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>
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<tr>
<td>Are services safe?</td>
<td>Inadequate</td>
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<tr>
<td>Are services effective?</td>
<td>Requires improvement</td>
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<tr>
<td>Are services caring?</td>
<td>Good</td>
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<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good</td>
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<tr>
<td>Are services well-led?</td>
<td>Requires improvement</td>
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Letter from the Chief Inspector of General Practice

We carried out an announced inspection of Bovington Medical Centre on 27 September 2017. Overall, the practice is rated as requires improvement. Our key findings across all the areas we inspected were as follows:

- There was a system in place for reporting and recording significant events. However, this was not embedded or always followed.
- There was a lack of risk assessments available in relation to the practice building and the working environment. For example, there were no emergency alarms in the building and staff did not have personal alarms. There was an urgent messaging feature on the practice computer system but this would not alert military personnel, for example in the guard room, of any emergency situation occurring in the practice building.
- The practice did not have arrangements in place to ensure that essential patient information was routinely shared with community based staff such as health visitors and midwives. These community based clinicians did not access the electronic patient notes, where updates may have been recorded.
- The practice used clinical coding to enable live registers of particular groups of patients to be kept, for example, those subject to shared care agreements and those on high risk medicines. However, we did come across some patients that did not have the correct read codes in their notes, meaning they did not appear on registers.
- Staff understood their responsibility to raise safeguarding concerns. However, follow-up actions required were not followed through.
- Evidence of clinical audit was available but evidence of continuous improvement in practice was limited.
- Overall, the arrangements for managing medicines (with the exception of some accountable drugs), including emergency medicines and vaccines in the practice, minimised risks to patient safety.
- 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.
- Some areas of governance required improvement.
- Results from the Defence Medical Services (DMS) 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 within the practice.
- Patients provided feedback on Care Quality Commission comment cards, saying they found it
easy to make an appointment with urgent appointments available the same day.

- Although the practice building was dated, the practice had good facilities and was equipped to treat patients and meet their needs.
- There was a leadership structure and staff said they felt supported by management. However leadership required improvement.
- 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:

- Review of training for all staff in relation to raising significant events, to ensure all incidents are reported, investigations are conducted, and that a practice level lead is appointed to address any follow-up actions that require implementation.
- A formal diary of governance, practice and multi-disciplinary clinical meetings is established and that all meetings are minuted and shared appropriately with community based staff.
- A review of governance to include, for example, effective removal of de-registered patients from the practice register and the prompt forwarding of patient notes without delay.
- Proactive work to capture an accurate record of patients’ smoking status, with increased intervention to refer on to smoking cessation advice and help.
- Establishing and maintaining a carers register.
- A review of patient access to a GP between the hours of 4.30pm and 6.30pm.
- A review of staff training in use of the electronic patient record system to assure it is effective. For example, in order that staff can run clinical searches, create specific patient registers, provide assurance around patient recall systems, easily identify vulnerable patients and produce accurate performance data.
- Development of health and safety checks for the building in relation to staff working environments, for example, the introduction of emergency alarms and/or panic buttons.

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

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as inadequate for providing safe services.

- The practice had a clear system in place for reporting and recording significant events. However, this was not embedded.
- Safeguarding systems were in place and staff knew how to raise safeguarding concerns. However, these were not always followed up. Safeguarding alerts on the practice electronic patient record were not correctly used. Communication between health visitors and the practice required review.
- There were no health and safety risk assessments available for the building and working environment of staff. There were no emergency alarms for staff throughout the building. There was an emergency messaging system on the practice computer but this system did not alert anyone outside the building to any emergency within the medical centre.
- There was evidence of staff being given oversight of key induction areas when starting with the practice, for example, fire safety induction.
- Overall, the management of medicines within the practice was safe. However, the management of accountable drugs required improvement. More work was required in the use of clinical coding to ensure that registers of patients on high risk medicines were accessible to all clinicians.
- The practice had adequate procedures and arrangements in place for responding to an emergency.

Are services effective?

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

- There was no effective calendar of practice, governance, and clinical multi-disciplinary team meetings in place.
- Communication between community health clinicians and the...
practice required improvement. Heath visitors who attend the practice do not use the practice electronic patient record system – DMICP - and cannot access patient notes. Midwives have no access to DMICP. The lack of minutes in relation to the two clinical meetings that had been held this year meant that staff could not review what had been discussed in their absence.

- There was a lack of evidence of effective, continuous improvement at the practice.
- Information on patients subject to shared care, who were on high risk medicines was accessible to clinicians.
- The management of call and re-call of patients required improvement. For example, the practice had approximately 285 patients (over 40 years of age) registered with the practice. Of these, 36 were overdue for the NHS over 40’s health check. Where audit showed that some asthma patients required re-call for a complete asthma review, this had not been addressed.
- From records available, we saw staff had been trained to provide them with the skills and knowledge required to deliver effective care and treatment. Staff had access to updated guidance from the National Institute for Health and Care Excellence (NICE) and to information on safety alerts, for example, from the Medicines and Healthcare products Regulatory Agency (MHRA) alerts.

