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

**Ratings**

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Requires improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services caring?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Requires improvement</td>
</tr>
</tbody>
</table>
Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at MRS Royal Military Academy Sandhurst (RMAS) on 22 September 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.
- Systems and processes to keep patients safe were not fully embedded at the practice; infection control and equipment testing required closer management. Other governance processes were not promoting patient safety as a priority.
- We saw several examples of collaborative working and sharing of best practice to promote better health outcomes for patients.
- There was a comprehensive programme of clinical audits including regular reviews of the service used to drive improvements in patient outcomes.
- 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). However, the systems in place for checking emergency medicines were not robust.
- 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. However, areas of staff training required updating to fully provide them with the skills and knowledge to deliver effective care and treatment. For example, training in infection control, chaperoning and safeguarding.
- The premises were clean and tidy. However, despite an infection control audit being undertaken the issues identified in the audit had not been actioned.
- Results from the patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Patients were positive about their interactions with staff and said they had been treated with compassion and dignity.
- Information about services and how to complain was available. The practice knew how to investigate and act on complaints received. However none had been received in the past two years.
- 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 provider was aware of the requirements of the duty of candour.

• The practice had a clear leadership structure. However, governance arrangements were not fully embedded.

The Chief Inspector recommends:

• Develop a system to ensure all staff receive training to carry out their duties effectively, including update training specific to their roles and induction training.

• Develop failsafe systems for testing and maintenance of medical equipment.

• Any backlog in note summarising to be treated as a priority to reduce risk to patients.

• Develop and embed systems to assess and monitor key risks including:
  o Ensuring that DBS checks and professional registers for staff are current.
  o Ongoing approach to timely notes summarisation.
  o Emergency medicines management.
  o Management of patient safety alerts.
  o Staff knowledge around the business continuity plan.
  o Improve the management of infection control to meet the requirements of The Department of Health national infection control guidance.

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.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong reviews and investigations were carried out.
- Although risks to patients were assessed, the systems to address these risks were not embedded. For example, the management of infection control and emergency medicines.
- Approximately 490 of registered patient records had not been summarised (22%). This included children’s notes.
- Not all staff who chaperoned had received an updated Disclosure and Barring Service (DBS) check.
- There was no process in place to ensure that Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and other patient safety announcements were understood by staff and that action had been taken to review patients as necessary.

<table>
<thead>
<tr>
<th>Inadequate</th>
</tr>
</thead>
</table>

**Are services effective?**

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

- Data shared with us before inspection showed patient health care was good.
- Staff were consistent in supporting people to live healthier lives through a proactive approach to health promotion and prevention of ill-health, and every contact with people was used to do so.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff we spoke with demonstrated competency in key mandatory training. However, staff training was not up to date in subjects such as infection control, safeguarding, and...

<table>
<thead>
<tr>
<th>Requires improvement</th>
</tr>
</thead>
</table>
chaperoning. Not all induction training had been completed.

- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients’ needs.
- The practice provided services for some dependants and children of military personnel. Data on the delivery of childhood immunisations and vaccinations was not available. This meant the practice were unable to provide assurances on the effectiveness of childhood health protection programmes.

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

- Data from the surveys showed patients gave positive feedback for all aspects of care.
- Information for patients about the service available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- We received 25 comment cards, all of which were positive about the standard of care received.

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

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- Patients commented they found it easy to make an appointment and there were urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had an effective system in place for handling complaints and concerns.

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

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

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

- An overarching governance framework supported the delivery of the strategy and good quality care. However, some arrangements to monitor and improve quality and identify risk required improvement. For example to effectively monitor and manage the business continuity plan, deliver updated staff training, ensure DBS checks and professional registers for staff are current and the effective checking of blood results.

- The provider was aware of the requirements of the duty of candour.

- There was a culture of openness and honesty. The practice had systems to effectively manage safety incidents, to share information with staff and ensure appropriate action was taken.

