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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<tbody>
<tr>
<td>Are services safe?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Good</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>Requires improvement</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Good</td>
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Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Shrivenham Medical Centre on 19 October 2017. Overall, the practice is rated as requires Improvement. Our key findings across all the areas we inspected were as follows:

- An effective system was in place for managing significant events and staff knew how to report events using this system.
- The management of risks was comprehensive and recognised as the responsibility of all staff.
- The arrangements for managing medicines minimised risks to patient safety.
- Staff were aware of current evidence based guidance and they referred to this guidance to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- Clinical audit had not been consistent. An audit calendar had been developed and audit had started to embed in the practice culture. There was evidence that audit was starting to have an impact on outcomes for patients.
- Results from patient feedback showed patients were treated with compassion, dignity and respect, and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The patients had access to a variety of health leaflets and information.
- Patients found it easy to make an appointment and urgent appointments were available the same day.
- There was a clear strong leadership structure and staff felt engaged, supported and valued by management.
- The practice had robust governance systems in place. These systems had been developed and introduced in the last year and all staff understood their role and responsibilities in the governance structure.
- Staff were aware of the requirements of the duty of candour and complied with these requirements.
- The building was not suitable as a medical centre. There was a history of vermin infestations and the treatment room did not meet best practice guidance for undertaking minor surgical procedures.
We identified the following notable practice, which had a positive impact on patient experience:

The practice recognised the importance of managing sick chits (temporary sickness absence notes) to ensure the safety of patients and other military personnel. They had adopted a robust system to send copies of all sick chits to the unit commander if a patient had been signed off from a certain task. The clinical detail remained confidential between the GP and the patient, so adherence to Caldicott principles was maintained.

The Chief Inspector recommends:

- A review of the premises to ensure treatment and care is always delivered in a safe, well maintained and adequately equipped environment.
- Ensuring patients have access to a GP between the hours of 08:00 and 18:30.
- Consideration is given to developing a patient participation group.

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

### The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**
The practice is rated as requires improvement for providing safe services.

- An effective and robust system was embedded for reporting and recording significant events. Significant events were reviewed at team meetings so lessons were shared with the wider staff team.
- When things went wrong patients received support, relevant information and a written apology. They were advised about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined systems, processes and practices in place to keep patients safe and safeguarded from abuse. All staff, including non-clinical, staff were trained to the appropriate level for their role.
- Risks to patients were assessed and well managed.
- Medicines were managed safely.
- Effective recruitment processes were in place.
- An Exercise Rehabilitation Instructor was not in post because the rehabilitation room was too small to provide for an extra member of staff.
- The building was not suitable as a medical centre. For example, there was a history of vermin infestations and the treatment room did not meet best practice guidance for undertaking minor surgical procedures.

<table>
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<th>Good</th>
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**Are services effective?**
The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above average.
- Practice staff assessed needs and delivered care in line with current evidence based guidance.
• A programme of clinical audit was in the early stages of development and most audits were on their first cycle.
• The practice valued and encouraged education by providing staff with training opportunities to deliver effective care and treatment.
• Patients were actively supported to live healthier lifestyles through health promotion and wellbeing initiatives.
• There was evidence of appraisals and personal development plans and support for all staff.
• There was some gaps in clinical coding.

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

• Patients were treated with compassion, dignity and respect, and were involved in decisions about their care and treatment.
• The patient’s experience survey demonstrated that patients were satisfied with the care and attitude of staff at the practice.
• Information for patients about the service available was accessible.
• Systems were in place to maintain patient and information confidentiality. However, the layout of the building was not ideal to support patient privacy at all times.
• We received six comment cards and interviewed one patient. All of the feedback was positive about the standard of care received.

Are services responsive?
The practice is rated as requires improvement for providing responsive services.

• The patient’s individual needs were central to the planning and delivery of their care.
• The service was flexible to ensure patients’ needs were met in a timely way. The complexity of the population meant the practice were successfully providing treatment and care at very short notice.
• Patients found it easy to make an appointment and urgent appointments were available the same day.
• A physiotherapist was employed at the practice. All referrals to this service were made by the doctors and the average waiting time for an appointment was two weeks.
• Effective medical cover was not in place on weekdays.
between the times when the practice closed and NHS 111 commenced providing medical cover.

