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

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<th>Overall rating for this service</th>
<th>Requires improvement</th>
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<td>Are services safe?</td>
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<td>Are services effective?</td>
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<td>Are services caring?</td>
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<td>Are services responsive to people’s needs?</td>
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Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Shorncliffe Medical Centre on 26 September 2017. Overall, the practice is rated as requires improvement. Our key findings across all the areas we inspected were as follows:

- There was a clear staffing structure and staff were aware of their role and accountabilities. Staff had defined lead roles in key areas.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal in the practice minimised risks to patient safety.
- There was a robust and consistent approach to the monitoring of patients on high risk drugs.
- A system was in place for managing incidents and significant events. Staffs' understanding of their responsibility in relation to using the system was inconsistent. Not all significant events had been reported and managed through the system.
- Processes for identifying and monitoring vulnerable patients and patients who could be subject to safeguarding procedures were not robust.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Clinical care for patients was person-centred and well managed. Patient feedback suggested the care was of a high standard.
- Effective medical cover was not in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- A pro-active approach to quality improvement was embedded, including a programme of clinical audit used to drive improvements in patient outcomes.
- Staff had a good understanding of the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Results from the Defence Medical Services patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment and urgent appointments were available the same day.
• Staff said the service was well led and they felt engaged, supported and valued by management.
• Patient feedback systems were in place for patients to provide their views about the service.
• The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
• The layout of reception and the waiting area meant that patients could not always be observed in the event of a medical emergency.

The Chief Inspector recommends:

• That all staff have access to, and a consistent understanding of the significant event management system.
• Reviewing the arrangements for identifying and monitoring patients who are vulnerable or subject to safeguarding procedures.
• Reviewing health and safety arrangements to ensure observation of patients in the waiting area, compliance with fire regulations and the personal safety of staff.
• Reviewing the outcome of audit, such as the infection protection and control audit to ensure actions are clearly identified, who is responsible for completing the action and the timeframe for completion.
• That patients have access to a GP during periods when the practice closes before 18.30.
• That the health and safety lead receives training to perform their role.
• Consideration is given to developing a patient participation group.
• Taking account of the patient population needs in relation to gender when recruiting staff.
• Providing awareness information for staff so they understand how to access the translation service.
• Reviewing the arrangements for using interpreters to ensure it is in accordance with the Caldicott principles.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice
We always ask the following five questions of services.

**Are services safe?**

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

- A system was in place for reporting and recording significant events. Significant events were reviewed at team meetings so lessons were shared with the wider staff team. However, not all staff had access to the system and not all significant events had been reported.
- When things went wrong patients were engaged and received reasonable support, relevant information and an apology.
- All staff, including non-clinical staff, were trained to the appropriate level in child and adult safeguarding. Processes for identifying and monitoring vulnerable patients and patients who could be subject to safeguarding procedures were not robust.
- Clinical risks to patients were assessed and well managed to minimise risks to patient safety. Patients on high risk drugs were closely monitored.
- Comprehensive protocols and guidelines to cover the dispensing of medicines were in operation.
- Effective recruitment processes were in place and sufficient numbers of staff were employed to meet population need.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- Facilities and equipment at the practice were sufficient to treat patients and meet their needs.
- Arrangements for identifying and monitoring patients who are vulnerable or subject to safeguarding procedures were not established.
- Patients could not be observed by staff in the waiting area in the event of a medical emergency.
### 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 demonstrated that staff embraced quality improvement to improve patient outcomes.
- Patients were actively supported to live healthier lifestyles through a targeted and proactive approach to health promotion and wellbeing.
- All registered patient records had been summarised.
- There was evidence of appraisals and personal development plans and support for all staff.

### 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 patients' experience survey showed that patients were satisfied with the care and attitude of staff at the practice.
- Information for patients about the service was available and was accessible. It was also available in other languages to meet the needs of the patient population.
- Systems were in place to maintain patient and information confidentiality.
- We received 33 comment cards and interviewed four patients. All of the feedback was positive about the standard of care received.
- Interpretors were not been being used in accordance with Defence Primary Health Care policy or Caldicott principles.
### Are services responsive?
The practice is rated as requires improvement for providing responsive services.

- Patients found it easy to make an appointment and urgent appointments were available the same day.
- Telephone consultations could be provided as an alternative to visiting the practice.
- From a cultural perspective, patients sometimes expressed a preference to see a male for any intimate consultations. There were female nurses employed so male doctors saw patients who requested to be seen by a male. Male cover for when the male doctors were absent had not been considered.
- Effective medical cover was not in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover.
- Physiotherapists were employed at the practice. All referrals to this service were made by the doctors and the average waiting time for an appointment was less than one week.
- Eye care and spectacles vouchers were available to service personnel at the medical centre.