- The practice had proactively sought feedback from patients, staff feedback was sought through more informal processes and staff felt they had a voice. No formal staff survey was undertaken.
Our inspection team

The inspection was led by a CQC Lead Inspector. The team included the Chief Executive of CQC, a GP specialist adviser, a practice nurse specialist adviser, and a practice manager specialist adviser.

Background to MRS Royal Military Academy Sandhurst Medical Centre

MRS Royal Military Academy Sandhurst (RMAS) is located in Camberley and is the British Army Officer Phase 1 training establishment. The Medical Reception Station (MRS) is a Primary Healthcare Military Medical Centre situated on camp with a bedding down facility consisting of 12 beds. During normal working hours it is a medical centre where the population at risk is Phase 1 Officer Cadets, other course attendees, permanent staff and dependants that live in the catchment area. During the quiet hours, whilst there is phase one training taking place the bedding down facility is used and is accessible 24 hours a day. Outside the training calendar the MRS is closed and the out of hour’s service is used. The camp has a highly fluid population. The officer training cadet population has a thrice yearly outflow of approximately 225 in April, August and December and a thrice yearly inflow in January, May and September. Fifty percent of the RMAS staff and families move every summer. The practice extends its reach outside the academy with external exercises and training. The medical officer (MO) and combat medical technicians (CMT) are deployed with up to 500 officer cadets, instructors and support staff.

In addition a primary care rehabilitation facility is provided. Physiotherapy is available for military personnel only. Dependants are referred to Frimley Park Hospital.

At the time of inspection, the patient list was approximately 2,200. Facilities are provided on two floors and the practice is fully accessible by a passenger lift.

At the time of our inspection, the practice had three full time GPs, 11 nurses, a pharmacy technician, three health care assistants and five combat medics (the work of a military medic has greater scope than that of a health care assistant found in NHS GP practices). The practice was led by a practice manager and supported by number of administrative staff. The centre also had four physiotherapists providing primary care rehabilitation services via physiotherapy and exercise training. The bedding down unit was open 24 hours a day and was manned by a nurse and health care assistant overnight.

The centre was open from Monday to Friday 07:30 to 16:30. Between 07:30 and 08:00 a walk in ‘sick parade’ was available for urgent appointments for military personnel. From 16:30 until 18:30 ‘shoulder cover’ was provided for any urgent cases. After these times outside of practice hours, a 24 hour NHS advice line is available by dialling 111. The nearest general NHS hospital was located at Frimley Park.
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 range of information we hold about the practice.

We carried out an announced visit on 22 September 2017. During our visit we:

- Spoke with a range of staff, including three GPs, the practice manager, the pharmacy technician, four practice nurses, two medics, staff from the physiotherapy department and three administrative staff. We were able to speak with three 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?
Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. 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. The practice had carried out a thorough analysis of the significant events and saw they were discussed within the practice and highlighted to all members of staff. They were a regular agenda item for the practice meetings held monthly and at the weekly clinicians meetings.

There were a number of ways in which staff kept themselves updated on Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and other patient safety announcements. However, there was no overall assurance process in place to ensure all staff had understood and, where necessary, acted on these alerts.

Overview of safety systems and processes

The practice had systems, processes and practices in place to minimise risks to patient safety. However some improvements were needed;

- 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 and a deputy lead member of staff for adult and children’s safeguarding. There were 550 dependants within the current population at risk of which 300 were children.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding. All GPs had received training to level three, however there were some gaps identified in level one and two training for some administrative staff, medics and nurses.
- We looked at evidence to show how the practice used information available to monitor safety. Every clinical area had the safeguarding policy on display. The policy was reviewed in July 2017 and covered contact details and referral process for both the Surrey and Berkshire and West Hampshire CCG’s and was easy to follow.
- Safeguarding/welfare meetings were attended by GP’s, nurses, the welfare officer and any other multi-disciplinary team member that may be needed. Patient records were annotated onto DMICP during the meetings and read coded appropriately. There was a safeguarding/welfare spreadsheet with case review notes mirroring DMICP entry with a monthly summary of each case.
- A notice in the waiting room advised patients that chaperones were available if required. All clinical staff acted as chaperones if required. They had not all received an updated 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). Admin staff did not have DBS clearance and no risk assessment in place so they were not used.