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

- The practice had had a turbulent few years until a fully established workforce, including a practice manager had been recruited over the last 12 months.
- Significant improvements had been made to the governance of the practice in order to effectively monitor quality and safety. The practice now had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- There was a very strong leadership structure and staff felt engaged, supported and valued by management.
- There were effective systems and processes in place to identify and monitor risks to patients and staff, and to monitor the quality of services provided. Regular practice and multi-disciplinary team meetings took place, which supported effective communication and shared learning within the team.
- The practice was aware of and complied with the requirements of the duty of candour. A culture of openness and honesty was promoted at the practice.
- The practice sought feedback patients, which it acted on.
Our inspection team

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

Background to Shrivenham Medical Centre

Shrivenham Medical Centre is located near to Swindon in the Defence Academy of the UK. It provides primary health care and occupational health to tri service military personnel registered at the practice. It also provides a primary medical service to entitled military personnel based at or on training courses at the Defence Academy, including entitled personnel from overseas. Dependants of military personnel are not treated at the practice. The patient list varies over a 12 month period as a number of training courses take place throughout the academic year. At the time of the inspection the registered patient list was 872.

The medical centre operates from a single storey building and is co-located with the Defence Academy Dental Centre. In addition to routine and emergency GP services, the medical centre offers: physiotherapy by referral; well woman and well man clinic; medicals, including aircrew medicals; vaccination and travel advice; family planning; smoking cessation and minor surgery. Maternity and midwifery services are provided by NHS practices and community teams.

At the time of our inspection a full civilian staff team was in post comprising a senior medical officer (SMO), civilian GP, two practice nurses and physiotherapist. The medical centre was led by a practice manager supported by three administrative staff.

The centre was open from 08:00 to 16:30 Monday, Tuesday, Wednesday and Friday. It opened on Thursday from 08:00 to 13:00 (until 16:30 for emergencies only). Emergency access was available for service personnel from 08:00 to 08:30 each morning. The practice operated an appointment only system only with emergency slots available each day.

The arrangements for access to medical care outside of opening hours were displayed and outlined in the practice leaflet and directed patients to the Swindon NHS Walk-In Centre and to the Swindon Urgent GP/Nurse Centre. After 18:30 patients are advised to contact NHS 111.

Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services
during inspection, we will report them by making a recommendation for action to the Surgeon General’s office.

**How we carried out this inspection**

Before the inspection we reviewed a range of information CQC holds about the practice.

We carried out can announced inspection on 19 October 2017. During the inspection we:

- Spoke with a range of staff including the SMO, practice manager, GP, senior practice nurse, practice nurse, administrator and physiotherapist. We also spoke with the station commander.
- Spoke with one patient who was attending the practice during the inspection.
- Reviewed six 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, including anonymised patient records.
- Looked at information used to monitor the quality and safety of services.

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 an effective system in place for reporting and recording significant events.

- The senior medical officer (SMO) was the lead for significant events. All staff were familiar with using the standardised Defence Medical Services (DMS) wide electronic system used to report, investigate and learn from significant events, incidents and near misses. The practice manager actively encouraged staff to use the system to report events, including of quality improvement initiatives.

- Using examples, staff illustrated how significant events were managed. For example, a patient contracted clostridium difficile (C.diff) following a prescription of antibiotic treatment in the dental centre. The matter was investigated and the Surgeon General carried out a root cause analysis, involving the regional infection and prevention (IPC) nurse. As a result training was provided to prescribing clinicians, the IPC policy was revised to include C.diff and the dental centre reviewed its practice in relation to antibiotic prescribing. A specific cleaning routine was introduced and the cleaning team informed.

- A significant event managed at the practice was reported in the March 2017 Defence Primary Health Care (DPHC) monthly newsletter so the lesson learnt was shared nationally with other medical centres. It involved the risks associated with use of non-steroidal anti-inflammatory drugs (NSAID) in the third trimester of pregnancy.

- A root cause analysis of significant events was carried out once a month at a practice meeting or more frequently if needed. We noted from the meeting in July 2017 that two new significant events were discussed.

- The practice manager had the lead for managing national patient safety alerts. They reviewed logged and disseminated the alerts to staff. Alerts were also discussed at practice meetings. For example, an alert in relation to the medicine, Rivaroxaban (used to treat deep vein thrombosis), led to the practice undertaking and identifying the patients prescribed it. Patients were then contacted and asked to check the packaging.

- When unintended or unexpected safety incidents happened patients received reasonable support, truthful information, a verbal and written apology, and were advised about any action taken to improve processes in order to prevent the same thing happening again. The previously mentioned significant events are examples.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
• Arrangements for safeguarding reflected relevant legislation and local requirements. The SMO was the lead member of staff for safeguarding. Effective deputising arrangements were in place.

