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>Requires improvement</th>
</tr>
</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>Requires improvement</td>
</tr>
</tbody>
</table>
Letter from the Chief Inspector of General Practice

We carried out an announced inspection at HMS Neptune Medical Centre on 21 June 2017. Overall, the practice is rated as requires improvement. 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.
- 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.
- Data showed patient outcomes in some areas were lower compared to the national average. For example, the management and recall of diabetic patients.
- Staff were aware of current evidence-based guidance. However, there was no formal system for guidance and this was not consistently discussed or shared.
- Areas of staff training required updating to fully provide them with the skills and knowledge to deliver effective care and treatment. For example, training in infection control, chaperoning and safeguarding.
- The premises were clean and tidy. However, an infection control audit had been undertaken but the issues found were not dated to be actioned by whom or by when.
- There was evidence of quality improvement in patient treatment; the practice conducted clinical audits, we reviewed two of these which showed they had been used to improve outcomes for patients.
- 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 understood its population profile and had used this understanding to meet the needs of its population— for example, they had introduced a twice-weekly physiotherapy clinic for acute muscular skeletal injuries.
- 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.
- 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:

- Definitive registers of patients to be in place, such as safeguarding registers and registers for patients on high risk medicines.
- Maximise the functionality of the DMICP (patient record system) in order that the practice can run clinical searches, provide assurance around patient recall systems, easily identify vulnerable patients and produce accurate performance data.
- Any backlog in note summarising to be treated as a priority to reduce risk to patients.
- Formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision to be embedded and understood by all staff. Including to effectively monitor and manage infection control, the monitoring of high risk medicines, the management of legionella, the business continuity plan, shared care agreements, complete staff training and assess competence at induction.
- Develop a system for proactively reviewing relevant and current evidence based guidance and standards. assessing the ones relevant to the practice, sharing out responsibility for summarising and disseminating to staff.

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 significant events 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. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.

- The practice had processes and practices to minimise risks to patient safety. However, these were not effectively overseen to ensure patient safety. For example infection control.

- 20% of registered patient records had not been summarised (1584/1990).

- Staff demonstrated that they understood their responsibilities with regard to safeguarding but not all staff had been trained to the appropriate level and there was no formal register of these patients.

- 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. However, there was no system for this to be discussed or shared.

- Governance systems had not identified risks to the effectiveness of patient care and treatment. For example, alerts to identify patients at risk or those on high risk medicines were not always used consistently and staff had not always been trained to utilise the full functionality of the electronic patient record system.
• We reviewed clinical audits undertaken by the practice. We saw that audits had been undertaken by the practice in the past year. We reviewed both and one was made up of at least two completed cycles and demonstrated quality improvement.

• There was evidence of appraisals and personal development plans for all staff.

• Staff worked with other health care professionals to understand and meet the range and complexity of patients’ needs.

• Data shared with us after the inspection showed patient health care could be improved, for example, the recall of diabetic patients with hypertension.

• Knowledge of and reference to national guidelines was inconsistent. For example knowledge of shared care agreements was limited. (A shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of a medicine can be shared between the specialist and general practitioner. Sharing of care assumes communication between the specialist, GP and patient.)

• Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients’ needs. We saw positive examples of physiotherapist involvement at the earliest stages to aid recovery of patients with musculoskeletal injuries.

• Staff we spoke with demonstrated competency in key mandatory training. However, staff training records were not up to date in subjects such as infection control, safeguarding and chaperoning.

---

**Are services caring?**

The practice is rated as good for providing caring services.

• Data from the Defence Medical services (DMS) patient experience survey showed patients gave positive feedback for all aspects of care.

• Information for patients about the service available was accessible.

• We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality. We received 30 comment cards, all of which were positive about the standard of care received.
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 the needs of its population. We saw a good example of this by the recent implementation of twice weekly clinics to see those patients with acute muscular skeletal injuries that would greatly benefit from prompt intervention from the physiotherapy team.
- Patients commented they found it easy to make an appointment and there were urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had an effective system in place for handling complaints and concerns.