We observed the premises to be clean and tidy. The medical centre was cleaned by an outside agency. The practice manager undertook a monthly walk round/cleaning audit, however documentation and actions regarding this were not complete.

- One of the practice nurses was the infection prevention and control (IPC) lead, but had not had any formal training. This had been articulated on the medical centre risk register but had not been actioned to date by Defence Primary Health Care (DPHC) headquarters. Advice was sought from the regional infection prevention teams to keep up to date with best practice.
- There was an IPC protocol in place but not all staff had received up to date training.
- Annual IPC audits were undertaken, the last in September 2017, and issues identified. However there was no evidence that action was taken to address any improvements required. For example the audit had been emailed to all staff with tasks to be completed such as all soap dispensers to be cleaned as they were soiled and not wall mounted. This had not been completed.
- Records of cleaning were not complete and clinical rooms did not have notices to state levels of cleaning required or any check sheets. The lead member of staff responsible for IPC was unsure when the last deep clean had been undertaken.
- Clinical waste was stored outside in a locked storage area, however we found a bag of waste in an unlocked storage area next to this, the bag had been left on the top of containers of drinking water which were used for the drinks dispenser within the practice.
- Whilst we evidenced that clinical waste was recorded properly for disposal the records were not fully complete.

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

- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had undertaken continuing learning and development.
- Dispensary staff showed us standard operating procedures that covered all aspects of the dispensing and medicines management processes (these are written instructions about how to safely dispense and manage medicines).
- Systems were in place to ensure doctors signed repeat prescriptions before the medicines were dispensed and handed out to patients. Dispensary staff identified when medicine reviews and blood tests were due and alerted the GP to any issues before a medicine was supplied.
- The pharmacy technician worked alone and most prescriptions were dispensed without a second check; however, staff described a process for ensuring second checks when dispensing certain medicines, for example controlled drugs.
- Blank prescription forms and pads were securely stored and there were systems in place to record their use. The standard operating procedure did not direct the staff to audit the accounting of blank prescription stationery, therefore the procedure did not identify if stock went missing.
• There was a process for recording near misses in the dispensary. Staff described an open and transparent approach to reporting medicine incidents. The practice investigated significant events and made changes to minimise the risk of repeating errors.

• The practice did not have a robust system to deal with medicine, medical device and patient safety alerts. Alerts were received via an automated system from Defence Primary Healthcare (DPHC) headquarters to the practice manager. Any alerts that required action were printed off and passed to the pharmacy technician who checked and kept them in a folder but these were not logged. There was no failsafe system in place for when they were away. We saw a spreadsheet that logged alerts but this had not been maintained with the last entry being in January 2017. There was no overall assurance system in place to confirm that all staff had received, read, understood and where required, acted on alerts.

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

• Patient Group Directions (PGDs) had been adopted by the practice and governance was in place to ensure that they were used safely.

• We saw two store rooms where medics kept their equipment and medication for use on medical cover for training exercises. A check of the medical bags used by the medics showed medication was not kept in a temperature controlled and monitored environment and the medicines were not labelled as per policy for single pack issue to a patient. The packs had been split and were not issued in line with DPHC protocols and policy.

• The dispensary provided a responsive service to patients. When the dispensary was closed, patients could take their prescription to a local community pharmacy.

The practice conducted regular medicine audits, for example, antibiotic prescribing audit, repeat prescribing audit and medicines management risk assessment audit. The practice was being proactive about asking secondary care providers for shared care agreements. This made sure that patients on high risk medicines were receiving safe care. We saw evidence that appropriate alerts were raised in the DMICP record and the condition was correctly coded within the active problems section. We also saw an audit that had been completed to ensure safe practice. Consultation entries confirmed regular review in primary care and correct scheduling and review of appropriate blood tests. A shared care agreement had been completed and appropriate instructions were available to guide the management of patients. We saw evidence that showed that prescriptions were only issued if this was the case, with supply limited to one month on each prescription.