Are services caring?

The practice is rated as good for providing caring services.

- Results from the Defence Medical Services (DMS) patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- The practice had not established a carers register that all staff could access.
- We received 22 completed CQC comment cards, 20 of which gave positive feedback on the services of the medical centre. One card had feedback on the dental service, which is based in a different part of the same building but is not covered by this inspection. Another card gave feedback on action following missed appointments, which was negative in nature.
- Our observations on the day of inspection were that staff treated patients with dignity and compassion. The views expressed by patients aligned with this.
Are services responsive?

The practice is rated as good for providing responsive services.

- Patients commented that they found it easy to make an appointment with a GP and there was continuity of care when required. Urgent appointments were available the same day.
- The practice had the facilities and equipment to treat patients and meet their needs.
- Information about services and how to complain was available within the practice.
- The practice responded positively to any complaints received and we saw that patients felt comfortable raising any concerns or complaints.
- The practice told us home visits were offered when clinical needs of patients made this necessary. The practice information leaflet reflected this.
- No routine or bookable appointments were offered after 15:45. Whilst this did not appear to meet the needs of a practice that treated dependants and children of all ages, there were no recorded complaints regarding this.
- Patients calling the practice from 16:30 to 18:30 were diverted by phone to the practice at Tidworth and offered telephone advice by a nurse. Notices on the doors of the practice advised patients that outside of these hours they should contact the NHS 111 service.

Are services well-led?

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

- There was a lack of shared responsibility around key duties, which would have supported the Senior Medical Officer (SMO) at the practice.
- Some responsibilities lacked managerial oversight, for example, pharmacy checks and the reporting of any medicines accounting errors.
- Governance required improvement. All staff training certificates were held by individual staff, other than for safeguarding training. There was no confirmed checking system in place to assure that all staff had completed recommended training or refresher courses.
- We saw that the practice had not undergone an internal quality assurance inspection for a number of years.
- Areas of the internal governance tool, the Common Assurance Framework (CAF) required review and follow-up.
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Our inspection team

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

Background to Bovington Medical Centre

Bovington Medical Treatment Facility is located just outside the perimeter fence of Bovington Army camp. The treatment facility was built in 1963, and offers care to both forces personnel and their dependants and children. At the time of inspection, the patient list was approximately 1,850. This was made up of approximately 734 civilians and 1115 military personnel. Of these patients, 479 were under 18 years of age with approximately 50 of these being military personnel. Occupational health services are also provided to personnel and a number of reservists.

In addition to routine GP services, the treatment facility offers physiotherapy services and travel advice. However, physiotherapy services and exercise rehabilitation services were not inspected as part of this visit. Family planning advice is available, with referral onwards to NHS community services if required. Maternity and midwifery services are provided by NHS community midwives who visit the practice weekly. Health visitors and a nursery nurse also visited the practice on a regular basis. Childhood immunisations and vaccinations are offered at the practice.

At the time of our inspection, the practice had a full time civilian GP who was the lead GP and Senior Medical Officer. The Senior Medical Officer was supported by a full time locum GP who had been in post for just over 12 months, and a part time civilian GP, who worked three full days each week. The combined hours of these clinicians gave 2.6 whole time equivalent GPs.

There were two part-time civilian practice nurses, whose combined hours provided 1.1 whole time equivalent nursing hours. There was one full time (military) senior nursing officer who was a qualified prescriber, one full time (civilian) health care assistant, and one full time (civilian) pharmacy technician who worked in the practice dispensary. The practice was led by a newly appointed (military) practice manager, who was away on a course at the time of our inspection. The practice clinicians were supported by an administrative team made up of one full time civilian administrator and two full time civilian administration and reception clerks.

The practice is open from Monday to Thursday each week between 08.00 and 16.30. The practice is open from 08.00 to 12.30 on Friday afternoon. From 16.30 each day until 18.30 and from 12.30 to 18.30 on Friday, patients are advised to ring a duty nurse based at another military base, Tidworth, for telephone advice. Outside these hours, patients are diverted to the NHS 111 service.
Why we carried out this inspection

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

How we carried out this inspection

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

We carried out an announced visit on 27 September 2017. During our visit we:

- Spoke with a range of staff, including two GPs, the acting practice manager, pharmacy technician, a senior nursing officer, two practice nurses and reception and administrative staff. Although there were patients attending the practice on the day of inspection, it was not convenient for them to speak with us.
- Reviewed comment cards completed by patients who shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.
- Reviewed practice records and governance documents.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people’s needs?
- Is it well-led?
Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. However, for the 12 month period leading up to our inspection, only four incidents had been reported. During our inspection, we found examples of incidents that should have been reported, but had not.

- Staff told us they knew they could report events, and they would notify the practice manager or Senior Medical Officer (SMO) if anything needed to be reported. However, staff went on to state that it was mainly the clinicians that reported incidents.

- For the four events that had been reported, we did see evidence that investigation and analysis of events took place. Where possible improvements were identified to reduce the risk of the incident happening again. For example, following an incident, it was identified that nurses doing vaccination parades should be booking a full 10 minute appointment for each patient to ensure all paperwork was reviewed and that vaccinations were recorded correctly.

