

Defence Medical Services

Army Training Centre Pirbright

Quality Report

Medical Reception Station
Alexander Barracks
Pirbright
Woking
Surrey
GU24 0QQ

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

Ratings

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

Summary of findings

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Army Training Centre Pirbright on 18 October 2017. Overall, the practice is rated as outstanding. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. We saw a culture where all staff were encouraged to report any concerns and felt safe in doing so.
- The assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff.
- We saw several examples of collaborative working and sharing of best practice to promote better health outcomes for patients. For example, carers were identified and the practice particularly ensured that any young carers were identified at the earliest opportunity.
- There was a comprehensive programme of clinical audits including regular reviews of the service used to drive improvements in patient outcomes.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the Defence Medical Services (DMS) patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

We identified the following notable practice, which had a positive impact on patient experience:

- The practice had developed a strong, sustainable system to ensure note summarising was completed without delay for all patients transferring into the practice. From figures made available to us on the day of inspection, we saw that the turnover of patients at the practice was typically between 5,500 and 6,000 per annum. From review of records we saw that notes were typically summarised within two days (48 hours). The practice also summarised approximately 20 sets of notes for reservist personnel per week. Where possible, the practice also took on some summarising from practices that could not keep up with this work. This work assisted in minimising risks to patients by ensuring key information was easily accessible to clinicians at the earliest opportunity.
- All clinicians and staff at the practice ensured that medical appointments for patients with any learning difficulty, were scheduled at weekends to avoid impact on learning whilst in education or on practical skills courses.
- Staff were aware of those patients who had entered the services from foster or other local authority care. Clinicians played a strong pastoral role in the wider safeguarding of these patients, for example, by liaising with army welfare to establish if these patients had anywhere to go when weekend leave was granted.
- The practice had established links with Surrey Military and Veterans Young Carer's Service and Surrey Independent Living Council. From registers kept by the practice, we could see that staff had a good awareness of who carers were, but particularly young carers whose needs may not be met without further intervention from these community based support groups.

The Chief Inspector recommends:

- A comprehensive review of all requests for maintenance/repairs to the building and how long it is taking for these to be responded to. At the time of our inspection, a leak from the roof in the reception area impacted on patient flow through the building.
- Provide clearer guidance to patients on the availability of GP advice and access, between 17:00 and 18:30 on weekdays.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Good



Are services safe?

The practice is rated as good for providing safe services.

- There was an effective system for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients were informed as soon as practicable, received reasonable support, information and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The arrangements in place for safeguarding of children and young people mirrored the gold standard for NHS practices.
- The practice had clearly defined systems, processes and practices to minimise risks to patient safety.
- We saw that these systems were embedded; the changeover of staff within the practice, due to postings and deployment did not reduce their effectiveness.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good



The practice is rated as good for providing effective services.

- Staff were aware of current evidence based guidance.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care.
- Clinical audits demonstrated quality improvement. Eighteen audits had been undertaken in the past 12 months. We saw evidence that the results of audits were shared widely and used to prioritise focus for improvement. Leaders prioritised short clinical meetings, held each morning to support peer

review and discussion of updates to clinical guidance.

- The practice held regular governance meetings. The minutes of this monthly meeting had been developed to include all key areas and were detailed and comprehensive. The minutes contained links to key documents including all upcoming training opportunities, both local and national. Staff said they found these to be a highly effective communication tool used at the practice and had become a 'one stop shop' which allowed them to update themselves following a period of absence.
- Summarising of patient notes was prioritised and completed without any undue delay, despite the high turnover of patients at this phase one Army training facility. Typical turnaround time on each new set of notes was 48 hours.
- The practice also took on note summarising for reservists and patients from other practices, to help them keep up to date with this task.
- There was evidence of appraisals and personal development plans for all staff.
- Staff and teams were committed to working collaboratively with all professionals in the health care of recruits to provide a joined up service that patients found accessible.

Are services caring?

The practice is rated as outstanding for providing caring services.

- Clinicians ensured that any patient with learning difficulties had access to appointments at weekends, to minimise the impact on any formal education or skills based training.
- The practice held a carers register which was detailed and updated weekly by staff. We saw the practice had identified 23 patients who were carers and also those carers who were children.
- We saw examples of positive patient feedback from young recruits which demonstrated the commitment of clinicians to meeting the needs of these patients, whilst supporting them to successfully complete their initial training.
- The practice reception and waiting areas had displays of information that was useful to patients, giving details of support organisations both within the military and those based in the community.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Feedback we received was consistently positive. Patients we

Outstanding



spoke to said all staff were caring and took time to listen to them to establish their needs.

Are services responsive?

Good 

The practice is rated as good for providing responsive services.