The staff had access to emergency medicines and equipment in the medical centre. The emergency trolley was checked regularly however, we found two cylinders of oxygen and a medicine used for epilepsy which was out of date and not suitable for use on the emergency trolley.

Recruitment checks had been undertaken on civilian staff prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. However, updated checks of the professional register for nurses and updated DBS checks for all relevant staff had not been undertaken.

Military note summarising had not been completed, approximately 350 sets of military patient notes were awaiting summarising. Dependants completed a questionnaire when registering with
the practice which was then placed into a folder by the administration team but not summarised. At the time of the inspection there were 80 such questionnaires with no action taken. When paper records subsequently arrived they are put into a male/female drawer pending summarising by the clinicians. At the time of the visit there were 140 such records haphazardly stored awaiting summary, these included children’s notes. No plans were in place to address this. We were told that this was due to summarising cadet’s notes as a priority.

**Monitoring risks to patients**

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

- The practice had a proactive approach to anticipating and managing risks using a risk register, alongside a monthly meeting where all staff were encouraged to raise any potential risk that may have arisen from an SEA. There was also a weekly management meeting to brainstorm risks and issues.
- There was a health and safety policy available.
- The practice had a fire risk assessment, and regular fire drills were carried out. There were designated fire marshals within the practice. Fire equipment was checked regularly, however we saw one extinguisher which had not been checked since 2014. This was located in the flat at the back of the practice.
- Not all electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. An external audit of equipment care had been undertaken in September 2016 and had a ‘red’ failure for various reasons and was due to be re-inspected within 3 months. There was no evidence that this had taken place or followed up by the practice.
- The practice had a risk assessments to monitor safety with 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.
- Despite daily checks being completed on equipment and the emergency trolley we saw medicines and oxygen cylinders that were out of date.

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

The practice had adequate 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.
- The practice had a defibrillator available on the premises and oxygen with adult and children’s 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.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. However, it was not clear if staff had read it, knew its location or had training on it with the last record of any consultation of its context being in April 2017.
• Alarms were fitted in each clinical area and sounded in both the relevant corridor and the administration area. Toilets were also fitted with patient alarms.
Are services effective?  
(for example, treatment is effective)

Our findings

Effective needs assessment

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients’ needs. Regular clinical meetings were held and we viewed minutes from meetings which confirmed that NICE guidance across several clinical domains had been discussed. Peer review between GPs further ensured that guidelines were followed.

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 4 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 70% of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control.
- There were 28 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. 90% had a record for their blood pressure in the past nine months. Of these patients with hypertension, 100% had a blood pressure reading of 150/90 or less.
- 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 periodic audiometric hearing assessment was below average compared to 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:

- 100% of patients had a record of audiometric assessment, compared to 97% regionally and 99% for DPHC nationally.
- 67% of patients' audiometric assessments were in date (within the last two years) compared to 78% regionally and 87% for DPHC nationally.

There was evidence of quality improvement including clinical audit:

- An ongoing programme of clinical audit was in place and demonstrated a commitment to improving outcomes for patients at the practice. We saw 29 audits had been undertaken in the past 12 months. Audits undertaken to date were cyclical and were relevant to the needs of registered patients. For example we saw an audit with regard to patients with non freezing cold injuries (NFCI). This was pertinent as military personnel, including those in training, were at increased risk from cold related injuries. The audit was undertaken to determine whether the management of NFCI presentation at Sandhurst complied with best practice. Following the audit recommendations were put into place to drive improvement. This included better use of the appropriate coding on DMICP, the use of templates to ensure the right information was captured, and obtaining some further equipment for assessing for NFCI. This was noted to be re audited in 12 months' time.

- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. When we reviewed the CAF we saw that any areas requiring further action or updating were not being managed effectively. We also noted that the practice had not used this self-assessment tool appropriately, which did not aid the effective management of areas requiring improvement. For example the maintenance of the DBS register.

**Effective staffing**

Evidence reviewed showed that not all staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However, there was no evidence to confirm these were being completed and the induction programme used was outdated. Locum staff were seen to have the mandated minimum induction and checks in place.