- Throughout the inspection day, we came across a number of events that should have been reported but had not. One involved the management of accountable drugs and one involved a possible safeguarding event.

We reviewed safety records, incident reports and national patient safety alerts. We could see that these were shared with staff in the practice. However, there was a lack of evidence of clinical meetings were these had been discussed. When we checked records of clinical meetings we could see there were minutes for meetings held on 4 May 2017 and 3 August 2017. Prior to this the last records of clinical governance meetings were from 17 October 2016 and 30 November 2016. We were told the practice had a communication meeting each morning but there was no record of these meetings; part time staff had no record of meetings to update them on matters discussed.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal apology and were told about any actions to improve processes to prevent the same thing happening again. We saw evidence on the day of inspection that confirmed this.

Overview of safety systems and processes

The practice described to us the systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- 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 who worked full time at the practice. Deputising arrangements were in place.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role.
- GPs were trained to child protection or child safeguarding level three. Nurses were trained to child safeguarding level two. Administrative staff were trained to child safeguarding level one.
- We reviewed how the training, policies and procedures were implemented in day to day work at the practice. The practice did not keep a register of patients subject to safeguarding arrangements, or of patients deemed to be ‘at risk’. Staff said they used the alert facility within the electronic patient record DMICP (Defence Medical Information Capability Programme) to ensure that risks showed clearly when the medical record was opened. When we reviewed this, no alerts were used in respect of patients known to be at risk.
- We were able to review safeguarding records. We saw that staff had raised and reported concerns correctly. However, these were not followed up. We also found that information on one case was not shared by the practice with the health visitors.
- We saw that health visitors, midwives and the nursery nurse did not access the electronic patient records, which can impact on their full understanding of the updates and needs of any child or adult at risk. Also, when patients at risk had moved practice, a print off of their electronic patient record, with any safeguarding concerns had not been sent onwards in a timely manner. We escalated this issue to the Inspector General, post inspection, who took action to ensure the safety of any patient known to be at risk.
- Notices in the waiting room and consultation rooms advised patients that chaperones were available if required. Staff who acted as chaperones were clinicians and were trained for the role. We were aware that requests for updated DBS checks had been submitted by the practice including those for two nurses and two GPs. These DBS checks were recently found to be more than five years old (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). The Common Assurance Framework (CAF), used as a governance tool by military practices, stated that all checks should have a maximum validity of five years. When we reviewed the CAF we saw that this was marked as green, i.e. compliant.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice had an infection control policy and lead who had attended infection control training. Infection control audits were carried out annually.
- All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. Spillage kits were available and staff knew of their location.
- Clinical waste was stored appropriately and securely and was collected from the practice by an external contractor on a fortnightly basis. However, the practice was only able to show us one consignment note for waste collected. We were told that these records were held by the contractor. It was not made clear to us at the time of inspection how an accurate record of waste produced by the practice was maintained to provide assurance that all waste was traceable.
- The arrangements for managing medicines (with the exception of accountable drugs), including emergency medicines and vaccinations in the practice, kept patients safe. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of these medicines.
- We reviewed arrangements in place for the management of patients on high risk medicines. We
saw that shared care agreements were in place for these patients and that alerts were used on patient records to assist clinicians. A register of these patients was kept as a Word document, and held by the SMO and not kept on a shared drive within the practice computer system. This meant other staff could not access this register. When we reviewed patients on high risk medicines, we saw some did not have the appropriate read code applied to their record. This meant that any register produced through the practice computer system, DMICP, would not be accurate.

- We reviewed the checks of accountable drugs, for example, Diazepam. We found that when a pharmacy technician alerted the practice to missing Diazepam tablets, the expected steps to support safe management of accountable medicines were not followed. An internal report by the pharmacy technician was not shared appropriately, for example, with the regional pharmacist. A significant event had not been raised in relation to the issue, which meant appropriate investigation and reporting did not occur. We brought this issue to the attention of the Inspector General, post inspection. A significant event has been raised and investigation is underway.

- We did not see some of the expected, regular audits for GP practice. For example, an audit of compliance with the Tri Service Formulary. This audit is carried out by all DMS practices to measure each practice’s level of compliance with prescribing guidance within DMS.

- Prescription pads were securely stored and there were systems in place to monitor their use.

- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation, and Patient Specific Directions for use when appropriate.

- No staff records were held at the practice. We were advised that Defence Business Systems carried out all recruitment checks for civilian staff. There were no copies of periodic checks of professional registration for the practice GPs, or on the professional registration for nurses or of the continuing professional registration of the pharmacy technician.

**Monitoring risks to patients**

Risks to patients were assessed and managed but improvements were required in monitoring safety of the premises.

- We were told there were procedures in place for monitoring and managing risks to patient and staff safety. The practice had access to the generic DMS health and safety policy. The practice had up to date fire risk assessments and carried out regular fire drills. The fire equipment was checked by an external contractor on an annual basis. Fire alarms were tested weekly and all electrical equipment was checked on a regular basis to ensure the equipment was safe to use.

