Defence Medical Services

Abbey Wood Medical Treatment Facility

Quality Report

Abbey Wood
Filton
Bristol
BS34 8JH

Date of inspection visit: 9/8/2017
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, and information given to us from the provider and patients.

Ratings

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

Summary of findings

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Abbey Wood Medical Treatment Facility on 9 August 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 assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff.
- We saw several examples of collaborative working and sharing of best practice to promote better health outcomes for patients. Specifically, ongoing health education programmes.
- Audits and regular reviews of the service were undertaken to drive improvements to patient outcomes. However, we found clinical audits were limited to those mandated audits we would expect to find in a GP practice, for example anti-biotic prescribing.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment 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. 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.

The Chief Inspector recommends:

- Maximise the functionality of the DMICP (patient record system) in order that the practice can run clinical searches, and establish systems to ensure safe care and treatment is provided to patients. This includes the implementation of a safeguarding register and the easy identification of more vulnerable patients, including carers.
- Maintain staff training to ensure all staff are trained to the correct level of safeguarding.
- 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.
- Develop a system to ensure clinical audits are undertaken to drive improvement.
- Develop a system for clinical peer review within the practice.
- Further staff awareness to enable them to utilise the significant event reporting system appropriately (ASER).
- Develop a failsafe system to confirm the receipts of sample tests and results.

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.

Good

Are services safe?

The practice is rated as good 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. 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.
- Staff demonstrated that they understood their responsibilities with regard to safeguarding and all but one person had received training on safeguarding children and vulnerable adults relevant to their role. We saw that one GP was only trained to level 2 in safeguarding but was booked to undertake level three in October this year.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Requires improvement

The practice is rated as requires improvement 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 did not utilise the full functionality of the electronic patient record

system.

- Data shared with us before inspection showed patient health care could be improved, for example, the recall of hypertensive patients to have a repeat blood pressure check was below the NHS target and the Defence Primary Healthcare average. Also improvement was required in relation to audiometric hearing assessments.
- Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with people was used to do so.
- All of the registered patient records had been summarised. Administrative staff had come in at the weekends to get this completed.
- Audits and regular reviews of the service were undertaken to drive improvements to patient outcomes. However, we found clinical audits were limited to those mandated audits we would expect to find in a GP practice, for example anti-biotic prescribing.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff. All staff were encouraged to develop and move forward with their careers and they were encouraged to do so by supportive management.
- Clinicians worked as lone workers, each GP undertaking one day per week at the practice. Because of this we saw no evidence of peer support being undertaken especially in real time when discussions were useful in assessing patient care. Instead peer support was gained retrospectively at Hanham Health from the other GPs. The practice nurse had no face to face peer support and did not attend nurse forums within Defence Primary Healthcare (DPHC) region or any clinical supervision sessions. However, since the inspection arrangements had been made by rearranging clinics to allow trained nurses to work alongside each other one morning every other week.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the DMS patient experience survey showed patients gave positive feedback for all aspects of care.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

- We received 34 comment cards, all of which were all really positive about the standard of care received.

Are services responsive?

Good

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.
- 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?

Requires improvement

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 the practice manager. The practice had policies and procedures to govern activity.
- The practice had an overarching framework which supported the delivery of the strategy and good quality care. However, improvements were required in some areas of governance.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The practice was aware of the requirements of the duty of candour.
- 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 and we saw examples where feedback had been acted on.

Abbey wood Medical Treatment Facility

Detailed findings

Our inspection team

Our inspection team was led by a CQC inspector. The team included the head of inspection of general practice (south region), a GP specialist adviser, a practice nurse specialist adviser, and a practice manager specialist adviser.

Background to Abbey Wood Medical Treatment Facility

Abbey Wood Medical Treatment Facility is a small tri-service medical treatment facility based on the MOD Abbey Wood site. Military personnel work alongside civil servants within an office based environment, providing equipment and support for current and future operations. The current population at risk (PAR) is 1,298. From this 996 patients are over 40, with 363 of these being over the age of 50.