Are services well-led?
The practice is rated as requires improvement 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. However, some arrangements to monitor and improve quality and identify risk required improvement. For example, to effectively monitor and manage infection control, the monitoring of high risk medicines, the management of legionella, the business continuity plan, shared care agreements, complete staff training and assess competence at induction.
- Staff told us they had received inductions, however the documentation relating to this was not complete.
- Staff had annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour.
- The senior management 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.
Our inspection team

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

Background to HMS Neptune Medical Centre

The Defence Primary Healthcare (DPHC) Medical Centre of HMS Neptune (referred to in this report as the practice) serves a military population of approximately 4,100 at Faslane. The practice did not treat families or dependents of service personnel.

The practice is made up of five permanent GPs and one locum GP, four nurses which equates to a 3.52 full time equivalent, five physiotherapists which equates to a 3.48 full time equivalent, exercise rehabilitation instructors, a pharmacy technician and medics. The practice was led by a practice manager, supported by a deputy and a number of administrative staff.

In addition to routine GP services, the practice offers minor surgical procedures, physiotherapy services, rehabilitation, occupational health and travel health services. Within the building the department of community mental health are situated and they have good communication links with the practice. The practice is fully accessible with all facilities being on the ground and first floor level, there is a patient lift.

The practice is open from Monday to Thursday between 7.45am and 4.30pm and on Friday 7.45am to 12 midday. From 12 midday on a Friday and after 6pm during the week. Twenty-four hour cover is provided by a duty watch consisting of a GP and two medics.

The practice has a dispensary which is open during practice hours.

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 an announced inspection on 21 June 2017. During the inspection, we:

- Spoke with a range of staff including three GPs’, two nurses, a physiotherapist, the practice manager, the pharmacy technician and seven members of administrative staff. We also spoke with seven patients who used the service.
- Observed how patients were being cared for in the reception area.
- 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 practice manager of any incidents and there was a recording form available on the practice’s 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 documented significant events 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 saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, two significant events were discussed in further detail, namely how lab results were handled and how formaldehyde from a specimen bottle leaked into the container-bag, contaminating driver’s hands. Although these did not result in any harm to the patients, both significant events led to changes in practice. The practice nurse now triages lab results before hard copies are scanned and tasked, highlighting abnormal results so these are dealt with more quickly. The hospital driver now has a separate carrier for post and for specimens.

Overview of safety systems and processes

The practice had clearly defined and embedded 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 Principal Medical Officer (PMO) was the lead for safeguarding whilst the usual lead was on maternity leave; all staff we spoke with were aware of this and how they could and should raise any concerns.

- Safeguarding was not a standard agenda item on multi disciplinary meetings within the practice although the practice manager stated that if there was an issue it would be discussed with the Principal Medical Officer, and then investigated. Any lessons learnt would be discussed at the next available meeting.

- 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 adults relevant to their role. We saw all but one of the GPs were trained to level three in safeguarding, one GP was only trained to level two. The practice did not treat families or dependents of service personnel.

- We saw evidence that showed how searches were efficiently used on DMICP to follow up patients waiting blood results and initiate their follow up appointment. We also saw evidence that showed that all outstanding blood results were monitored daily and by a weekly review undertaken.

- Patients needing a referral to secondary care were given an index card by the GP containing their up to date contact information. The patient handed this to the administrator responsible for appointments, this acted as a failsafe for the administrator to check they had received a referral letter form the GP.

- We found 20% of registered patient records had not been summarised meaning that information in the patients past medical history may not have been captured on the electronic record system which poses a risk to patient safety.

- Chaperone training is “on-the-job” training. All staff were Protection Vulnerable Groups (PVG) cleared (this is Scottish version of DBS). Only those on absences i.e. maternity leave were out of date, these staff were scheduled to complete this training on their return.

We observed the premises to be clean and tidy. However,

- The infection control lead was the advanced nurse practitioner, who held an Infection, Prevention and Control (IPC) qualification. She had good communication links with the local IPC leads at two local hospitals and was able to contact them with any concerns or to share good practice. There was good appropriate availability of personal protective equipment (PPE) in each clinical area, appropriate cleaning products to control contamination from body fluid spillage, correct cleaning of reusable equipment and cleaning schedules in each clinical bay. In addition risk assessments were in place to ensure risk stratification of equipment or processes that exposed patients to risk.