- Clinical equipment was checked in line with Defence Medical Services policy to ensure it was working properly.

- The practice did not have other risk assessments in place to monitor safety of the premises such as health and safety environmental risk assessments. We noted that there were no staff alarms in the building, which were linked to support outside the practice, for example, the guardroom. Staff did not have personal alarms. The practice electronic patient notes system had an urgent messaging facility but this would not alert staff outside of the practice of any emergency.

- Infection prevention and control and legionella risk assessments were in place (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff
needed to meet patients’ needs. There was a rota system in place for all staffing groups to ensure that enough staff were on duty. When we reviewed the cover from 16.30 to 18.30 we were told that cover during this time is shoulder cover, which involves patients calling another local practice, Tidworth, for telephone advice from a nurse. After 18.30, callers are advised to ring NHS 111. Staff confirmed there were no appointments available to book after 15.45.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place 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 and in the reception office.
- The practice had a defibrillator available on the premises and oxygen with adult and children’s masks. A first aid kit was available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. A copy of this plan was available to staff and additional copies were kept off the premises.
Are services effective? (for example, treatment is effective)

Our findings

Effective needs assessment

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) guidance.
- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients’ needs.
- There was a lack of regular clinical meetings held at the practice. From a review of the GPs clinic times and administrative time we did not see that meetings were planned effectively, or consistently. We were told that communication meetings were held each morning which all staff attended. There were no minutes of these meetings. It was unclear how any part time staff could update themselves on matters discussed at these communication meetings.
- When we asked for minutes of clinical meetings that had been held, we could see that two had been held in 2017, on 4 May 2017 and on 3 August 2017. Previous to this there had been two meetings in 2016, on 17 October and 30 November 2016. The practice could not provide further evidence of meetings prior to this.
- The Defence Primary Health Care (DPHC) Team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant patient safety updates, including those from the Medicines and Healthcare products Regulatory Agency (MHRA). GPs we spoke with could refer to this and gave examples of updates they had acted on.

Management, monitoring and improving outcomes for people

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

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

- There were five patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. For four of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For five diabetic patients, the last blood pressure reading was
150/90 or less which is an indicator of positive blood pressure control.

- There were 26 patients recorded as having high blood pressure. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. Of these patients with hypertension, 18 had a blood pressure reading of 150/90 or less which is an indicator of positive blood pressure control.

- Where patients’ blood pressure readings did not fall within these parameters we were reassured that follow-up support and advice was offered to patients to help them achieve a healthy blood pressure reading. We did see one patient had missed their recall and had not picked up medication to control their blood pressure as required. This had gone unchecked for 22 months. When we asked the practice to check if this patient had been recalled since then, we found they were no longer registered with the practice.

The number of patients who smoke and whose notes contained a record that smoking cessation advice, or referral to a specialist service had been offered within the previous 24 months was 166 which is 52% of the smoking patient population. The NHS target for this indicator is 90%. There was no plan in place detailing how the practice were going to improve on this.

- There were 52 patients with a diagnosis of asthma. Of these 37 had received an asthma review in the preceding 12 months which included an assessment of asthma control using the 3 Royal College of Physicians (RCP) questions. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. Steps to improve on this figure included all clinicians using the asthma review template within the practice computer system to ensure a complete review of asthma is conducted with each patient.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that instance of audiometric hearing assessment was in line with DMS practices regionally and and above achievement 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:

- 100% of patients had a record of audiometric assessment, compared to 100% regionally and 99% for DPHC nationally.
- 95% of patients’ audiometric assessments were in date (within the last two years) compared to 91% regionally and 86% for DPHC nationally.

There was evidence of clinical audit:

- A programme of clinical audit was in place. We were presented with an asthma audit, an audit of diabetic eye screening, a hypertension audit, an infection prevention and control audit, an audit of newly registered families note summarising and an audit of military patients note summarising, an audit on the quality of patient notes, and a pre-acceptance audit on clinical waste.

- We reviewed the audits provided. The clinical waste pre-disposal audit, carried out on 20 June 2017, demonstrated that waste checked at that time, was being disposed of correctly and that the correct designated containers for safe disposal and carrying of waste were being used by staff. However, the practice could only show us one consignment note for waste. There was no evidence available that bags disposed of were security sealed and recorded in a practice log, and that all waste was traceable.

- The audit on infection prevention and control, carried out in July 2017 showed 95% compliance
with required standards. Any areas for improvement had been addressed.

- An audit on diabetic eye screening showed that 100% of patients who required screening received this in 2016. The practice had held this rate of achievement since 2013. This had improved from 80% initially in 2009. Although numbers of patients involved was small (five patients), this audit demonstrated effective working with Dorset Diabetic Eye Screening, effective use of DMICP clinical coding and application of DMICP patient searches.

- A Yellow Fever Vaccination audit consisted of a data collection to verify that those patients administered with the vaccine, had this recorded accurately in their DMICP record and in the Yellow Fever Vaccine Log. The objective was to ensure that no patients were double vaccinated. The audit had been conducted following a significant event, where a patient had received a vaccination in error. No harm came to the patient.