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

- The practice had a vision and strategy to deliver high quality care and promote good outcomes for patients.
- Some elements of governance required improvement. For example, the management of significant events, vulnerable adults and safeguarding systems and out-of-hours medical cover.
- There was a strong leadership structure and staff felt engaged, supported and valued by management.
- 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 from staff and patients, which it acted on. A patient participation group was not established.
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 practice manager specialist adviser.

Background to Shorncliffe Station Medical Centre

Located in Folkestone, Shorncliffe Medical Centre occupies a single storey building in Sir John Moore Barracks. The centre provides treatment, care and occupational health services to service personnel. Dependents of personnel are not catered for at the medical centre and are signposted to a number of local NHS GP services. At the time of inspection the patient list was approximately 919.

In addition to routine doctor services, the medical centre offers travel advice, a vaccination clinic, audiology, cervical screening and a health check clinic. Affiliated services included rehabilitation, physiotherapy and the Department of Community Mental Health. Patients can also be signposted to community health services, such as the local sexual health clinic.

At the time of our inspection the medical centre staff team comprised a Senior Medical Officer (SMO), Regimental Medical Officer (RMO), a civilian doctor, a General Duties Medical Officer (GDMO), two practice nurses and a health care assistant (HCA). A pharmacy technician was in post and they were responsible for the practice dispensary. The medical centre was led by a practice manager supported by two administrative staff. Located in a nearby building and integral to the practice team, was the primary care rehabilitation team consisting of two physiotherapists and an exercise rehabilitation instructor (ERI).

The medical centre was open from 08:00 to 17:00 Monday to Wednesday and Thursday and Friday from 08:00 to 12:30. Emergency access was available from 08:15 to 09:30 each morning. Routine doctor appointments were available from 08:30 to 12:00 and from 14:00 to 16:00 Monday to Friday. Routine nurse clinics were available by appointment. The dispensary opening times were displayed at the practice and in the practice leaflet.

The arrangements for access to medical care outside of opening hours were outlined in the practice leaflet and directed patients to contact NHS 111 or to attend the minor injuries centre in Folkestone Royal Victoria Hospital. There were no arrangements for access to a GP when the practice was closed and NHS 111 commenced at 18:30.

The medical centre was inspected by CQC in December 2011.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice.

We carried out an announced inspection on 26 September 2017. During the inspection we:

- Spoke with a range of staff including the SMO, two doctors, two nurses, the HCA, office manager and pharmacy technician. We also spoke with the physiotherapy team and checked some details with the practice manager after the inspection.
- Spoke with four patients who were attending the practice during the inspection.
- Reviewed 33 comment cards completed by patients who shared their views and experiences of the service.
- Looked at information, including patient’s records, the practice used to deliver care and treatment.
- 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 established system in place for reporting and managing significant events. Our findings show an inconsistency with staffs’ understanding of and access to the system.

• Both the senior medical officer (SMO) and practice manager were leads to oversee significant events. The practice used the standardised Defence Medical Services (DMS) wide electronic system to report, investigate and learn from significant events, incidents and near misses. One member of staff said they did not have access to the system and another said they were unaware they had authorisation to use the system to report an event. We confirmed that not all staff had been registered on to the system or had an account to use it. Staff said they would approach the lead if they were unsure of any issues in relation to significant events.

• Seven significant events had been identified and managed at the practice in the last 12 months. Staff provided examples and described how the incidents were managed. They highlighted any changes made as a result of the investigation. For example, it was identified through audit that an incorrect form was used for the prescription of a controlled drug. This was then reported as a significant event. Re-training was provided for the member of staff and the induction pack day was revised to ensure the doctors; including locum doctors were aware of the correct process for prescribing controlled drugs.

• The practice carried out a root cause analysis of significant events with the relevant staff. Staff advised us that significant events were discussed at the four to six weekly practice meetings and any lessons learned shared with the wider staff. Despite staff providing a good account of lessons learned, this level of action was not reflected on the system for all significant event reporting.

• Throughout the inspection staff described incidents and events, including good practice, that should have been reported and managed through the system to support shared learning and demonstrate quality improvement. For example, we were informed of an event involving a prescription of the incorrect dose of antibiotics. This had been well and safely managed but had not been raised as a significant event.

• We reviewed safety records and national patient safety alerts, including the minutes of meetings where these were discussed. The practice manager received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the Department of Health Central Alerting System (CAS). Alerts were recorded on the healthcare governance workbook.