- Patients we spoke with said they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had maintained highly responsive interventions for patients in all areas, despite the high throughput of patients and constantly changing patient register. For example, we saw that 100% of patients, who smoked and had a long term condition, had received advice on smoking cessation.
- The practice sought feedback from staff and patients and acted on this to improve services when possible.
- Information about how to complain was available and evidence from examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice GP was on-call 24 hours a day. This was primarily to support any clinical needs of patients in the bedding down facility at the practice outside of normal opening hours. Patients calling the practice outside normal, advertised opening hours, could have their complaint triaged by a nurse or medic, who could refer onwards to a GP if required. This was not clear in the practice patient information leaflet.

Are services well-led?

Outstanding 

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- Leaders were respected and valued, both by colleagues and patients. We saw leadership that inspired staff to succeed in what could sometimes be a challenging environment.
- Staff were clear about the vision and their responsibilities in relation to it. We saw very high levels of staff engagement and commitment. Staff we spoke with on the day of inspection demonstrated the sense of pride they felt in working at a medical facility that was integral in helping young recruits achieve their ambition of a career in the military.

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- There was a clear leadership structure and all staff we spoke with said they felt supported by management.
 - The practice had policies and procedures to govern activity and held regular governance meetings. Significantly, we saw that all working processes were embedded at the practice. This meant that when key figures were deployed or posted elsewhere, the same high standards of governance remained.
 - An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
 - Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
 - The provider was aware of the requirements of the duty of candour. In examples we reviewed we saw evidence the practice complied with these requirements.
 - The practice leaders encouraged and promoted an open, learning culture where any mistake or error was treated as a learning opportunity for all.
 - Staff training was a priority and was built into staff rotas.
 - GPs that were skilled in specialist areas used their expertise to offer additional services to patients, for example, surgical procedures.
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Army Training Centre Pirbright

Detailed findings

Our inspection team

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

Background to Army Training Centre Pirbright

The Army Training Centre (ATC) Pirbright medical treatment facility (referred to in this report as 'the practice') is located on the Pirbright military base, which is near Woking, Surrey. The practice offers care to both forces personnel and some dependants and their children. At the time of inspection, the patient list was approximately 3,900. Occupational health services are also provided to personnel and a number of reservists.

The practice has a weekly intake of civilians training to be soldiers at a rate of between 100 -150 per week. The practice is a training practice hosting GP registrars and student nurses. The practice also trained phase two combat medical technicians (CMT).

In addition to routine GP services, the practice offers minor surgical procedures, child immunisation clinics, well woman clinics, new patient health checks, latent TB clinics, smoking cessation clinics and midwife clinics. Physiotherapy services are available for military personnel and travel advice will be offered to those dependants who accompany their partner on military postings. Family planning services are also available. Maternity and midwifery services are provided by community teams, who hold clinics at the practice on a weekly basis. The practice also hosted community psychiatric nurses who held regular clinics at the practice and community opticians who visited twice each week. The facility was manned, 24 hours a day. In the out of hour's period, manning was made up of a medic, a nurse and a healthcare assistant. A doctor was also on call at all times for telephone advice; this was mainly in support of patients in the bedding down facility.

At the time of our inspection, the practice had six full time GPs, one part time GP of 20 hours per week and nine full time practice nurses. There were two part time nurses, whose combined hours gave 0.9 of full time equivalent nursing hours. The practice had its own dispensary and employed two pharmacy technicians whose combined hours provided 1.8 full time equivalent. At the time of our inspection, there were 12 full time medics based at the practice (the work of a military medic has greater scope than that of a health care assistant found in NHS GP practices). The practice was led by a practice manager, supported by four full time and three part time staff. The practice provided primary care rehabilitation services via physiotherapy and exercise training. However this facility did not form part of our inspection.

A bedding down facility was attached to the practice, with capacity for 15 patients. Wards were split into groups of four beds, offering privacy for male and female patients. There were also individual side rooms available. This unit was staffed by a full time nurse ward manager, supported

by one full time senior nurse. A further full time senior nurse post was vacant at the time of our inspection. The senior nurse was supported by two full time and one part time Band 5 nurse and two full time health care assistants. At the time of our inspection, a third, part time health care assistant post was vacant, awaiting financial approval for recruiting into.

The facility was open from Monday to Friday each week, between 08:00 and 16:00. The practice told us emergency appointments would be seen between 16:00 and 17:00. The telephone is manned 24 hours a day. We were advised patients could access triage from a medic or nurse at the practice, who may refer onwards to the on-call GP. However, the patient information leaflet sent to us following clarification of patient access, still requests that patients should contact Woking Community Hospital Walk-In Centre between the hours of 17:00 and 18:30. Outside these hours all patients were diverted to NHS 111.

Why we carried out this inspection

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

How we carried out this inspection

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

We carried out an announced visit on 18 October 2017. During our visit we:

- Spoke with a range of staff, including four GPs, the practice manager, pharmacy technician, two practice nurses, one ward nurse, two medics, a physiotherapist and two administrative staff. We were able to speak very briefly with two patients who used the service.
- Reviewed comment cards completed by patients who shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.
- Conducted a tour of the premises
- Reviewed governance records, audits and anonymised patient information.