- Training for 10 members of staff was out of date. The practice manager stated that this was due to the new database. We asked for evidence that the 10 individuals had completed IPC training but the practice were unable to produce this.

- The last infection control audit had been undertaken in June 2017 and issues were identified. However the audit did not show when and by whom this would be resolved.

- The practice held a hepatitis B register for staff and all were up to date.

- We saw the building to be clean and tidy. Cleaning was undertaken by a contract cleaner. The practice manager had regular meetings with the contract team manager to address issues when they arose. Waste management was dealt with appropriately.

There were arrangements in place for managing medicines, including emergency medicines and vaccines (including obtaining, prescribing, recording, handling, storing, security and disposal). However, some improvement was needed.
• The dispensary was managed by a pharmacy technician who was registered with the General Pharmaceutical Council. Their competence was checked regularly by the lead GP for the dispensary. The dispensary was usually staffed by two pharmacy technicians and a robust procedure for checking was incorporated into the dispensing process. This procedure was introduced following the root cause analysis of a dispensing error. Additional steps had been taken to mitigate the risk of future errors.

• Dispensary staff clinically checked prescriptions, within their competency and had remote support from the regional pharmacist. We saw dispensary staff checking a patient’s electronic record to ensure the necessary monitoring tests had been done before dispensing a repeat prescription for a medicine which could cause harmful side effects.

• All prescriptions were signed by the doctor before medicines were dispensed and handed out to patients. Dispensary staff alerted the doctor when a patient was due for a medicines review. Doctors prescribed medicines in accordance with the defence primary care formulary.

• We saw treatment protocols that allowed medical assistants to supply a limited range of medicines. Patient Group Directions had been adopted by the practice to allow nurses to administer vaccines in line with legislation.

• Blank prescription forms were securely stored and their distribution was controlled. There was an audit trail to account for private prescription forms for controlled drugs. The practice had a system to deal with medicine, medical device and patient safety alerts. The records were comprehensive and detailed any actions taken.

• The temperatures of medicine refrigerators were checked and recorded twice daily to make sure vaccines and other medicines stored in them were safe to use.

• The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely.

• The dispensary provided a responsive service to patients. We saw patients waiting less than five minutes for their prescriptions and being counselled about their medicines. However, the design of the dispensary meant that prescriptions were handed to patients through a hatch at a height appropriate for wheelchair users. The low level of the hatch made eye contact and communication difficult and was not ideal for either the dispensary staff or most patients. When the dispensary was closed, doctors had access to a supply of commonly prescribed, pre-labelled medicines.

• There was inconsistency in the system and procedures for the review of high risk medicines. For example the monitoring of disease modifying anti rheumatic medicines which were initiated by secondary care. The practice said they took bloods regularly, checked the results, gave short prescriptions and put alerts on the clinical system but no consistent system of formal recall or management was in place.

• Recruitment checks had been undertaken on civilian staff 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 PVG.

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.

• There were no copies of fire risks assessments available as they were held by the fire station.
on camp. The practice manager telephoned the contractor during the inspection and they confirmed they held the risk assessment and that all fire checks were completed on a weekly basis. We saw there was a live fire evacuation due to fire alarm activation within the practice, and last practice evacuation was in December 2016.

- Electrical and clinical equipment was checked and calibrated in November 2016 to ensure it was safe to use and was in good working order, and all issues identified had been dealt with.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous.
- The practice manager stated that legionella testing had been completed but had no record of any testing and the member of staff responsible was on leave. (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.

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

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

- There was no panic alarm which alerted staff to any emergency. A statement of need was submitted by the practice to the regional headquarters for urgent attention following an incident which involved a patient at risk.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult masks. A first aid kit and accident book were available.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. However, there was no hard copy available and it was unsure which or if any staff had read and understood it.
Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards.