• The pharmacy technician reviewed the alerts to check if any patients were affected. Alerts relevant to the practice were logged, emailed to individual staff members and were discussed at practice meetings. For example, an alert about medicine used in the treatment of angina was
reviewed and it was identified that one patient was taking it so the practice reviewed the patient’s treatment and determined the medicine was safe for the patient to continue taking.

- 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. For example, the patient who was prescribed the incorrect dose of antibiotics was recalled, the error explained to them and an apology offered.

**Overview of safety systems and processes**

Not all systems were effectively developed or consistently used to keep patients safe and safeguarded from abuse.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Information was displayed in each clinical room and included contact details of designated safeguarding teams in the local area.

- We were advised that the practice did not have a formal register to log vulnerable patients and/or patients subject to formal safeguarding procedures as there were too few. An alert could be placed on a patient’s record to identify that they were vulnerable. We were shown an example of how the alert system had been used for a patient currently assessed as vulnerable. The practice manager confirmed that in the last three years there had been no safeguarding referrals made by the practice.

- The SMO was the lead member of staff for safeguarding and had completed level three training in January 2016. Effective deputising arrangements were in place.

- The staff we spoke with demonstrated they understood their responsibilities regarding safeguarding. They had received training appropriate to their role regarding the safeguarding of children and vulnerable adults. Doctors had received level three training in child safeguarding.

- A representative from the practice attended station welfare meetings with the chain of command on a regular basis. The meeting was also attended by the welfare team and any safeguarding matters were discussed at these meetings, including an agreed plan to support the patient and maximise their safety.

- Notices in the waiting area and clinical rooms advised patients that a chaperone was 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.

- The lead nurse for infection prevention and control (IPC) had attended annual infection control training relevant to the role. An IPC handbook was in place and all staff had been issued with the link to access the handbook. IPC audits were carried out annually and the last audit was completed in June 2016. A list of suggested recommendations was recorded. Because an action plan approach had not been used, there was no record against each recommendation detailing the action to be taken, who was to complete the action and the timeframe the actions should be completed by.

- Environmental cleaning was carried out by an external company twice a day. The practice was clean and tidy when we inspected. Environmental cleaning equipment was used and in the morning we observed that it was not stored in accordance with national guidance. We noted in the afternoon that it was being stored correctly.
• The practice manager was the lead for waste management. Clinical waste was stored appropriately and securely. Waste was collected from the practice by an external contractor and appropriate documentation was in place to support effective waste collection. A waste audit completed in June 2017 showed compliance.

• All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. Spillage kits were available.

• Effective arrangements for managing medicines, including emergency medicines and vaccinations, were established to keep patients safe. The SMO was the medicines management lead for the practice. A policy and procedures was in place, including arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines.

• The pharmacy technician and SMO conducted an internal stock check of controlled drugs each month and a quarterly external quality check was undertaken by the duty officer. We found no discrepancies or gaps in the checking system. The cold storage unit for medicines was monitored twice a day to ensure temperatures were within the correct parameters. A small back-up fridge was available in the event of the main fridge failing.

• 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 processes in place were comprehensive demonstrating that PGDs were well managed.

• We found that effective processes were in place to manage patients on high risk drugs. Patients on such drugs were coded correctly. A ‘risky medicines’ register was established and this was monitored regularly. It included a patient prescribed a high risk drug by secondary care and clarified that the prescribing doctor was monitoring the patient whilst they were taking this drug. Two patients on high risk drugs were being monitored at the practice and also a patient receiving an ‘off label’ medicine. ‘Off label’ means a medicine is prescribed outside its terms of the licence but in the best interest of the patient based on available evidence.

• The full range of recruitment records for permanent staff was held centrally. However, the office 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. A system was in place to monitor each clinical member of staff’s registration status with their regulatory body. They confirmed all clinical 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.

• The current staffing level at the practice was considered appropriate to meet the population need. Weekly diary checks were undertaken to ensure sufficiency of staffing levels, both through discussions with staff and patients, including patient feedback. No concerns were raised about staffing levels. Effective links were maintained with the station chain of command to discuss staff deployment planning and increases in population.

Monitoring risks to patients

Some risk management processes needed to be reviewed and revised to minimise the risks to patients.

• There were procedures in place for monitoring and managing risks to patient and staff safety, including a health and safety policy. A member of staff was the lead for health and safety. They
had not had specific training for the role and this was reflected in their understanding and some of the responses to our health and safety questions. We noted that this training need was identified on the Common Assurance Framework (CAF), a DMS internal quality assurance audit tool. The practice manager advised us that health and safety training was currently being sourced for the lead.