- The audit on quality of electronic patient notes was dated 5 July 2017. This consisted of the data gathering and initial application of standards to be met, and the report of initial findings. No second cycle had been undertaken. The findings showed the standard of patient records was good, with small areas for improvement. The exercise highlighted that four out of 20 patients had left the practice but remained on the practice register. The conclusion was that there was no evidence that patients were being de-registered from DMICP as part of their leaving routine. The recommendation made was that administrative staff were to look back at each patient on the practice list and de-register those that had left the service. We did not see evidence that this had been actioned or applied. One set of anonymised patient notes we reviewed, were those of a patient that had left the practice, but was still registered on the practice list.

- We reviewed the audit of new registered families. This was an audit with repeated cycles. The audit showed that 61.5% of families’ notes were summarised within eight weeks in 2016. This compared with 73.2% in 2015 and 87.9% in 2014. The recorded conclusion was that there continued to be a downward trend in the time taken to summarise families’ notes and that this continued to be below the ‘80% by eight weeks’ summarising target. The audit also noted that the number of dependants registering in 2016 (the most recent cycle of the audit) had reduced from 246 to 200 compared with the previous year. It was noted that the nursing workforce was cut in 2016 following the closure of the bedding down unit and that there was a gapped GP post (currently covered by a full time locum). The action proposed was that increased protected time should be given to the part time doctor who summarises patient notes. There was no further cycle of audit to monitor any progress made.

- We reviewed the audit of asthma reviews. The first cycle completed in September 2016 identified 49 applicable patients; 51% of these patients had received a review, with 38% (17) of those patients being asked the three Royal College of Physicians (RCP) recommended questions for asthma review. The audit noted that the percentage of patients receiving an asthma review had dropped considerably from 83% in 2014. This was attributed to the loss of a trained asthma nurse since then. Proposals to achieve the improvements required, where to use the new, dedicated asthma nurse to run clinics, and that diary alerts on DMICP should be used to call these patients when their asthma review was due. It was noted that if the nurse was not available then GPs could use the asthma template on DMICP to prompt them to cover all required areas of the review.

- The audit was repeated in May 2017. This identified 49 applicable patients; 30 patients, (61%) had received a review, with 49% of those reviews that asked the Royal College of Physicians (RCP) recommended questions for asthma review. This represented an improvement but still fell short of the standard set by the audit of 70%.

- We reviewed the audit on hypertension. This was carried out in December 2016 and consisted of the data gathering, application of criteria and standard, the data summary and conclusion. There was no repeat cycle. This audit showed 30 patients on the practice register with
hypertension. Of these, 22 patients had a record of blood pressure reading, taken within the previous 12 months that was 150/90 or less (73%). This result is above the minimum standard set of 45% but below the achievable 80% target set. The date set for second cycle of audit was 12 months’ time.

- Although the practice was able to present evidence of audit, evidence of actions taken to drive improvement were limited. For example, work to capture patients where audits demonstrated that these patients were not being reviewed, was not targeted or driven by results of audit. Numbers of patients concerned who did require follow-up were relatively small.

- Monitoring exercises were in place to check that standard operating procedures continued to meet the needs of the practice and its patients.

- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. When we reviewed the CAF we saw some areas had been highlighted as requiring further action.

**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 included topics such as safeguarding, infection prevention and control, fire safety, general health and safety, information governance and Caldecott accountability. Staff had access to and made use of e-learning training modules and in-house training.

- Staff had all received mandatory training in subjects such as fire, basic life support and infection control. In addition staff had received role-specific training. For example, the infection prevention and control lead had attended a relevant course and all clinicians had been trained around the application of Gillick competence (Gillick is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge). Staff who acted as chaperones had received training.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training including an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes. The medical centre was Yellow Fever registered and the practice nurses and Senior Nursing Officer were up to date with training for this.

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

- The 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. We were unable to review the staff training records or matrix on the day of our inspection but asked for this to be provided following inspection. The practice have not provided us with this document.
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. However, communication between community health clinicians and the practice required improvement. Health visitors who attend the practice do not use the practice electronic patient record system (DMICP) and cannot access patient notes. Midwives have no access to DMICP. The lack of minutes in relation to the two clinical meetings that had been held this year meant that staff could not review what had been discussed in their absence.

- Risk assessments, care plans, medical records and investigation and test results for patients were held on the electronic patient record at the practice. Information was shared between services, for example, secondary care, with patients’ consent, using a shared care record.

- From the sample of anonymised patient notes we reviewed we found that the practice shared relevant information with secondary care in a timely way.

- When we reviewed incoming patient records we saw there were 22 sets of patient records waiting to be summarised. (Less than 1% of the practice population).

- Reports were usually received from the Out of Hours (OOH) service within 48hrs of a patient having accessed treatment. These reports were scanned on to DMICP and alerts sent to a doctor to ensure they were read and appropriate follow up instigated if necessary. The reviewing doctor coded problems/conditions as necessary on DMICP. Patients seen by the Out of Hours service (OOH) were required to present to the practice, if practicable, the next day for review.