- Staff received some training that included: safeguarding, fire safety awareness, basic life support and information governance. However, not all staff had received updated training in subjects such as infection control, safeguarding and chaperoning.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training including an assessment of competence. Some medics had been trained to administer vaccines and their competency was monitored by a nurse. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes.

- We spoke with medics who said they were well supported and were able to ask for advice if required. The medics assessed “fresh cases” (patients being seen for the first time for a certain issue). There was no daily clinical oversight in place to monitor and discuss decisions made and...
treatment given by the medic.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. Information was shared between services, with patients’ consent, using a shared care record. However, because approximately 490 (22%) of registered patient records had not been summarised, the shared care record was not up to date for these patients.

- From the sample of anonymised patient notes we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services, or when discharging junior soldiers from the armed forces due to medical reasons.

- Patients seen by the out of hours service (OOH) were required to present to the practice, if practicable, the next day for review. New cases were initially seen by a medic but more complicated and follow up cases were dealt with by a GP. The GP undertaking clinic on that day maintained clinical oversight of consultations delivered by the medic, in parallel with the medic on duty to provide support and to ensure the appropriate care was given.

- Reports were usually received from the OOH service within 48 hours 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.

- Sandhurst was rated as good by Ofsted in their most recent report for the management of cadets. The practice engaged with all forms of welfare and engaged with the rehabilitation platoon to ensure early intervention and to aid recovery and return to training.

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.

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 followed up any areas of concern, such as raised blood pressure.

• The practice offered basic sexual health advice including the issue of free condoms and referred on to local clinics in the community for more comprehensive services including family planning.

• Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50-64 years who were entitled to breast screening. The number of women aged 50-64 whose notes recorded that a cervical smear had been performed in the last 3-5 years was 17 out of 21 eligible women. This represented an achievement of 81%. 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.

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 patients using this practice:

• 87.5% of patients were recorded as being up to date with vaccination against diphtheria compared to 94.5% regionally and 95% for DPHC nationally.

• 87% of patients were recorded as being up to date with vaccination against polio compared to 94% regionally and 95% for DPHC nationally.

• 67% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 81% regionally and 83% for DPHC nationally.

We were advised that statistics were low with regard to hepatitis A and B due to there being a national shortage of the vaccine at the present time.

• 80% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 94% regionally and 94.5% nationally.

• 87.5% of patients were recorded as being up to date with vaccination against Tetanus, compared to 100% regionally and 100% 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.

• The practice provided services for some dependants and children of military personnel. Data on the delivery of childhood immunisations and vaccinations was not available. This meant the practice were unable to provide assurances on the effectiveness of childhood health protection programmes.
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 male GP at the practice, a chaperone was always available. Arrangements were in place for women to access a family planning clinic in the community.
- There was an accessible toilet in the waiting area. A room was available for baby changing and/or breastfeeding.
- We were able to speak with three patients. They told us they thought the care was good and said they were able to get an appointment when needed.
- 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 latest Defence Medical Services Patient Experience Survey showed patients felt they were treated with compassion, dignity and respect. For example:
  - 68% of patients said the practice was good at listening, 1% said no and 30% said it was not applicable.
  - 95% of patients said if family, friends and colleagues could use the practice, they would recommend it to them, 4% said it was not applicable and 1% said no.

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

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.

**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 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.

- 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 form the patient experience survey, February to May 2017 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example from 79 surveys returned;
  - 76% of patients said they felt involved in decisions about their care, 15% said they were not involved and 9% said it was not applicable.

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

- The practice provided a service to 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. We saw notices in the reception areas informing patients this service was available.

**Patient and carer support to cope emotionally with treatment**

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic was prominently displayed and accessible.

- The practice proactively tried to identify patients who were also carers although none were registered. The practice were keen to make them identifiable so that extra support or healthcare could be offered as required. Patient information leaflets and notices were available in the patient waiting area which informed patients how to access a number of carer support groups and organisations.
Are services responsive to people’s needs?  
(for example, to feedback)

Our findings

Responding to and meeting people’s needs

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

- A wide range of clinics were available to service personnel and their dependants, for example, minor surgery services, physiotherapy, 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 20 minute appointments with the practice nurse. Patients requiring them could book a double GP appointment of 30 minutes.