• Staff were aware of their role in the reporting and management of incidents, including when to report in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Such incidents were reported through the DMS-wide electronic incident reporting system.

• A risk register was established for the practice and health and safety was a standard agenda item at the practice meetings. Risk assessments were in place for each room in the building, including the clinical areas. A legionella risk assessment was undertaken by an external contractor in 2017 and water outlets were checked regularly. Legionella is a term for a particular bacterium which can contaminate water systems in buildings. Other risk assessments in place included: lone working; infection control; assessments relating to the control of substances hazardous to health; chaperoning; medication outsourcing; controlled drug prescribing and pharmacy access.

• The station was responsible for the electrical and gas safety of the building. Portable electrical equipment was checked on a regular basis to ensure the equipment was safe to use. It had been completed shortly before our inspection.

• An external workplace inspection was undertaken in June 2017 that took account of health and safety, including staff training, risk assessments, equipment and the environment. A Recommendation was made regarding carpet lifting and presenting a trip hazard. A request had been submitted for it to be fixed.

• We noted that the layout of the practice meant not all patients in the waiting area could be observed by reception staff. In addition, patients who had received an injection waited in the corridor outside the treatment room for 20 minutes to ensure their safety. This area was also not routinely monitored so staff response would likely be delayed in the event of a medical emergency. Staff said they would ask patients to wait in the waiting area instead.

• The fire safety risk assessment was arranged by the station. The folder of fire safety checks showed fire drills, systems to minimise the risk of fire and firefighting equipment were routinely checked in accordance with policy. We observed fire doors held open with door wedges throughout the inspection. Wedging fire doors in the open position with objects means the escape routes were not protected, placing people’s safety at risk in the event of a fire. Mandated fire training had been completed by all staff.

• The health care assistant (HCA) was the designated equipment lead. Clinical equipment was checked in line with Defence Primary Health Care (DPHC) policy to ensure it was working properly. A calibration record was held and calibration of equipment was in-date. Evidence of staff competency checks was in place in relation to the use of equipment.

• Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients’ needs. There was a rota system in place for all staffing groups to ensure that enough staff were on duty.

• A triage system was in place for patients who presented without an appointment (sick parade). Nurses undertook the triage. If a patient needed to be seen outside of sick parade then the triage nurse reviewed the diary to see if appointments were available. Patients were always seen on the same day if their health need was assessed as urgent.
Arrangements to deal with emergencies and major incidents

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

- There were no emergency alarms installed in clinical rooms at the practice. This had been raised to Regional Head Quarters (RHQ) seven years ago and was logged in the practice risk register. Each member of staff carried a personal alarm but they did raise concern that alarms may not be heard due to the size and layout of the building.

- A resuscitation trolley was in place and records confirmed it was checked monthly and all items were in-date. It included the appropriate equipment and emergency medicines as described in recognised guidance. Oxygen was stored in a separate area to the trolley, which was not ideal in the event of a medical emergency. Staff said they would review this. A first aid kit and accident book was available. The staff training records provided assurance that all staff received basic life support training on an annual basis.

- Reviewed in August 2017, the business continuity plan took account of 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 on the premises. A member of staff had completed a disaster management course and had a date set in October 2017 to review both the major incident plan for the station.
Are services effective?
(for example, treatment is effective)

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). Nurses said they received NICE and other guidance updates electronically from the practice manager and if appropriate the guidance was discussed at practice meetings. They referred to this information to deliver care and treatment that met patients’ needs. Nurses described how updates to NICE guidance and medicines management were also outlined in a newsletter circulated to clinical staff by the Defence Primary Health Care (DPHC) team each month.

- Doctors said they referred to NICE and the BNF (British National Formulary) page for chronic disease management. We were provided with a number of examples whereby NICE was taken into account in relation to treatment for patients.

Management, monitoring and improving outcomes for people

The practice nurse had the lead for long term conditions management. 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.

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

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

- There were 19 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 had a record for their blood pressure in the past nine months. Of these patients with
hypertension, 15 had a blood pressure reading of 150/90 or less. Two of the patients were deployed at the time of the inspection and staff said they would be reviewed on their return. Two patients had not complied with their prescribed medication.

- 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 five which is 100% of the smoking patient population. The NHS target for this indicator is 90%.

- There were six 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 six patients had had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

- There were no patients with a new diagnosis of depression in last 12 months.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that instance of audiometric hearing assessment was above 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 July 2017 showed:

- 100% of patients had a record of audiometric assessment, compared to 99.5% regionally and 99% for DPHC nationally.