• The staff we spoke with demonstrated they understood their responsibilities in relation to safeguarding and had received relevant child and vulnerable adult safeguarding training. Doctors had received level three training in child safeguarding.

• The practice had systems in place to monitor patients who were considered vulnerable, ‘at risk’ or patients who could be subject to safeguarding arrangements. Staff provided us with examples and it was clear they worked closely with the unit commanders if there was concern about any patients. The SMO and/or practice manager attended the unit health committee meeting with unit commanders every month where concerns about vulnerable patients were discussed. An alert facility within the patient record system; Defence Medical Information Capability Programme (DMICP) ensured any risks showed clearly when the medical record was opened. A vulnerable patient register was established.

• Notices were displayed advising patients that chaperones were available if required. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

• An infection prevention and control (IPC) policy was in place. Both nurses had completed IPC training. The lead nurse for IPC had been in post since June 2017. They had not completed IPC training specific to the role and were sourcing and costing courses at the time of our inspection. IPC audits were carried out every year and the last audit was completed in May 2017. It identified concerns with the effectiveness of handwashing facilities in the main treatment room and female staff toilet.

• Appropriate standards of cleanliness and hygiene were in place. The IPC lead monitored the environmental cleaning that was carried out by a contractor. A cleaning audit took place in October 2017. Actions were identified and a repeat audit was due in January 2018.

• All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. The practice manager was the lead for waste management and had reviewed and revised the approach to waste management to ensure it was managed and disposed of appropriately.

• Effective arrangements for managing medicines, obtaining, prescribing, recording, handling, storing and the security of medicines. The SMO was the lead for medicines management, supported by the practice manager who monitored policies and protocols. One of the nurses was responsible for monitoring stock and ordering. Medication was outsourced to Lloyds Pharmacy, who delivered each day. This included controlled drugs. Medication was stored securely and appropriately documentation was maintained to ensure the patient received it safely and it was accounted for.

• The cold storage unit for medicines, including vaccinations was monitored daily to ensure temperatures were within the correct parameters. Oxygen and Entonox were in-date. No ‘grab bag’ was held at the practice as the practice did not act as the first responder for the station.

• Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The PGDs for vaccinations were signed and in-date. The PGDs for primary care treatment were out-of-date. The practice manager confirmed shortly after the inspection that these had been reviewed and up-dated. A system was in place to
• The full range of recruitment records for permanent staff was held centrally. However, the practice manager could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. They also monitored each clinical member of staff’s registration status with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

**Monitoring risks to patients**

Risks to patients had been identified.

• There were procedures in place for monitoring and managing risks to patients and staff safety, including a health and safety policy. The practice manager was the lead for health and safety and had completed relevant experience for the role.

• Staff were aware of their role in the reporting and management of incidents, including when and how to report in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

• The practice recognised the importance of managing sick chits (temporary sickness absence notes) to ensure the safety of patients and other military personnel. They had adopted a robust system to send copies all sick chits to unit commanders if a patient had been signed off from a certain task. This is important where the safety of the patient or their colleagues might be compromised where someone is temporarily unfit to perform a duty e.g. flying. The clinical detail remained confidential between the GP and patient.

• A risk register was established for the practice. A range of risk assessments were in place and had been reviewed within the last year. They included assessments for handling sharps, bodily fluid spills, sample handling, vermin and lone working. An asbestos risk assessment was carried out in 2007. A legionella risk assessment was conducted in September 2016 and the water temperatures were checked each month. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.

• The station health and safety department was responsible for the fire risk assessment, which was last completed in April 2015. Records showed the fire alarm and firefighting equipment were checked regularly. The practice manager was the fire marshal for the practice and confirmed the annual fire evacuation drill took place in March 2017.

• The station was responsible for the gas and electrical safety of the building and certificates were in place to show checks were current. Portable electrical equipment was checked on a regular basis to ensure the equipment was safe to use. The last portable appliance check was undertaken in June 2017.

• Concerns with the building, including fittings were well documented. Relevant statements of need (requests for improvement) had been submitted to Regional Headquarters (RHQ) in relation to the building. The building, a 1946 guardroom, was not suitable to function as a medical centre and this was outlined as an area of risk in the June 2017 biannual assurance report. The risks identified were in relation to damp, insufficient space, ergonomics, lack of sound proofing and a history of vermin infestations. Our review of the premises and equipment supported these concerns.