Consent to care and treatment

Staff told us they sought patients’ consent to care and treatment in line with legislation and guidance.

- Staff demonstrated that they 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, we were told the GP assessed the patient’s capacity and, recorded the outcome of the assessment. When providing care and treatment for young recruits, many of whom are aged between 16-18 years, we were told GPs carried out assessments of capacity to consent in line with relevant guidance. Where there was any parental or guardian involvement in patients’ care or treatment, this would be with the consent of the patient.

- One of the practice nurses confirmed they had not received training on the Mental Capacity Act 2005.

- The practice had not conducted any audit on the process for seeking consent to, monitor the correct application of guidance by clinicians.

Supporting patients to live healthier lives

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

- Patients at risk of developing a long-term condition and those requiring advice on their diet,
smoking and alcohol cessation.

- All new patients were asked to complete a proforma on arrival. The practice nurse followed up any areas of concern, such as raised blood pressure.

- The management of call and re-call of patients required improvement. For example, the practice had approximately 285 patients (over 40 years of age) registered with the practice. Of these, 36 were overdue for the NHS over 40’s health check. Where audit showed that some asthma patients required re-call for a complete asthma review, this had not been addressed.

- The practice offered sexual health advice including the issue of free condoms. There was a GP at the practice who could deliver family planning services but patients could be referred on to local clinics in the community if this GP was not available or if this was preferred by a patient.

- The practice held health fairs to promote good health within their local community. This included outside agencies visiting and manning stalls at the fair, to give advice and information on topics such as healthy eating and weight management.

- The practice engaged with all national screening programmes and had a mechanism to ensure that any eligible patients were referred into these, for example, the bowel cancer screening program. Flu vaccinations had been offered to all patients who required this.

- The number of women aged 25-65 whose notes recorded that a cervical smear had been performed in the last 5 years was 219 out of 242 eligible women. This represented an achievement of 82%. 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.

- Childhood immunisation rates were provided by the practice. In the information provided, the practice had identified those patients that were known to have been immunised. Where it was recorded in free text in a patients notes that vaccination had been received, but not formally coded (usually at the time of immunisation), the practice explained what they were doing to update the patient record, or to contact the parent of the child concerned to confirm that the vaccination had definitely been received.

Figures supplied by the practice showed:

- 80% (four out of five) of the children registered with the practice, aged from 56 days to 12 months had a clear, documented record of immunisation.

- 27 out of 33 eligible children (82%) had a record of the required vaccinations for children in this age group.

- 46 out of 58 eligible children (79%) had a record of the required vaccinations for children in this age group.

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

- 93% of patients were recorded as being up to date with vaccination against diphtheria compared to 93% regionally and 95% for DPHC nationally.

- 93% of patients were recorded as being up to date with vaccination against polio compared to
93% regionally and 95% for DPHC nationally.

- 76.5% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 82% regionally and 83% for DPHC nationally.

- 94% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 93% regionally and 94% nationally.

- 93% of patients were recorded as being up to date with vaccination against Tetanus, compared to 93% regionally and 95% for DPHC nationally.

- 36% of patients were recorded as being up to date with vaccination against Typhoid, compared to 43.5% regionally and 53% for DPHC nationally.

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

Our findings

Kindness, dignity, respect and compassion

- During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Curtains were provided in consulting rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The practice offered patients the services of either a female or a male GP. For any intimate examinations that were to be performed by a GP a chaperone was available. Arrangements were in place for women to access a family planning clinic in the community should they wish to use this service.
- There was an accessible toilet in the waiting area. A room was available for baby changing and/or breastfeeding.
- There were no patients available for us to speak with on the day of inspection. However, CQC comment cards had been completed by patients, prior to our visit. Views expressed indicated patients were satisfied with the care provided by the practice and that patients were able to get an appointment when needed.
- Patients commented on CQC comment cards that they felt involved in decision making about the care and treatment they received. We received 22 completed comment cards, 20 of which gave positive feedback about the service. Patients 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. One card gave feedback on the dental service, which is provided within another part of the same building. However dental services were not included in this inspection. Another card gave comments on actions following missed appointments, which was negative in nature.
- Results from the latest Defence Medical Services Patient Experience Survey showed patients felt they were treated with compassion, dignity and respect. For example:
  - 84% of patients said the practice was good at listening to any compliments, comments or complaints.
  - 97% of patients found it easy to get an appointment.
  - 100% of patients said they thought reception staff were helpful.
94% of patients said they were happy with the information given to them by their doctor or nurse.

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 aligned with the views above.

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

Care planning and involvement in decisions about care and treatment

The clinicians and staff at the practice, under the leadership of the Senior Medical Officer, demonstrated that they recognised at all times that the more junior soldiers they provided care and treatment for, could be making decisions about treatment themselves for the first time. Staff demonstrated how they gauged the level of understanding of patients, avoided overly technical explanations of diagnoses and treatment and encouraged and empowered young patients to make decisions based on sound guidance and clinical facts. We saw this type of engagement and involvement across all treatment and in handover between GPs, nurses and physiotherapy staff.