- 95.7% of patients’ audiometric assessments were in date (within the last two years) compared to 88.8% regionally and 86.3% for DPHC nationally.

There was evidence of quality improvement including clinical audit:

- An active programme of audit was in place that demonstrated a commitment to improving outcomes for patients. The clinical audits we looked at and discussed with staff included: long term use of Terbinafine (prescribed medicine to treat fungal infections); prescription interventions; use of Metformin modified release (MR) in Type 2 Diabetes; the use of CENTOR score in decision making in relation to sore throat symptoms and a results handling audit. Examples in more detail include:

- The long term oral Terbinafine and LFT (liver function test) monitoring involved three cycles of data collection and analysis; January 2016, August 2016 and May 2017. Changes were made after each data analysis, including discussing prescribing practice at local and regional level and ensuring LFTs were checked every four weeks into treatment.

- CENTOR is a valid assessment tool supported by NICE for patients presenting with a sore throat. In total five cycles of data were collected and analysed between 2014 and 2016. Improvement was noted in the use of the CENTOR assessment. For example, the data analysed in January 2015 showed 50% compliance, in December 2015 compliance reached 65% and in May 2016 compliance was at 96.5%. Findings from the audit showed that nurses used CENTOR 100% of the time. Furthermore, it was identified on the last data analysis that five patients diagnosed at other medical centres had not been assessed using CENTOR.

- The prescription intervention audit conducted in June 2017 was undertaken due to an increase in the number of prescriptions requiring alteration. A random sample of 20 prescriptions were analysed and 15% showed errors, albeit minor errors. The auditor recognised that a large section of the patient population have English as a second language so it was paramount that
patients could understand the labelling on their medication. The errors were rectified and findings discussed with prescribers. The matter was also discussed at the practice meeting and a training session had been scheduled.

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

The CAF internal quality assurance tool was used to monitor safety and performance. The 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.

The CAF we were provided with pre-inspection (undated) had been undertaken by the practice manager. When we reviewed the CAF it showed 10 areas of partial compliance, which were similar to some of our findings.

**Effective staffing**

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

- The practice had a generic induction programme for all newly appointed staff. This included topics such as safeguarding, infection prevention and control, fire safety, health and safety and information governance. Staff also received training in the Caldicott principles, which outline what organisations should do to ensure that information that can identify a patient is protected and only used when it is appropriate to do so. 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 modules and in-house training. Relevant competency checks were undertaken before staff engaged in practice or a procedure that was new to them.

- The practice manager organised mandatory training. Records confirmed all staff had received mandatory training in subjects such as fire, basic life support and infection control and this training was refreshed in accordance with organisational policy.

- Staff told us there was a strong culture of continuous learning promoted at the practice. Dedicated time was allocated each week for training and continual professional development (CPD). They received role-specific training where appropriate. For example, the IPC lead was due to undertake an advanced level IPC course. From our discussions with nurses and doctors, we determined they had a detailed knowledge relevant to their specialist roles and shared their knowledge when relevant with the wider staff team. Nurses and doctors told us they maintained their own CPD. They said they attended both internal and external training events and conferences.

- Information was shared with the staff team at the practice meetings. Doctors organised clinical meetings as and when needed to discuss updates regarding clinical guidance; new anti-malarial protocol, for example. Doctors advised us that peer support was informal.

- A General Duties Medical Officer (GDMO) worked at the practice. A GDMO is a junior army doctor attached to a field unit before commencing higher specialist training. The SMO was the GDMO’s supervisor. Dedicated time was provided for the SMO to support and advise the GDMO’s clinical decision making, and with maintaining high quality patient records.

- The SMO was part of the local NHS GP trainer forum and said this was useful for keeping up to date with developments in the NHS and for the sharing of information.

- Trainee medics were also offered supervised clinical sessions at the practice. In the army a
A medic or combat medical technician is a soldier who has received specialist training in field medicine. It is a unique role in the forces and has greater scope than that of a health care assistant found in NHS GP practices.

- All clinical staff had been trained around the application of Gillick competence. Gillick is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment without the need for parental permission or knowledge. Staff who acted as chaperones had received training.

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

- The learning and support 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

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. The DMICP system was used for managing patient records. Read coding, a system used to support clinical coding of patient details, including diagnosis, was used by all clinical staff with access to patient records. The sample of anonymised patient notes we looked at was of a very 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.