• We observed damp in the storage room for medicines and dry products; regular maintenance was required to manage it. A false roof had been installed in one of the clinic rooms due to a
A colony of protected bats lodging in the roof space and urine from the bats had trickled down one of the walls. Staff had also seen bats flying about the premises. Since the installation of the false roof staff said they had not seen the bats. The clinic room had since been refurbished, although a malodourous smell remained. There were a large number of various sized animal burrows and traps around the building. This issue was being managed by vermin control. Staff said they had not had an infestation throughout 2017.

- In addition, we found that the treatment room used for minor surgery was not in accordance with IPC best practice guidance; for example, the flooring needed attention and handwashing facilities were not suitable. Staff advised us that there was no facility for staff to shower or change. They used the accessible toilet or the shower in the dental centre. There was poor soundproofing throughout the premises and conversations could be heard in consultation rooms and at reception.

- The physiotherapy room was of an inadequate size to support further staff and the installation of a full range of equipment. Temperature control was inadequate and we were advised it was very cold in winter and reached a temperature of 30 degrees in the summer. The administrative office/reception was exceptionally small for the number of staff who used it. The receptionist’s computer was propped up on bundles of print paper. The computer screen needed to be lowered each time a patient came to reception and the receptionist had to stand on their toes to have a conversation with the patient at the reception hatch. Ergonomics had been identified on the risk register. The practice manager was working closely with the station commander regarding the current infrastructure concerns.

- The practice manager was the lead for equipment management and had a system in place to monitor when that equipment was due to be checked or calibrated. An ‘equipment care training regime’ was in place, meaning a piece of equipment was regularly discussed at the meetings to ensure staff knew how to use it.

- The practice manager closely monitored the staffing levels alongside the patient population to ensure there were sufficient numbers of staff to meet patient need. This was important as the Defence Academy population was subject to regular fluctuation throughout the academic year. The deficit with staffing was in relation to the rehabilitation team. There was one physiotherapist employed but no exercise rehabilitation instructor (ERI). This meant that the physiotherapist also took on the ERI role leading to a two to three week wait for patients to be seen.

- A triage system was in place for patients who presented without an appointment and a duty doctor and nurse were available throughout the day for patients with urgent health care needs.

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

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

- There was an emergency pull cord in all the consultation and treatment rooms which alerted staff to any emergency. These were tested regularly to ensure they were in working order.

- An emergency kit, including a defibrillator, oxygen with adult masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of their location. A first aid kit and accident book was available. Routine checks were in place to ensure the required kit and medicines were available and in-date. Medicines we checked were in date.

- The staff training records provided assurance that all staff received basic life support training on an annual basis.

- The practice had a comprehensive 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 on the staff intranet and additional copies were kept off the premises.
Are services effective?  
(for example, treatment is effective)

Good

Our findings

Effective needs assessment
The practice assessed needs and delivered care in accordance with relevant and current evidence based guidance and standards.

- Clinical staff were aware of evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE). Staff referred to this information to deliver care and treatment that met patients’ needs. They described how updates on NICE and medicines management were outlined in a newsletter circulated to clinical staff by the Defence Primary Health Care (DPHC) Team each month.

- NICE guidance was discussed at the monthly clinical meetings. Staff said the NICE guidance prompted the practice to undertake audits in relation to statin prescribing and the management of gout.

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 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.

It is noteworthy that approximately 33% of the patient population was static and the remaining two thirds were temporarily registered at the practice while undertaking a training course. This meant that diagnosis and agreed treatment plans may have been determined and were being managed at the patient’s regular practice. The practice provided the following examples of patient outcomes data to us from their computer system on the day of the inspection.

- There were three 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 two of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For all three patients the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

- There were 39 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. All 39 patients had a record for their blood pressure in the past nine months. Of these patients with
hypertension, 29 had a blood pressure reading of 150/90 or less. Patients were being supported to encourage them to make lifestyle changes in order to reduce risks associated with hypertension.

- The number of patients with long term physical or mental health conditions, who smoke and whose notes contained a record that smoking cessation advice or referral to a specialist service had been offered within the previous 15 months, was 208 which is 100% of the smoking patient population. The NHS target for this indicator is 90%.

- There were seven patients with a diagnosis of asthma. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. All seven patients had had an asthma review in the preceding 12 months which included an assessment of asthma control using the 3 Royal College of Physicians questions.