- Staff had access to relevant and current evidence based guidance and used this information to deliver care and treatment that met patients’ needs. However, there was no system for proactively reviewing recent updates, assessing the ones relevant to the practice, summarising and disseminating to staff.

There was no active back up system of safety searches, with pro-active recall, on DMICP for those patients receiving high risk medicines. There were discrepancies with how and if this search was undertaken. The GP and the pharmacy technician had differing accounts as to how or when this was undertaken.

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).

DMS opted to be benchmarked against NHS targets for the year 2011/12. The practice QOF results from 2016 showed;

- There were 15 patients on the diabetic register.
- The percentage of patients with diabetes whose last measured total cholesterol (within the preceding 15 months) was 5mmol/l or less was approximately 62%, compared to the NHS target of 70% and the achievement of approximately 67% for DPHC nationally.
- The percentage of patients with diabetes in whom the last blood pressure reading (measured in the last 15 months) was 150/90 or less was 79%, compared to the NHS target of 72%, and the achievement of 87% for DPHC nationally.
- The percentage of patients with diabetes, in whom the last blood pressure reading (measured in the last 15 months) was 140/80 or less, was 45%, compared to the NHS target of 60%, and the achievement of 53% nationally for DPHC.
- There were 100 patients recorded as having high blood pressure. The percentage of patients with hypertension in whom there is a record of their blood pressure in the past nine months was
97%, compared to the NHS target of 90% and the achievement of 86% for DPHC nationally. Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that management of audiometric hearing assessment was below average for DMS practices regionally and nationally. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data from March 2017 showed:

- At HMS Neptune practice 95% of patients had a record of audiometric assessment, compared to 98% regionally within Defence Medical Services (DMS) and 99% for DPHC nationally.
- At HMS Neptune practice, 68% of patients’ audiometric assessment was in date (within the last two years) compared to 88% regionally within DMS and 88% for DPHC nationally. We were told this was due to two audio machines being unserviceable for a period of three months. The audio machine had since been serviced and a nurse was in the process of recalling all out of date patients.

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. A diabetes audit, undertaken by the practice nurse was in its 4th cycle and showed improvement in diabetic indicators since inception. Another audit was of patients diagnosed with irritable bowel syndrome (IBS) and included coeliac screening to exclude coeliac disease prior to a diagnosis of IBS. The 2nd re-audit had not yet taken place.

Effective staffing

Evidence reviewed showed that not all 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 topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However, but there was no evidence to confirm these were being completed.
- Staff received some training that included: safeguarding, fire safety awareness, basic life support and information governance. However, not all staff had all received updated training in subjects such as infection control, safeguarding and chaperoning. The practice did not have specific training days for staff to complete any training, but if training was required this was arranged on a Wednesday afternoon. The pharmacy technician had protected time in the pharmacy to complete their continual personal development (CPD) and this was reflected in the pharmacy opening hours. Mandatory training was completed by individual staff as and when they had time within their working day.
- 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 on line resources and discussion at practice meetings.
- The medical centre was Yellow Fever registered and the practice nurse was up to date with training.
- The nurses maintained their own continual professional development. We saw good evidence
of one member of staffs workbook in which their competencies were assessed and signed off. We saw evidence of shared training they had organised with their peers which included clinical scenarios, for example the care of the patient with chest pain.

- There was good skill mix within the nursing team including the individual roles and responsibilities of the lead practice nurse and the advanced nurse practitioner.
- Nurses attended monthly meetings where they discussed current evidence base practice, and included Nursing and Midwifery Council (NMC) updates, Scottish Safety Patient Group, Department of Health and NHS Scotland Guidelines and NHS Greater Glasgow and Clyde recommendations.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.

**Coordinating patient care and information sharing**

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We spoke with the administrator who undertook booking 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. However, knowledge of shared care agreements was limited. (A shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of a medicine can be shared between the specialist and general practitioner. Sharing of care assumes communication between the specialist, GP and patient.)
- Physiotherapists and the community mental health team were also based within the medical centre and communication between the different departments was effective.