- Multi-disciplinary (MDT) meetings took place on a monthly basis with the chain of command and involved representatives from the practice, including the rehabilitation team. These meetings looked specifically at the health and fitness of service personnel, including the patient sicklist. In addition, quarterly unit health committee meetings were also established and they had a broader remit, such as participation of the welfare team. The SMO attended these meetings.

- When patients moved or were deployed their medical records were transferred electronically. In July 2017 a regiment returned from abroad, which meant a change to the patient population list of approximately 600. The SMO advised us that such a change to patient population in a short period of time was unusual. Twenty five percent of the patent records supplied had not been summarised. These notes were all successfully summarised, including a review of Read coding, at the practice within a two month period. Read codes are the standard clinical terminology system used in NHS medical practices in the UK. They provide a standard vocabulary for clinicians to record patient findings and procedures.

- The practice had a pro-active approach to screening new service personnel registering at the practice. A search of the Joint Personal Administration (JPA) system was undertaken each week to identify new joiners. Approximately four to five new joiners were screened by the nurse each week, including the status of their vaccinations and audiometry testing. They were then screened by the doctor so any issues in relation to their medical history were identified as early as possible. Appropriate concerns were discussed at the station MDT or unit health committee meetings.

- We found the practice managed information from other services in an efficient way. For
example, any external correspondence, such as NHS 111 feedback, laboratory results and secondary care letters were scanned onto the system and sent to the doctor to review and code accordingly.

- The practice had a good relationship with the co-located dental centre. Doctors referred patients to the dentist for any suspicious oral lesions. If dentists then referred a patient on to secondary care the medical centre received a copy of the outcome letter.

- One of the administrators was the dedicated lead for managing and monitoring the progress of referrals to secondary care services. The referrals register was checked weekly and any delays followed up. Equally, laboratory samples sent were logged and checked and results followed up if not received in a timely way.

**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 (MCA) 2005.

- Where a patient’s mental capacity to consent to care or treatment was unclear, the clinician assessed the patient’s capacity. For example, a patient who presented as drowsy was assessed using both a neurological assessment tool and a mental capacity assessment. It was determined they lacked capacity and a best interest clinical decision was appropriately taken regarding the next stages of their treatment and care. Had a formal significant event analysis been used to highlight how the MCA had been applied, then it could have been shared widely within the DPHC as an example of good practice.

- If occupational health information about a patient needed to be shared then the patient was informed and they signed a form to agree to this. The form was then scanned onto their medical record.

**Supporting patients to live healthier lives**

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

- Staff understood their patient population and identified smoking and a diet high in sugar as key concerns for the population. Staff said the population was particularly at risk to developing diabetes and gout. 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 cessation. A dedicated lead was identified for health promotion.

- The health promotion lead monitored smoking in the patient population. The population had high rates of smoking, including chewing tobacco. The practice identified and monitored smokers through regular searches of the system. If a patient was identified that had not been offered smoking cessation support, then a letter was sent inviting them to the smoking cessation clinic held at the practice each week. Staff said they had seen a decrease in the number of smokers but this had not been formally measured. It was a new initiative so at the point of inspection an audit or analysis had not taken place of uptake or success with cessation to determine the impact.

- The practice participated in the unit health fairs, which were held regularly to promote good
health and lifestyle amongst the population. Staff said these were well attended by patients

- Patients had access to appropriate health assessments and checks. Searches were undertaken for patients aged 50-64 years who were entitled to breast screening; there was just one patient identified at the time of inspection. 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. There were no patients identified who were eligible for these screening programmes at the time of our inspection.

- 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 eight eligible women. This represented an achievement of 100%. 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, polio and measles, mumps and rubella. The data below from September 2017 provides vaccination data for patients using this practice:

- 97% of patients were recorded as being up to date with vaccination against diphtheria compared to 95.5% regionally and 95% for DPHC nationally.

- 97% of patients were recorded as being up to date with vaccination against polio compared to 95% regionally and 95% for DPHC nationally.

- 85% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 84% regionally and 83% for DPHC nationally.

- 96% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 94% regionally and 94.5% for DPHC nationally.

- 97% of patients were recorded as being up to date with vaccination against Tetanus, compared to 95.5% regionally and 100% for DPHC nationally.

- 99% of patients were recorded as being up to date with vaccination against Typhoid, compared to 69% regionally and 53% for DPHC nationally.
Are services caring?