- There were 45 patients with a new diagnosis of depression in last 12 months, 33 had been reviewed within 10-35 days of the date of diagnosis. We noted that these reviews had not being coded consistently and staff told us that they were addressing this issue.

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 the instance of audiometric hearing assessment was below average compared to practices regionally and nationally. It is noteworthy that audiometric assessment is an occupational requirement and the responsibility of the patient’s regular practice. 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 July 2017 showed:

- 69.5% of patients had a record of audiometric assessment, compared to 99.9% regionally and 99% for DPHC nationally. Staff explained that many patients arrive at the Academy with an out-of-date audiometric assessment

- 69.5% of patients' audiometric assessments were in date (within the last two years) compared to 86.5% regionally and 86.3% for DPHC nationally.

The practice manager told us that, due to a long standing staffing shortage, quality improvement activity had not been consistent or embedded. An audit programme had started and 11 audits had been initiated in the last 12 months; some were in progress and most were on their first cycle. We noted from the practice calendar that repeat audits had been scheduled.

The range of completed clinical audits available that we looked at and discussed with staff included statin prescribing, breast screening, vaccine storage, antibiotic use, gout and asthma. In addition, a results handling audit had been undertaken and the practice had 100% compliance.

The following are some of these audits in further detail.

- The asthma audit was completed in June 2017. It took account of the 3 Royal College of Physicians questions, QOF, smoking status and national guidance. The audit showed the practice was not meeting criteria for having an asthma review in the last 12 months. Patients identified were contacted to arrange a review. Because of the transient population, a regular audit search was added to the clinical calendar. A repeat audit was added to the audit calendar for May 2018.

- Two antibiotic audits had been undertaken. Results showed the practice appropriately prescribed antibiotics 100% of the time. It also highlighted that some courses of antibiotics prescribed did not conform to guidance. Actions had been identified to address this and had been put in place. A repeat audit was added to the audit calendar for January 2018.

- Breast screening of women over the age of 49 was completed in October 2017. A number of
actions were identified, such as a biannual search of registered women over 49 and the negotiation of a protocol with the local NHS trust to acquire a copy of the mammogram result so it can be added to the patient's record.

- The clinical team met with the regional NHS midwife in September 2017 to review and agree working arrangements. This led to the development of a postnatal policy and an agreed communication safeguarding pathway given that a child will be registered separately to its mother at an NHS GP practice. Staff said this quality improvement initiative had led to a more effective and coherent service for pregnant patients.

- The processes to monitor patients prescribed high risk drugs (HRD). A HRD register was established and it included review dates for patients.

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

- An internal self-assessment quality assurance tool consisting of seven domains, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance. The CAF was formally introduced in September 2009 and since then has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery. When a CAF assessment is undertaken by RHQ it is referred to as a Health Governance Assurance Visit (HGV).

A CAF and HGA were completed in June 2017. The practice was rated as having substantial assurance overall with required action needed across six of the domains. The seventh domain (Care environment and amenities) was identified as requiring urgent action. An action plan was in place to address the work required to improve the practice and the practice manager was working through this plan in conjunction with the wider staff team, RHQ and the station commander.

This CAF showed significant improvements had been made since the outcome of a HGV undertaken in July 2015. The HGV assessed two domains in detail; safety and patient experience. The overall grading highlighted that no assurance was in place and immediate action was required.

**Effective staffing**

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

- The practice had a generic induction programme for all newly appointed staff that included the mandated training, such as safeguarding, health and safety and information governance. There was also a specific programme and training for new staff depending on their role, and a separate induction for locum staff. Staff had access to e-learning training and in-house training. Relevant competency checks were undertaken before staff engaged in practice or a procedure that was new to them.

- Records confirmed that over the last 12 months all staff had completed the mandated training required of them.

- Staff told us there was a culture of continuous learning and said the practice manager was supportive with releasing them for courses and/or updates. They also received role-specific training where appropriate, such as ear syringing training. Staff administering vaccines and taking samples for the cervical screening programme had received specific training including an assessment of competence. They could demonstrate how they stayed up to date with changes to the immunisation programmes.
• Nurses and doctors told us they maintained their own continual professional development (CPD). Learning and support needs of staff were identified through appraisal, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.

**Coordinating patient care and information sharing**

There were well managed systems in place to ensure effective coordination of patient care.

• 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. Read coding, a system used to support clinical encoding of patient details, including diagnosis was used by all clinical staff with access to patient records. We were advised that the coding of reviews for patients with depression did not always take place.