- Same day appointments were available for those patients who needed to be seen quickly. Appointments for children were always available on the day.

- Referrals to the physiotherapists were made by the GPs and the average waiting time for an appointment was less than one week.

- There were accessible facilities which included interpretation services when required. Transport for military patients to hospital appointments was available if needed.

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

- The practice used a text reminder service to inform patients of hospital appointments.

- The practice trialled an evening clinic one evening per week but this was cancelled due to lack of uptake.

- Staff from the medical centre attended the local community forum for dependants to give briefings on services and listen to feedback.

Access to the service

The centre was open from Monday to Friday 07:30 to 16:00. Between 07:30 and 08:30 a walk in ‘sick parade’ was available for urgent appointments where patients were triaged by a GP or a nurse. A duty GP was always available daily for urgent appointments. From 16:30 until 18:30 ‘shoulder cover’ was provided for any urgent cases with a GP being available within 15 minutes. After these times outside of practice hours, a 24 hour NHS advice line was available by dialling 111. The nearest general NHS hospital was located at Frimley Park.

We spoke with three 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. From 79 returned surveys

- 73% of patients that this applied to said that their appointment was at a convenient time, 6% said no it wasn’t at a convenient time and 20% said it did not apply to them.

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

**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. No complaints had been received in the past two years. We saw that information was available to help patients understand the complaints system in the practice itself, displayed on the walls and within the practice booklet.
Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Requires improvement

Our findings

Vision and strategy

The practice had a vision to deliver quality care and promote good outcomes for patients. There was a clear staffing structure; staff were aware of their own roles and responsibilities.

Governance arrangements

On the day of our inspection, we found that not all staff had the knowledge or experience to ensure appropriate governance arrangements were in place to support the delivery of good quality care, for example:

- There were insufficient arrangements in place for identifying, recording and managing risks and issues, and for implementing mitigating actions. For example, patients were at risk of harm because systems and processes were not in place, to effectively monitor and manage infection control, deliver updated staff training, ensure DBS checks and professional registers for staff were current, ensure staff understanding of the business continuity plan, the effective checking of blood results and the maintenance of equipment.
- The systems in place for ensuring medicines, oxygen, stored fluids (eyewash) and dressings were disposed of and replenished when they were out of date was not robust.
- Our findings on inspection indicated that the DMS Common Assurance Framework (CAF) was being used as a self-assessment tool, adopting a policy checking approach, rather than using the CAF as a management interrogation tool to check the integrity and stability of safety measures, designed to reduce the risk of harm to staff and patients using the practice.
- Robust systems were not in place to monitor patient safety updates and alerts sent by the Medicines & Healthcare products Regulatory Agency (MRHA).
- Notes summarising was not effectively managed.

Leadership and culture

On the day of inspection the leaders in the practice were not able to demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. However evidence we gained on the inspection day and from communications with the practice prior to the inspection did not always support this.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The practice manager
encouraged a culture of openness and honesty. The practice gave affected people reasonable support, truthful information and a verbal and written apology.

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with welfare workers to monitor vulnerable patients.
- Staff told us the practice held regular 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 and supported in doing so.
- Staff said they felt respected, valued and supported.

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

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

- Patients through the patient experience survey.
- Through complaints and compliments received
- There was no formal staff survey undertaken although feedback from staff was gained generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues.
- RMAS has its own webpage called The Wishstream. This has extensive information about RMAS as a whole but also has a medical and dental section which is updated on a regular basis. It provided a range of information regarding clinics, services available and it also had all contact numbers and opening hours. The medical centre worked closely with the HIVE, welfare and the community centre. The medical centre staff were actively involved in all community meetings including the Additional Needs support group meetings and the local community forums.

**Continuous improvement**

The practice was a training practice. The teaching and support was embedded. We spoke with the foundation year two doctor who was there on the day, they spoke highly of the support and level of teaching they received.