Our findings

Kindness, dignity, respect and compassion

- During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Clinic room doors were closed during consultations. Curtains were provided in clinic rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.
- The layout of the reception area and the seats in the waiting area meant that conversations between patients and reception could not be easily overheard. A television was also playing in the waiting area. 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.
- There was an accessible toilet in the building. A room was available for baby changing and/or breastfeeding.
- A suggestion box for patients to leave feedback was located in the waiting area. Patients also were given the opportunity to participate in the patient experience survey.
- We had the opportunity to speak with four patients during the inspection. They told us they were satisfied with the care provided by the practice and said they were treated with dignity and respect. All told us they could get an appointment when they needed one.
- Results from the June 2017 Patient Experience Survey showed patients valued the care at the practice. For example:
  - 91% of patients said they would recommend the practice to friends, family and colleagues.
- We did not receive any comparator data from Defence Medical Services to set out alongside the above data. We received 33 completed comment cards prior to the inspection and feedback about treatment and care was very complimentary. Patients said that they felt involved in decision making about the care and treatment they received. Comments indicated that patients felt listened to and supported by staff, and they had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Care planning and involvement in decisions about care and treatment

- The feedback provided by patients indicated that clinical staff took the time to explain their condition or injury and treatment plan.
- Data received from 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. For example:

- 86% of patients said they were involved in decisions regarding their care.
- Health promotion information leaflets were available for patients on notice boards throughout the medical centre. Relevant information was available in other languages.

**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. We saw that information that was relevant to the patient demographic was prominently displayed and accessible.
- At the time of our inspection there was one patient registered who had caring responsibilities. Although an alert had not been placed on the patient’s record, a Read code had been applied to identify the patient as a carer.
- A representative from the practice attended station welfare meetings with the chain of command on a regular basis. The meeting was also attended by the welfare team and any vulnerable patients were discussed at these meetings, including a strategy to support the patient.
Are services responsive to people’s needs? (for example, to feedback)

Our findings

Responding to and meeting people’s needs

- A wide range of services and clinics were available to patients. For example, a smoking cessation clinic, over 40’s health screening, cervical screening, audiology screening, physiotherapy and travel advice.

- 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 up to 30 minute appointments with the nurse. If needed, patients could book a double appointment of 30 minutes with the doctor. Telephone consultations were available with a doctor if a patient requested that option.

- Both male and female doctors worked at the practice so patients could choose the gender of doctor they wished to see. From a cultural perspective, staff highlighted that many registered patients were reluctant to see a female nurse for intimate health concerns and examinations. However, all the nurses at the practice were female. Staff confirmed it was not unusual for a male patient to request to see a male doctor for consultation usually undertaken by a nurse. While the patients’ need for a male clinician was being met, it meant doctors were undertaking nurse activity which is an ineffective use of their time. We were also informed that male cover had not been provided in the absence of male doctors due to deployment. Both male doctors were military so they were subject to short notice deployment.

- At the time of our inspection the practice provided a service to a large regiment of international service personnel who did not have English as their first language. Staff did not appear to be aware of the DPHC’s ‘Big Word’ translation service and said non-medical staff from the guard room opposite the medical facility sometimes acted as interpreters. This was not in accordance with DPHC policy and constitutes a breach of Caldicott Principles as it does not protect against the inappropriate disclosure of patient identifiable information.

- All referrals to the rehabilitation team were made by the doctors and the average waiting time for an appointment was less than one week.

Access to the service

- The medical centre was open from 08:00 to 17:00 Monday to Wednesday, and Thursday and Friday from 08:00 to 12:30. Emergency access was available from 08:15 to 09:30 each morning. Routine doctor appointments were available from 08:30 to 12:00 and from 14:00 to 16:00 Monday to Wednesday. Routine nurse clinics were available by appointment. The dispensary opening times were displayed at the practice and in the practice leaflet.

- Extended hours were not available. The SMO said the practice used to hold an evening clinic but did not have the staffing resource to continue these.
The practice displayed information for patients about who they needed to contact when the practice was closed. NHS 111 was identified as the cover arrangements between 17:00 and 08:00 hours and when the practice closed at 12:30 on Thursday and Friday. However, this was contrary to the arrangement in place with NHS England which states that NHS 111 cover is available from 18:30 on week days. The practice should ensure that patients can access a GP between the hours of 08:00 and 18:30 every week day.

Of the 33 feedback cards we received, three patients commented on access to emergency medical care. One suggestion was that emergency care should be provided by the practice when required. The other two comments suggested there should be emergency cover at the weekend. An example was provided in relation to a patient contacting the guard room at the weekend because they were ill. They were advised to ring 999 or make their own way to the hospital. We received these comments despite the practice leaflet outlining out-of-hours arrangements for access to medical and emergency care. The practice leaflet was available in various languages.