• The sample of anonymised patient notes we looked at was of a high standard. Notes included risk assessments, care plans, consultation records and investigation/test results. There was an appropriate summary screen of patients’ health needs on DMICP.

• We discussed with the practice manager the arrangements for summarising patient records, particularly given the transient patient population. It was ‘ad hoc’ and reliant on staff availability. Until the end of August 2017 summarising was up-to-date. The practice was now working through the summarisation of the notes for 500 students who joined in September. The practice manager highlighted that throughout the academic year there was a periodic turnover to the patient population of 1000. They were in the process of exploring peaks in the population so that searches could be aligned to prioritise the summarising of patients taking high risk drugs and/or patients with a need for a review.

• An administrator was responsible for scrutinising the patient records and this involved a check to ensure vaccinations, audiometric assessments etc were up-to-date. They also looked for notes that had not been summarised in the last two years and passed these to clinical staff for summarisation.

• We found the practice engaged with external health providers in an effective and timely way. Reports were usually received from the out-of-hours service (OOH) service within 48 hours of a patient having accessed treatment. These reports were scanned on to DMCIP and alerts sent to a doctor to ensure they were reviewed and appropriate follow up instigated if necessary. The reviewing doctor coded problems/conditions as necessary on DMCIP.

• A register was in place for samples sent to the laboratory. It was checked weekly and any outstanding results were followed up. Results received at the practice were logged, dated, stamped and scanned onto the patient’s record by the administration team. They were then passed to the doctor to review.

**Consent to care and treatment**

Staff sought patient 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. They accurately described the type of circumstances when the Mental Capacity Act would apply to their patient population.

• Where a patient’s mental capacity to consent to care or treatment was unclear, the doctor or practice nurse assessed the patient’s capacity and, recorded the outcome of the assessment.
Consent was recorded and coded for all consultations.

Supporting patients to live healthier lives

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

- All new patients to the practice were asked to complete an assessment form on arrival. The practice nurse followed up any areas of concern such as raised blood pressure.
- The practice took a pro-active approach to health promotion particularly in relation to patients at risk of developing a long term condition and those requiring advice on their diet, smoking habits and alcohol use.
- Health promotion information was displayed in the waiting area to promote specific issues relevant to the service population and its requirements. For example, there was a display on the impact of smoking.
- The practice participated in the station health fairs, which were held periodically to promote good health and lifestyle amongst the population and local community.
- Patients had access to appropriate health assessments and checks. Regular searches were undertaken for all patients aged 50-64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs. Flu vaccinations had been offered to all patients if they met the criteria.
- The number of women aged 25-49 and 50-64 whose notes recorded that a cervical smear had been performed in the last 3-5 years was 113 out of 119 eligible women. This represented an achievement of 82%. The NHS target was 80%.

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 September 2017 provides vaccination data for patients using this practice:

- 94% of patients were recorded as being up to date with vaccination against diphtheria compared to 95% regionally and 95% for DPHC nationally.
- 95% of patients were recorded as being up to date with vaccination against polio compared to 95% regionally and 94.9% for DPHC nationally.
- 84% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 83.4% regionally and 83% for DPHC nationally.
- 99% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 95.1% regionally and 94.5% for DPHC nationally.
- 95% of patients were recorded as being up to date with vaccination against Tetanus, compared to 95% regionally and 100% for DPHC nationally.
- 91% of patients were recorded as being up to date with vaccination against Typhoid, compared to 33.5% regionally and 53% for DPHC nationally.
Are services caring?

Our findings

Kindness, dignity, respect and compassion

- During our inspection we observed that staff were courteous and helpful to patients, and treated them with dignity and respect.
- Curtains were provided in clinic rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.
- Clinic room doors were closed during consultations. Conversations taking place in clinical rooms could be overheard from the corridor. Staff managed this by the use of a radio and discouraging patients from waiting in the corridor.
- Reception staff said that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The clinical staff were all female. Staff said no requests had been made by patients to specifically see a male clinician. If that did happen then the patient would be referred to another medical centre with a male clinician. A chaperone service was available.
- There was an accessible toilet in the building. A room was available for baby changing and/ or breastfeeding.
- The practice did not routinely provide home visits to patients. As an exception, the SMO carried out a home visit with a unit commander due to concern about the welfare of a vulnerable patient. This was an example of the practice acting with care and compassion to ensure a patient was safe and supported.
- We only had the opportunity to speak with one patient during the inspection and they stated they were very happy with their care. Results from the September 2017 Patient Experience Survey showed patients were satisfied with the practice. All patients said they would recommend the practice to their friends, family and colleagues.
- We received six completed comment cards prior to the inspection and spoke with one patient; feedback was very complimentary about the practice. Patients said that they felt involved in decision making about the care and treatment they received, felt listened to and had sufficient time to make an informed decision about the choice of treatment available to them.