The primary health services are provided by Hanham Health, a local GP practice. All staff working at Abbey Wood Medical Treatment Facility, including the physiotherapist, work for Hanham Health.

The practice provides a full range of medical services including minor surgery. The staff complement is made up of four GPs, one male and three female, one female nurse, a health care assistant, the practice manager, deputy practice manager, two reception staff, a hearing technician/medical administrator and one physiotherapist. The practice is open from 8am to 12.30pm and 1.30pm to 4.30pm Monday to Friday. After 4.30pm and before 6.30pm patients can contact Hanham Health which has a surgery located eight miles away. After this, patients are diverted to the NHS 111 service. Each day the practice has ‘sick parade’ where patients who are unwell telephone for triage between 8am and 9.30am. Appointments are available for these patients should they require a consultation with a GP or nurse.

There is no dispensary at the practice although nurses and medics hold a stock of over the counter medicines that can be issued if required. A contract is in place for all prescriptions to be dispensed by a local pharmacy.

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 9 August 2017. During the inspection, we:

- Spoke with a range of staff, including one GP, the practice manager, deputy practice manager, one practice nurse, a health care assistant, the physiotherapist and two administrative staff. We were able to speak with two patients who used the service.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans and reviewed patient records.

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?

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff told us there was a clear process for reporting and recording incidents. We saw that 12 significant events had been recorded in the past 12 months. Staff said there was an open, no blame culture and added that they were supported through this reporting process. However, although administrative staff were fully aware of the clinical system on which to report significant events (ASER system) and what to report, they did not have a log in account in order to electronically report concerns. We were told that they would send email to the practice manager detailing what had occurred.

The practice had carried out a thorough analysis of the significant events. We saw evidence that lessons had been shared and action was taken to improve safety in the practice. For example we saw an incident recorded regarding the delay of results to a patient following an MRI scan. This was fully investigated and although not due to the fault of the practice was still discussed and followed up.

Significant events were discussed within the practice and highlighted to all members of staff. They were a regular agenda item for the GPs and practice manager at the monthly team meetings.

Overview of safety systems and processes

The practice had clearly defined systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. We saw that three GPs were trained to level three but that one was only trained to level two, level three training had been booked in for October of this year.
- A notice in the waiting room advised patients that chaperones were available if required. All the staff who acted as chaperones were trained for the role and were identified within the policy. They had all 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).
- Alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) were received

into the practice by the practice manager, who circulated these to all staff. We looked at a selection of alerts and saw that they had shared them with staff and that no actions were required.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. 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.
- The practice nurse at Hanham Health was the infection prevention and control (IPC) clinical lead who liaised with practice nurse at Abbey Wood Medical Treatment Facility and the DPHC 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. We saw that an in house audit was undertaken in January 2017, this scored 87% with the level of compliance and was accompanied by action plan and was dated when actions were completed. We noted that some areas were ongoing, for example the change of notice board in the treatment room.

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

- Systems were in place to ensure doctors signed repeat prescriptions before the medicines were dispensed and handed out to patients. There was no full time, fully operational dispensary at Abbey Wood Medical Treatment Facility. Arrangements were in place to send all prescriptions to a local community pharmacy. These were fulfilled and returned to the practice for collection by patients within 48 hours. We were not made aware of any delays in patients receiving medication.
- The regional pharmacist carried out regular medicines checks and audits, which the practice contributed to.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. Records showed that staff recorded fridge and room temperatures; this made sure medicines were stored at the appropriate temperature. Staff were aware of the procedure to follow in the event of a fridge failure.
- The practice did not hold any controlled drugs (medicines that require extra checks and special storage because of their potential misuse).
- We saw evidence that medicines were disposed of correctly but that incorrect sharps container was used. This was brought to the practice nurses attention who agreed to immediately address this and source the correct pharmaceutical disposal bin.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. All of these were reviewed and signed appropriately.

The staff had access to emergency medicines and equipment in the medical facility. The emergency trolley was checked regularly and suitable for use.