**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 all complaints in the practice. They and the staff team adhered to the DPHC’s established policy on the management of complaints.
- Information was available in the waiting area to support patients’ understanding of the complaints system. How to make a complaint was summarised in the practice leaflet.
- We spoke with four patients who told us that they would feel comfortable with making a complaint and knew how to complain if the need arose.
- There had been one complaint raised in 2017. This had been managed effectively in accordance with the complaints procedure. Clinical complaints were forwarded to the SMO or, in their absence, one of the other doctors.
- Staff advised us that if there was any learning from complaints then this would be shared at the practice meetings. Complaints were audited through the CAF.
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 worked to the DPHC mission statement:

- “To deliver unified, safe, efficient and accountable primary healthcare services for entitled personnel to maximise their health and deliver personnel medically fit for deployment.”

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. We found that some areas of governance required improvement.

- There was a clear staffing structure and that staff were aware of their own roles and accountability. Staff had defined lead roles in key areas. For example, there were leads identified for chronic disease, equipment and Caldicott.

- A system was established for incident management including significant event analysis. Staffs’ understanding of their responsibility in relation to using this system to report incidents and events was inconsistent. Not all staff were registered or had an account to use the system. During the inspection we were told about incidents and events, although managed safely, had not have been reported formally through this system.

- There was evidence from minutes of meetings and discussions with staff that lessons learned from significant events, complaints and other investigations led to change and improvement in practice.

- We identified a need to improve information governance and, specifically, to ensure that translation arrangements at the practice adhered to the Caldicott Principles.

- The practice used the CAF as a governance tool to monitor the safety and quality of the service. The CAF did not identify that the significant event reporting system was inconsistently used or not used to its full potential. A risk register to monitor safeguarded/vulnerable patients as required by the DPHC had not been developed. This register should be in place even if no patients are listed on it.

- There were arrangements for identifying, recording and managing risks and a risk register was in place. We identified practices that could present a risk to the safety of patients and others. For example, patients waiting for 20 minutes following an injection could not be seen by reception staff in the event of a medical emergency.

- Effective medical access was not in place to provide cover when the practice closed and before NHS 111 provided medical cover.

- The nominated lead for health and safety was unsure of the processes for accident or infectious
They had not received training and this had been identified and rated accordingly on the CAF. We checked the system and clarified that accident reporting was taking place but not by the nominated lead.

- All previous actions from the CQC inspection in December 2011 had been met except in relation to moving the controlled drug cabinet. The practice had a certificate of exemption for this action from the police due to the position of the cabinet on an external wall.

- Notes summarising was effectively managed. It was particularly noteworthy how the practice managed this especially as a unit of 600 service personnel arrived in July 2017.

- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly. Staff confirmed they were familiar with policies and other protocols, and used them in the delivery of high quality care.

- Practice meetings were held regularly and were used as an additional governance communication tool. Minutes were comprehensive and took account of matters such as performance indicators, health and safety, staff training, complaints, audit and summarising. Minutes were available for practice staff to view.

- A programme of quality improvement, including clinical and administrative audit, was used to monitor quality and to drive improvements. An audit calendar was established for the practice.

- Effective measures were in place to manage performance by staff. We were provided with an example that clearly showed the member of staff was supported in a positive way to improve their practice.

- Robust systems were in place to monitor patient safety updates and alerts sent by the Medicines & Healthcare products Regulatory Agency (MRHA).

### Leadership and culture

- Staff said they felt respected, valued and supported by management and said the practice was well led. They said managers and senior staff were approachable and took the time to listen to their views. They felt involved and engaged in how the practice was run.

- Staff told us the SMO and practice manager were visible, approachable and always took the time to listen to all members of staff.

- 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. The doctors and practice manager encouraged a culture of openness and honesty. We found that the practice had systems to ensure that when things went wrong with care and treatment, the practice gave affected people 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 through:

- Patient surveys and from any individual patient feedback received.
- The suggestion box available in the waiting area for patients to leave feedback.
• A patient participation group or similar type of collective forum was not established to seek the views of patients.

• Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

**Continuous improvement**

• Improvements implemented were evident from the quality improvement activity, mainly the outcome of audits and investigation into significant events. It was clear to us that the practice used its audit work to identify learning and make change. For example, the prescription intervention audit led to a change in how prescriptions were recorded and labelled.

• The practice was keen to ensure the environment was safe for clinical practice. For example, the carpets in clinical areas had been identified as a concern and the practice had submitted a relevant statement of need (request for improvement) to RHQ for the carpet to be replaced. We also noted that carpets in clinical areas had been identified on the CAF, indicating that the issue had first been identified as a risk and first reported to RHQ six years ago.