Care planning and involvement in decisions about care and treatment

- Data received form the latest DMS patient experience survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The practice received a 100% rating in relation to receiving relevant information about their treatment, including involvement with making decisions about care.
- The data presented by the practice was not benchmarked against regional and national averages for the DMS or against the previous year’s performance.

- The practice provided a service to international military personnel and a translation service was available to clinicians if required. There were notices displayed in the patient waiting area about the translation service. The practice leaflet could be made available in alternative languages should the need arise.

Patient and carer support to cope emotionally with treatment

- Patient information leaflets and notices were available in the patient waiting area, which advised patients about how to access a number of organisations. The nurses provided a briefing for international military personnel when they first joined the Academy. The briefing included information about access to the welfare team and pastoral support.

- The practice proactively identified patients who had caring responsibilities for a dependant. A code was added to the patient record in order to make them identifiable so that extra support or healthcare could be offered as required.
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 the patients.

- The population at the Academy was complex, mainly due to the fluctuation throughout the academic year. The population had a higher upper age range than other stations. The average age range was 35-45 years, with the oldest patient aged 60.

- It was expected that students attending the Academy for short courses and not assigned to the Academy received their occupational health from the medical centre where their unit was based. This was not always the case and through scrutiny of patient records it was often identified that vaccinations and occupational medicals, for example, were out of date. Returning students to their parent unit was impracticable. In addition, students due to deploy often sought travel medicine at short notice. The practice always responded to these requests and we saw an example of this happen on the day of the inspection.

- In addition to routine and emergency GP services, the practice offered: physiotherapy by referral; well woman and well man clinic; medicals, including aircrew medicals; vaccination and travel advice; family planning; smoking cessation and minor surgery. Maternity and midwifery services were provided by NHS practices and community teams.

- Access to a doctor was good for patients; most patients were seen within 48 hours of requesting an appointment. Patients could have 15 minute appointments with the doctor and nurse. If needed, patients could book a double appointment of 30 minutes. Same day appointments were available for those patients who needed an emergency appointment.

- A physiotherapist was employed within the practice. Because there was no Exercise Rehabilitation Instructor in post patients referred to the physiotherapists had a two to three week wait for an appointment.

Access to the service

- The practice was open from 08:00 to 16:30 Monday, Tuesday, Wednesday and Friday. It opened on Thursday from 08:00 to 13:00 (until 16:30 for emergencies only). Emergency access was available for service personnel from 08:00 to 08:30 each morning.

- The arrangements for access to medical care outside of opening hours were displayed and outlined in the practice leaflet. It advised patients to attend the Swindon NHS Walk-In Centre or the Swindon Urgent GP/Nurse Centre. After 18:30 patients were advised to contact NHS 111. This arrangement was not in accordance with the DPHC policy on ‘shoulder cover’ which requires patients to have access to a GP between the hours of 08:00 and 18:30 every week.
Results from the Defence Medical Services Patient Experience Survey showed that overall patient satisfaction levels with access to care and treatment were high (score of 75% or more). For example:

- 90% of patients said they were able to book an appointment at an appropriate time.
- 97% of patients said they got to see or speak to the doctor or nurse of their choice.
- 80% of patients said they had seen a doctor urgently on the same day.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- The practice manager was the designated responsible person who handled complaints in accordance DPHC’s policy on the management of complaints. All clinical complaints were forwarded to the SMO or, in their absence, one of the other doctors.
- We noted that information was available in the waiting area to support patients understand the complaints system. How to make a complaint was summarised in the practice leaflet.
- Learning from complaints was shared at practice meetings. We noted from the minutes of the meeting held in July 2017 that a compliment received about the practice was discussed. There had been one complaint raised in the last 12 months. This was clinical in nature and had also been raised as a significant event. The documentation showed the complaint had been managed effectively and to the satisfaction of the patient. The lessons learnt had been shared widely across the DPHC.
- 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.
Our findings

Vision and strategy

The practice had undergone a significant period of change over the last 12 months. It had been without a consistent manager for two years until September 2016 and had also been short of key clinical staff. At the time of our inspection a full time practice manager had been in post for just over a year and the practice was almost fully staffed.