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

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

Data received from the Defence Medical Services (DMS) mandated questions survey of July 2017 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:

97% of patients said they felt involved in decisions about their care.

100% of patients said they would recommend the facility to family and friends.

The data presented by the practice was not benchmarked against regional and national averages for DMS, or against the previous year’s performance.

Staff told us that interpreter services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Information leaflets were available in reception and these were updated and changed regularly to reflect national health campaigns running at certain times of year, for example, Stoptober and Sober for October health initiatives.
Patient and carer support to cope emotionally with treatment

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic. This was prominently displayed and accessible. For example, we saw posters which explained how to use a condom safely, another on symptoms that may suggest a sexual health screening appointment would be useful, information on access to contraception and information on the importance of completing any prescribed course of treatment.

- The practice did not proactively identify patients who may also be carers. There was no carers register in place. There were military welfare meetings with other professionals to discuss where extra support and care was needed.

- Patient information leaflets and notices were available in the patient waiting area which informed patients how to access a number of support groups and organisations.
Are services responsive to people’s needs?
(for example, to feedback)

Our findings

Responding to and meeting people’s needs

The practice staff told us they understood their population profile and had used this understanding to meet the needs of its population:

- A wide range of clinics were available to service personnel and their dependants, for example, physiotherapy, health checks, travel advice, well woman clinics and family planning advice. Pre and post-natal clinics were held at the practice every week. Patients were able to receive travel vaccines when required. The practice was a Yellow Fever centre and nurses had received training to support this.
- Patients could have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse. Patients requiring them could book a double GP appointment of 30 minutes.
- The practice had the facilities and equipment to treat patients and meet their needs.
- Same day appointments were available for those patients who needed to be seen quickly. We noted that two, 15 minute urgent appointments were held for ‘book on the day’ patients requiring to see a GP straight away, for example, children.
- Physiotherapists were employed within the practice. 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. Transport for patients to hospital appointments was available if needed.

Access to the service

- The practice was open from Monday to Thursday from 08.00 to 18.30. On Friday of each week, the practice closed at 12.00. ‘Sick parade’ (an opportunity for military patients to attend the practice for advice in person) took place at 08.00 each morning before clinics started at 08.30.
- The practice told us home visits were offered when clinical needs of patients made this necessary. The practice information leaflet reflected this.
- The practice provided three GP and nurse clinics each day between Monday and Thursday, with 15 minute appointments bookable from 08.30 to 09.45, 10.30 to 11.45, and 14.00 to 15.45. The last bookable appointment was 15.45. On Friday, there were morning clinics only.
- After these hours, patients were advised to telephone the nurse at Tidworth medical centre, where telephone cover was provided.
- If a patient needed to be seen by a GP, a request would be made by the triage nurse to the duty
doctor. If the duty doctor was at the military base in Poole, this would involve a journey of approximately 17 miles to the Poole surgery. If the duty doctor was at the military base in Blandford, this would involve a 12 mile journey to the Blandford surgery.

- After 18.30, patients were diverted to the NHS 111 service, or could visit Weymouth and Portland Community Urgent Care Centre, which was open from 08.00 to 23.00, seven days a week.
- Results from the Defence Medical Services Patient Experience Survey showed that overall patient satisfaction levels with access to care and treatment were high. For example:
  - 97% of patients said they found it easy to get an appointment.

We were not made aware of any complaints from patients regarding access to services beyond 15.45. We were not shown any audit of calls to Tidworth from patients at Bovington practice, or given any access to data on use of the local urgent care centre. We were told by the SMO that in the last two years there have been no requests to the Tidworth triage nurse to see a doctor between 16.30 and 18.30. We were told there have been occasional consultations on a Friday between 12.30 and 16.30 but that this is unusual.

**Listening and learning from concerns and complaints**

The practice had a system for handling complaints and concerns.

- Defence Primary Health Care had an established policy and the practice adhered to this.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.
- Evidence provided on the day demonstrated patients felt comfortable and knew how to complain if they needed to. Evidence confirmed that military rank would not be a barrier to patients raising issues with the practice. We saw that changes were implemented in response to patient feedback. For example, in response to feedback from a patient, which indicated they had felt ‘rushed’ when seeing a GP, the practice had extended GP appointments to 15 minutes from 10 minutes.
- There had been five complaints raised within the last 12 months. We saw that there were processes in place to share learning from complaints. Complaints were audited through the Common Assurance Framework (CAF). This was used to focus on improvements to the service and to ensure that designated standards were being met on the handling of complaints.
Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

- The practice had a vision to deliver quality care and promote good outcomes for patients. Consistent, safe and effective care was at the forefront of the vision for the practice. All staff we spoke with were content with their working environment. Staff acknowledged that their opinions, observations and views were heard.

- The practice had a mission statement; “Bovington medical centre staff are committed to providing safe, caring and effective services. Better healthcare, better deployability.”

- Staff we spoke with throughout the day could identify this mission statement, which was displayed in the waiting areas. The practice had a strategy and supporting business plan which was regularly monitored.

Governance arrangements

- The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. Some areas of governance required improvement.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. GPs had lead roles in key areas but much of the GP lead responsibility sat with the Senior Medical Officer (SMO).