Practice records showed recruitment checks had been undertaken on civilian staff prior to employment. For example, 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.

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 which had been reviewed, was in date and had been implemented throughout the unit.

Suitable and sufficient risk assessments were completed for staff and patients and were in date.

- Suitable fire safety security and emergency procedures are in place. The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice.
- 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.

Arrangements to deal with emergencies and major incidents

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

- 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.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage.

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

Requires improvement 

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. However, there were no processes within Abbey Wood Medical Treatment Facility to review updates or discuss these with clinical colleagues to ensure evidence-based best practice was updated in line with amendments.

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).

Administrative assistants ran a search on the clinical system and recalled any patients due for review of their long term condition. The patient's records were then reviewed the day prior to their appointment to address any clinical needs, for example blood tests that maybe required.

There was inconsistency in the system and procedures for the review of high risk medicines. There were three patients receiving them and we saw the practice 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.

Administrative staff supplied Hanham Health surgery with a daily record of any patient awaiting blood results that may come through after 4.30pm when Abbey Wood Medical Treatment Faclity was closed. Hanham Health were then able to contact the patient and ask them to contact Abbey Wood Medical Treatment Facility the following day for another appointment or prescription if required.

QOF results from 2016, which were benchmarked against NHS targets for the year 2011/12 showed: 85 patients were eligible;

- There were seven 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 86%, 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 100%, 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 67%, compared to the NHS target of 60%, and the achievement of 53% nationally for DPHC.
- There were 81 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 79%, 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 Abbey Wood Medical Treatment Facility 99% of patients had a record of audiometric assessment, compared to 100% Defence Primary Health Care (DPHC) Wessex region and 99% for DPHC nationally.
- At Abbey Wood Medical Treatment Facility, 79% of patients' audiometric assessment was in date (within the last two years) compared to 91% Defence Primary Health Care (DPHC) Wessex region and 86% for DPHC nationally.

Abbey Wood Medical Treatment Facility employed a hearing technician; this was a positive asset for the practice as they performed all audiometric assessments. They worked closely with the GP who was their mentor and they attended further training for the role. Administrative staff provided a list of potential patients requiring assessments; they were then recalled by the hearing technician to attend the practice. On the patients arrival an audiometry health questionnaire was completed and discussed with the patient prior to testing, and then audiometric assessment performed. Any concerns were discussed with the GP and if required a repeat hearing test was performed within two weeks.

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

- 87% of patients at Abbey Wood Medical Treatment Facility had a record of vaccination against diphtheria which was in date, compared to 93% Defence Primary Health Care (DPHC) Wessex region and 95% for DPHC nationally.
- 87% of patients at Abbey Wood Medical Treatment Facility had a record of vaccination against polio which was in date, compared to 93% Defence Primary Health Care (DPHC) Wessex region and 95% for DPHC nationally.
- 75.5% of patients at Abbey Wood Medical Treatment Facility had a record of vaccination against Hepatitis B which was in date, compared to 82% Defence Primary Health Care (DPHC)

Wessex region and 83% for DPHC nationally.

- 97% of patients at Abbey Wood Medical Treatment Facility were recorded as being up to date with vaccination against Hepatitis A, compared to 94% Defence Primary Health Care (DPHC) Wessex region and 94.5% nationally.

There was limited evidence of quality improvement including clinical audit:

- We reviewed two audits, one in relation to antibiotic prescribing and another in asthma both had two completed cycles, however they did not show any significant improvements for patients but were used more of a data collection tool. Other non-clinical issues were audited including an audit of patients who required weight management and another undertaken by the physiotherapist following feedback from patients regarding poor access to appointments. As a result of the physiotherapists audit the timetable for appointments was changed and access had improved for this service.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and 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.
- The learning needs of administrative 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 and coaching and mentoring.
- Clinicians worked as lone workers, each GP undertaking one day per week at the practice. Because of this we saw no evidence of peer support being undertaken especially in real time when discussions were useful in assessing and discussing patient care. Instead peer support was gained retrospectively at Hanham Health. The practice nurse had no face to face peer support and did not attend nurse forums within Defence Primary Healthcare (DPHC) region or any clinical supervision sessions. However, since the inspection arrangements had been made by rearranging clinics to allow trained nurses to work alongside each other one morning every other week.
- Staff received training that included: safeguarding, fire safety awareness, and basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. We evidenced a very strong training and staff development ethos within the practice driven by the practice manager. Administration staff were encouraged and supported to develop and progress their careers.

