minutes of meetings we reviewed, we saw that they were used as an additional governance communication tool, for example in reminding nurses to complete all parts of paperwork in respect of significant events. Where it was identified that there was a learning need in this area, appropriate training was requested and tasked to be delivered. The meetings were also used for forward planning to enable responsiveness in a safe environment, for example, in the event of the bedding down unit being full, with a busy sick parade. This also provided an opportunity for staff to learn about how the performance of the practice could be improved, and how each staff member could contribute to those improvements.
- A programme of clinical and internal audit was used to monitor quality and to make
improvements. We saw that the practice audited sick parade management to identify any learning and action points. For example, one audit cycle identified the need for training for nurses on the management of sore throat and ear infections and common skin complaints.

- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. This included plans developed each year that took account of manning levels at the practice due to deployment of some staff.
- We saw evidence from minutes of meetings, a structure that allowed for lessons to be learned and shared following significant events and complaints.

**Leadership and culture**

On the day of inspection the leaders in the practice demonstrated they had the experience, capacity 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 from communications with the practice following the inspection, supported this.

Staff told us the practice leaders were approachable and always took the time to listen to all members of staff. We particularly noted the ‘learning atmosphere’ in the practice, which was promoted by leaders. All staff we spoke with were confident in their role and spoke of their respect and admiration for leaders at the practice.

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 support 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.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of meetings including meetings with other professionals, internal and external to monitor and support any vulnerable patients. GPs, where required, met with external health professionals, such as social services, to manage any safeguarding concerns in relation to patients being discharged from the military.
- 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 and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the Senior Medical Officer and the civilian GP and practice manager. All staff were involved in discussions about how to run and develop the practice. Nurses, although employed by an external contractor, felt part of the practice team. The nursing matron had identified that full clinical team meetings would benefit communication across the practice and leaders said they were happy to accommodate this.
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 the Defence Medical Services surveys and from any individual patient feedback received.
- The practice were looking at the possibility of forming a Patient Participation Group (PPG) but were aware that limitations were inevitable due to the transient nature of the patient population and deployable status of operational staff at the practice.
- 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.
- 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

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and from minutes of meetings we reviewed we saw that the leaders of the practice focussed on improving the speed and quality of delivery of care for all patients. Improvements implemented included appointed escorts to be with junior soldiers visiting outpatient appointments at local hospitals. These escorts would also wait to provide transport home for those patients. We saw that a submission had been made by the Senior Medical Officer for a patient crash trolley designed with side bars to prevent any fall of a patient suffering seizures. Where any clinical event required investigation this provided learning points for all. For example, when a clinician at the practice acted outside the scope of their duties, this was investigated and a standard operating procedure was introduced to prevent the incident re-occurring in future. It also provided learning points to all clinicians on the chain of clinical command within the practice.

The focus of the GPs and physiotherapists was to increase the speed of full recovery of all patients to enable them to complete their 22 week training period. Feedback on comment cards and from patients we spoke with made it clear that this was incredibly important to patients. In this regard, the practice clinicians demonstrated that they were completely dedicated to assisting all their patients to achieve this.