- An understanding of the performance of the practice was maintained. The practice used the Common Assurance Framework (CAF) as a governance tool. However, the response to risk identified through this tool was not always addressed in a timely manner. Although risk associated with the practice being outside the perimeter of the base had been highlighted, staff did not have access to alarms that would alert, for example, the guard room of any emergency within the building. Staff did not have access to personal alarms.

- There appeared to be a lack of leadership in the management of the significant event reporting and recording process within the practice. We did not see a culture where staff were encouraged to report incidents. When asked about this, we were told that professional pride meant staff may be reluctant to report events.

- We saw that the section on significant events within the CAF was marked as amber, meaning there were some actions required, but were unable to see what these actions were. In respect of significant events, the SMO told us that four had been recorded in the past 12 months. Minutes of the practice meeting, held on 16 August 2017 did not include details of discussion of a significant event recorded on 26 July 2017. During inspection we found a number of events that should have been recorded using this system, but had not. Following inspection we found that approximately eight incidents had been reported in the past 12 months. This demonstrated the lack of oversight in this area of governance.
• The section regarding safeguarding within the CAF was marked as green, meaning no follow up governance or other action was required. This section also stated that meetings are held monthly with health visitors, so any safeguarding concerns can be shared. We found a safeguarding incident that was correctly raised by the practice, but there was no evidence that the matter had been discussed and shared with health visitors. It was confirmed during our inspection that access to DMICP for health visitors had lapsed as they did not use the system.

• The section of the CAF that covers staff background and DBS checks was marked green, indicating there was no follow-up or governance action required. At the time of our inspection, two nurses and two GPs had DBS checks which were out of date, i.e. were more than five years old. These had been requested by region at the beginning of September 2017 but had not been received at the time of our inspection.

• The section of the CAF for medicines management was marked as amber, indicating further action is required. When checked we found this was in relation to the staff cover of the dispensary and to the out-sourcing of prescriptions for fulfilment. This section of the CAF also stated that any significant events involving medicines should be reviewed and action taken. We found an incident involving accountable drugs was not managed in line with military policy on the safe management of accountable drugs.

• We found that there was a lack of evidence of practice meetings historically. For example, we saw that four sets of minutes for practice meetings were held on the MOSS system. These were from 26 April 2017, 3 July 2017, 19 July 2017 and 17 August 2017. There was no record of practice meetings prior to these dates. For clinical governance meetings, we saw that these had been held on 17 October 2016, 30 November 2016, 4 May 2017 and 3 August 2017. Other than these there were no records of clinical meetings.

• A programme of clinical and internal audit was used to monitor quality and to identify areas for improvements. However, results of audit were not always used to drive and deliver improvements in care for patients.

• There were appropriate arrangements for identifying and recording risks and issues. However, there was a lack of risk assessments in relation to the building and staff working.

• We did not see evidence from minutes of meetings, a structure that allowed for lessons to be learned and shared following significant events. We saw that staff were concerned that their professional standing would be compromised by reporting significant events. Although leaders told us they reassured staff this was not the case, evidence indicated that staff did not feel comfortable or supported when recording significant events.

Leadership and culture

• On the day of inspection the leaders in the practice told us they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, quality and compassionate care.

• There was a clear leadership structure and staff we spoke to said they felt supported by management. Staff told us the practice held regular meetings although evidence provided on the day suggested that meetings were not consistently held.

• Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at meetings.

• The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included training for
all staff on communicating with patients about notifiable safety incidents. The GPs said they encouraged a culture of openness and honesty. We found that the practice had systems to ensure that when things went wrong with care and treatment, they gave affected people reasonable support, information and a verbal and written apology if required.

- Throughout our inspection, we observed that the SMO at the practice held lead responsibility for a number of areas. There seemed to be little delegation or sharing of some of these duties. When we spoke with other clinicians they confirmed this was the case. We were made aware that the post of a military medical officer (GP) was gapped, and that this was being filled by a locum who had worked at the practice for approximately 12 months. The current GP complement provided 2.6 whole time equivalent GPs. Work was almost complete on the recruitment of a further part time GP, taking the GP complement to 3 whole time equivalent GPs. Clinicians within the practice acknowledged that should the current SMO leave or be away unexpectedly, things would be ‘fragmented’.

**Seeking and acting on feedback from patients, and staff**

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

- Patients through the Defence Medical Services surveys and the friends and family survey, and from any individual patient feedback received.
- Staff told us they could give feedback and discuss any concerns or issues with colleagues and management. Staff told us they were engaged to improve how the practice was run.
- Completed CQC comment cards from patients supported our findings, that there was an open door policy when it came to patient input and feedback. The practice responded quickly, honestly and openly to any patient complaints. We saw that complaints were reviewed to see if improvements could be made.

**Continuous improvement**

The practice leaders said there was a focus on continuous learning and improvement at all levels within the practice. We saw that audits were conducted, both clinical and operational, to help gauge performance and to identify areas for improvement. Not all audits were followed up by improvement actions, especially in cases were performance had fallen.