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.
- The practice ensured that all relevant information on patients was recorded and highlighted to the GP. We noted there were no outstanding patient's records that required summarising.
- 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. The practice had a good working relationship with the mental health team who were based at Tidworth.
- Monthly meetings were held with the welfare team to discuss those patients that were vulnerable. However, we saw no evidence of any multi-disciplinary meetings with other healthcare professionals to discuss those patients with more complex needs.

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.
- The process for seeking consent was monitored through patient records audits.
- We saw that consent was sought before a patient was added to the medical welfare list this and an explanation given to them about what this meant. It also allowed a note to be added to the patients electronic records which helped facilitate them getting an appointment with one of the medical team when needed and not having to wait.

Supporting patients to live healthier lives

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

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- All new patients were asked to complete a proforma on arrival. The practice nurse then considered this comparing it to the guidance and would follow up any areas of concern, such as raised blood pressure.
- The practice's uptake for the cervical screening programme was 99%, which was above the national average of 82%. There was a policy to send a reminder letter for patients who did not attend for their cervical screening test. Results were recorded on the electronic record system when received and any abnormal results were flagged to the GP. A search was also done monthly to ensure all results had been received and actioned.
- Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50-64 years who would be entitled to breast screening. The

practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs. Searches were undertaken by the administrator and all patients over 50 years who had not had cholesterol check in the past five years were called in to be tested.

- A recent campaign held was a self-help forum around making small changes to promote a healthy lifestyle. It was hosted by the medical facility but presented by one of the patients. This patient had made small changes to their lifestyle resulting in significant improvements to their health and wellbeing. The practice recognised if the help and advice came from a peer who understood the challenges of working in the Abbey Wood Medical Treatment Facility environment that patients would be more likely to engage more enthusiastically. The session was received very well by those who attended and the practice received positive feedback. Further events were planned in the future but on a larger scale to target more patients.
- The practice recognised the enforced sedentary working and diverse nature of their population being a military, civilian mix and because of this were holding a ‘Health & Well Being Event’ in October 2017. This open day would also address mental health with an aim to promote, reduce stigma and address rank and grade expectation and behaviour towards mental health issues.

Good

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. There was a radio playing to provide a sound barrier, phone calls regarding patients were only made in the closed office. No calls were taken on reception. Recent patient feedback (April 2017) showed from 30 surveys;
- 94% of patients said their privacy and dignity was respected and maintained throughout the visit.

Patients could be treated by a clinician of the same gender.

All of the 34 patient Care Quality Commission comment cards we received 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.

We spoke with two patients. They told us they were satisfied with the care provided by the practice and said the practice provided them with everything they needed. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Patients commented in feedback provided on CQC comment cards that they felt involved in decision making about the care and treatment they received. They commented that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Results from the DMS Patient Survey Experience showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example feedback from 19 surveys sent out in March 2017 showed:

- 100% of patients said they felt involved in decisions regarding their care.

The practice dealt with patients from different countries and some of these patients did not have English as a first language. Staff told us that interpreter services were available for patients who did not have English as a first language. Information leaflets were also available in reception.

The Choose and Book service was used with patients as appropriate (Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).

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. Currently the practice had no systems in place to identify if a patient was a carer.

Information about other facilities and support groups was also available through HIVES. The HIVE is an information network available to all members of the service community. It provided a range of information on local unit and civilian facilities including health care facilities.