The complex population at the Academy created challenges for the practice. At the time of our inspection the assigned population was 872, which did not include international students and military personnel attending the Academy for shorter courses. In reality the total population was approximately 1400.

In addition, there was a lack of clarity about which international students were entitled to receive health care from the practice. This was important in terms of ensuring sufficient resources for the patient population and indemnity cover. This issue was compounded by students due to deploy turning up at the practice seeking treatment at short notice for travel medicine. Communication between the Joint Personnel Administration (JPA) and the practice regarding new cohorts of students due to arrive had not always been timely. We were provided with evidence to show that the practice was addressing these issues with the relevant departments, including the RHQ, JPA and station commander.

Staff said the practice was at a point now where it was delivering high quality care and promoting good outcomes for patients. It was working effectively to the DPHC mission statement of:

“Delivering a unified, safe, efficient and accountable primary health care for entitled personnel to maximise their health and to deliver personnel medically fit for operations”.

The practice had also identified its own aim:

“To provide the highest standard of health care to our patients within the limits of available resources”.

Governance arrangements

Over the last year the governance framework had been revised to ensure it was strong enough to support the delivery of good quality care. The practice manager used the CAF as an effective governance tool. Both a CAF and HGAV were completed in June 2017 and they showed significant improvements had been made to the service. We found that:

- There was a clear staffing structure and that staff were aware of their own roles and
responsibilities. Doctors and nurses had defined lead roles in key areas.

- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.

- Effective communication arrangements were in place with unit commanders. The practice manager attended a weekly meeting with the station commander and was actively engaged with pursuing plans for new premises. The SMO and/or the practice manager attended the unit health committee meeting each month. The station commander attended the practice meetings on a regular basis.

- A complete restructure of health and safety procedures had taken place to align with current policy and unit requirements.

- Equipment care procedures and equipment care training had been revised resulting in RHQ acknowledging this as a quality improvement.

- Significant changes had been made to staff mandatory training to ensure staff remained in date. This led to all staff completing outstanding training in a three month time frame.

- Structured practice meetings had been put in place. They included standard agenda items, such as significant events, complaints and audit. They were held weekly and were used as an additional governance communication tool. Minutes were comprehensive and were available for staff.

- A full revision of clinical waste management had been undertaken.

- All protocols and guidance documents were up-to-date and current.

- A structured approach to audit, including clinical audit, had been developed.

- A more effective and consistent use of the significant event reporting system had been put in place, including the reporting of good practice.

- A more effective and targeted use of the DMCIP search system was in use.

- The practice manager submitted regular progress reports to RHQ. The report from June 2017 included an update on the action plan following a HGAV visit. The progress report from August 2017 was themed around quality improvement.

**Leadership and culture**

- On the day of inspection the practice manager demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care.

- There was a clear leadership structure and staff told us they felt supported. They said the practice manager and SMO were approachable and took the time to listen to their views.

- Staff told us they welcomed the structure and organisation that had been introduced over the last year. They described how the leadership was effective and a no blame culture was promoted.

- Systems were in place to ensure compliance with the requirements of the duty of candour and all staff had a good understanding of the matter. Duty of candour is a set of specific legal requirements that leaders of services must follow when things go wrong with care and treatment. This included ensuring all staff understood to communicate with patients about notifiable safety incidents. We found that the practice had systems to ensure that when things went wrong with care and treatment, patients were given reasonable support, information and a verbal and written apology.
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 practice surveys and from any individual patient feedback received.
- A suggestion box for patients to leave feedback was located in the waiting area.
- Completed CQC comment cards from patients supported our findings that there was an open door policy when it came to patient input and feedback.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.
- There was no patient participation group or similar at the practice.

Continuous improvement

- Improvements implemented were evident from the quality improvement initiatives, outcome of audits and investigation into significant events. For example, changes had been made to antibiotic prescribing as a result of two significant events and the learning had been shared nationally.
- The practice developed a package to improve awareness of access to the medical centre, including entitlement and requirements for deployment. Staff provided a talk to new cohorts of students and course leaders. The impact was evident as the practice had seen a reduction in short notice and inappropriate requests from students.
- The practice manager and SMO acknowledged that clinical audit had been 'ad hoc' until 2017. Clinical audit had started and an audit calendar developed. Most audits were on their first cycle and we noted that further cycles had been scheduled.
- There was clear evidence from minutes of meetings that lessons learned from significant events, complaints and other investigations led to change and improvement in practice.