**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.
- Written consent process was gained when undertaking invasive procedures such as minor operation and ear syringing.
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 99 out of 108 eligible women. This represented an achievement of 99%. 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 fail-safe 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 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. 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:

- 94% of patients at HMS Neptune practice had a record of vaccination against diphtheria, in date, compared to 96% regionally within DMS and 95% for DPHC nationally.

- 94% of patients at HMS Neptune practice had a record of vaccination against polio, compared to 95.5% regionally within DMS and 95% for DPHC nationally.

- 81% of patients at HMS Neptune practice had a record of vaccination against Hepatitis B, in date, compared to 86% regionally within DMS and 84% for DPHC nationally.

- 94% of patients at HMS Neptune practice were recorded as being up to date with vaccination against Hepatitis A, compared to 95% regionally and 95% nationally.
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 gender.

All of the 30 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

We spoke with seven patients. They told us they were satisfied with the care provided by the practice and said they were able to get an appointment when needed.

Results from the latest Defence Medical Services Patient Experience Survey from May 2017 showed patients felt they were treated with compassion, dignity and respect. For example:

- 86% of patients said they felt involved in decisions about their care.
- 83% of patients said they felt decisions were made in their best interests.
- 94% of patients said if family, friends and colleagues could use the practice, they would recommend it 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. Patient
feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from HMS Neptune showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 88% of patients said the last GP they saw was good at involving them in decisions about their care compared.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language.
- Information leaflets were available in reception.
- The Choose and Book service was not available in Scotland. We saw reliable systems to ensure patients with referrals that were more urgent were dealt with promptly by the practice.

**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:

- Patients were able to have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse. Double appointments were available if required.
- Same day appointments were available for those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines when required.
- Five physiotherapists were employed within the medical centre. In addition there were two exercise rehabilitation instructors. All referrals to this service were made by the GPs and the average waiting time for an appointment was less than one week.
- The practice had introduced a twice weekly physiotherapy clinic for acute muscular skeletal injuries that were seen as fresh cases. This was instigated as it was recognised the sooner a patient was seen with for example for a sprain and treated, the most likely the sooner their recovery.
- There were accessible facilities, which included interpretation services when required.

Access to the service

The practice was open from Monday to Thursday between the hours of 7.45am and 4.30pm and on a Friday 7.45am to 12 midday. Twenty four hour cover was given by the duty watch. A walk in “fresh case” clinic was available between 7.45am and 8.30am every day.

Results from the DMS survey May 2017 showed that patient’s satisfaction with how they could access care and treatment was comparable to local and national averages.

- 79% of patients said they don’t normally have to wait too long to be seen

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. Nine complaints had been made since September 2016. We saw that there were processes in place to show how learning from complaints was shared and managed with staff and other stakeholders. Complaints were audited to show any trends and areas for subsequent improvement. We saw that information was available to help patients understand the complaints system.
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 clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and 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.
- A programme of clinical and internal audit was used to monitor quality and to make improvements.
- We saw evidence from minutes of meetings, a structure that allowed for lessons to be learned and shared following significant events and complaints.

However, we saw that some areas of governance that required improvement;

- There were insufficient arrangements in place for identifying, recording and managing risks and issues, and for implementing mitigating actions. For example, patients were at risk of harm because systems and processes were not in place, to effectively monitor and manage infection control, the monitoring of high risk medicines, staff training and assess competence at induction.
- 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 defined registers within the practice, for example, safeguarding registers and registers of patients on high risk medicines. Although numbers were small, this arrangement would reflect best practice and aid any incoming locum GP if regular GPs were unavailable.
• There was scope to maximise the functionality of the DMICP (patient record system) in order that the practice can run clinical searches, provide assurance around patient recall systems, easily identify vulnerable patients and produce accurate performance data.

Leadership and culture

We found on the day of inspection the GPs and management of the practice prioritised good quality and compassionate care.

Staff told us the management were approachable and always took the time to listen to all members of staff. 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). 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 valued 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

There was good evidence of quality improvement activity and the practice team were forward thinking in trying to improve outcomes for patients. For example the introduction of the twice physiotherapy clinic for acute muscular skeletal injuries that were seen as fresh cases.