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

Good

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 10 minute appointments with the GP and up to 30 minute appointments with the practice nurse.
- Same day appointments were available for those patients with medical problems that required it.
- Patients were able to receive travel vaccines when required. The practice was a yellow fever centre.
- One physiotherapist was employed within the medical facility. All referrals to this service were made by the GPs and the average waiting time for an appointment was less than one week.
- There were accessible facilities, which included interpreter services when required.
- Eye care and spectacles vouchers were available to service personnel from the medical facility.

Access to the service

The practice was open from 8am to 12.30pm and 1.30pm to 4.30pm Monday to Friday. After 4.30pm and before 6.30pm patients could contact Hanham Health which had a surgery located eight miles away. Outside of these hours, patients were diverted to the NHS 111 service. Each day the practice had 'sick parade' were patients who are unwell telephoned for triage between 8am and 9am. Appointments were available for these patients should they require a consultation with a GP or nurse.

Results from the DMS Patient Survey Experience showed patients responded positively to questions about access to their care and treatment. For example We saw a recent patient survey from February/March 2017 which showed from 19 surveys sent;

- 95% of patients who responded said that they felt their appointment was at a convenient time.

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

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. The policy was on display in the waiting room. In the main office there was a copy of a Hanham Health policy which has been adapted to incorporate the Ministry of Defence (MOD) process. Three complaints had been received since October 2016. We saw each one had been dealt with thoroughly and investigations had been undertaken.
- We saw a recent patient survey from February/March 2017 which showed from 19 surveys, 18 patients said that they felt the practice listened to their comments, compliments and complaints.

Are services well-led?

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

Requires improvement 

Our findings

Vision and strategy

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

'The aim of Hanham Health as a General Medical Practice (Community) is to provide the best possible health care for our patients while promoting better physical and mental health by offering a planned programme of health promotion and preventative care based on local and national guidelines'.

The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored. The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. However, improvements were required in some areas of governance:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs said they felt well supported by the management at Hanham Health
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of internal audit was used to monitor quality and to make improvements. However clinical audit was undertaken as more of a mandatory function than to drive improvement. This was due primarily to GPs working only one day per week each at the practice and having little other time to commit to other clinical audit.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, some systems were not robust enough to reduce risk, for example the management and system of recall of those patients on high risk medicines and the identification of those patients that were more vulnerable.
- We noted the practice did not keep a formal register of patients subject to safeguarding arrangements, or of those deemed to be 'at risk'. Instead the practice held a 'welfare' list and an alert was placed on the electronic patient records system (DMICP), however this was not coded to enable a search to be undertaken or to create appropriate registers.
- We looked at the handling of pathology links, lab' reports and outpatient report letters from hospitals. The practice staff scanned all hospital letters on receipt and sent a task to alert the relevant GP of their arrival. Results were randomly audited by selecting 20 patients on a monthly basis to check they had been received back. There were no failsafe systems in place to confirm the receipts of sample tests.

- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

The management at the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. They were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. All staff we spoke with spoke highly of the practice manager and said the GPs were approachable and supportive.

When there were unexpected or unintended safety incidents:

- The practice gave affected patients reasonable support, truthful information and a verbal and written apology.

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

- Staff told us the practice held regular team meetings. We saw evidence of minutes and agendas for these, which included quarterly clinical meetings, monthly welfare meetings weekly administrative meetings and monthly whole team 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 in doing so and felt supported if they did.
- The practice manager emailed a weekly update for all staff which included the rota and any other news or information.
- The practice held regular social events which they told us most staff went to and everyone enjoyed them.
- Staff said they felt respected, valued and supported, by the more senior staff in the practice. All staff were involved in discussions about how to run and develop the practice, and the more senior staff encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

We saw a focus on continuous learning and improvement within the medical facility. The practice had a strong ethos on the training and development of staff and worked hard to ensure patients received a good service.

Due to the nature of the practice none of the GPs or practice nurse could evidence a system of peer review used at the practice to continually improve. Instead this was gained at Hanham Health surgery retrospectively and not specific to Abbey Wood Medical Treatment Facility. This included the sharing of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.