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.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. We saw all staff knew how to access the system. Review of incidents demonstrated that all staff felt safe to report incidents or raise concerns and were supported to do so.
- The practice carried out a thorough analysis of the significant events. Senior staff understood their roles in discussing, analysing and learning from incidents and events.
- We saw that all staff completed significant event record forms. Events were discussed at practice meetings, which took place monthly, and information and learning was made available in detailed minutes of meetings. All staff had access to these minutes.
- Learning points were captured and action taken to prevent the same or similar events occurring in future. For example, following the practice response to paediatric illness, it was identified that a pulse oximeter for use on children should be available within practice, to reduce the need to refer children to hospital. A business case was made to secure this equipment, with the practice using supporting evidence in the form of NICE guidance. Having secured the equipment, the practice felt it made a positive difference for patients, with less chance of young children having to be referred to hospital, perhaps unnecessarily.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. When we reviewed all incidents reported in the last 12 months, we saw there was no unnecessary delay in closing these down, and the lead on significant events at the practice progressed chased any that were awaiting further action, for example, from Defence Medical Services (DMS) HQ.

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, which included:

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff.

- The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding and this was a GP who worked full time at the practice. Effective deputising arrangements were in place.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role.
- GPs were trained to child protection or child safeguarding level three and nurses were trained to child protection or child safeguarding level two as a minimum. Administrative staff were trained to level one as a minimum. The practice maintained an accurate and up to date register of patients subject to safeguarding arrangements and patients deemed to be 'at risk'. The practice also used alerts on records of those patients with access to a child or young person deemed to be at risk, to ensure a full picture was available to clinicians. These governance arrangements mirror the gold star standard advocated in NHS practices.
- Staff used the alert facility within DMICP (Defence Medical Information Capability Programme) to ensure that risks showed clearly when the medical record was opened.
- Notices in the waiting room and consultation rooms advised 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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice had an infection control policy and lead who had attended annual infection control refresher training. Infection control audits were carried out at least annually.
- All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. Spillage kits were available and clinical waste was stored appropriately and securely and was collected from the practice by an external contractor on a fortnightly basis.
- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines.
- The practice carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Prescription pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had a system for production of Patient Specific Directions to enable nurses to administer vaccinations after specific training when a doctor or nurse was on the premises.
- We reviewed personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. A health and safety policy was available and a poster was displayed in the practice office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. The fire equipment was checked on a monthly basis. Fire alarms were tested weekly and all electrical equipment was checked on a regular basis to ensure the equipment was safe to use. Clinical equipment was checked in line with Defence Medical Services policy to ensure it was working properly.
- Systems in place to monitor patients on high risk medications were effective and prioritised patient safety and safe prescribing practice.
- The Defence Primary Health Care (DPHC) Team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. GPs we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The practice was taking the necessary action to manage the maintenance of the practice. However, staff spoke of their frustration when waiting for maintenance repairs. We saw from records kept by the practice that requests for maintenance were acknowledged but not necessarily responded to in a timely manner. At the time of inspection, the roof over the reception area was leaking. Staff cordoned off this area and patients had to walk around the cordon in what is a very busy reception area. Although the risk was well managed by staff, the risk remains present until repairs are carried out.
- 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. The practice had a record of the minimum number of GP sessions needed per week and used this to manage GP staffing levels. The practice would use the same locums if required and completed the necessary checks. Staff had a flexible approach towards managing the day to day running of the practice.

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 instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. There was also an alarm system in consulting rooms.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room and in the reception office.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- 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 practice computer system and additional copies were

kept off the premises.

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

Good



Our findings

Effective needs assessment

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

Management, monitoring and improving outcomes for people

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

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

- There were 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 all of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For all diabetic patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were 10 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. Review showed 90% (nine out of 10) had a record for their blood pressure in the past nine months. Of these patients with hypertension, 80% (eight out of 10) had a blood pressure reading of 150/90 or less.
- The number of patients with long term physical or mental 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 19, which is 100% of the smoking patient population. The NHS target for this indicator is 90%.

- There were 27 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 for 25 of them. Two patients had not had an asthma review in the last 12 months which included the three Royal College of Physicians (RCP) questions. Both of these patients had been recalled for an updated asthma review.
- There were 14 patients with a diagnosis of depression in last 12 months. Of these, 11 had been reviewed within 10-35 days of the date of diagnosis. One patient was reviewed 39 days post diagnosis. Two patients did not attend follow-up appointments; both patients had been contacted to offer a further appointment. All patients had appropriate alerts set on their electronic patient record.
- 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 in line with DPHC 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 provided on the day of inspection showed :
 - 100% of patients had a record of audiometric assessment, compared to 99.5% regionally and 99% for DPHC nationally.
 - 86% of patients' audiometric assessments were in date (within the last two years) compared to 89% regionally and 86% for DPHC nationally.

There was evidence of quality improvement including clinical audit:

- An ongoing programme of clinical audit was in place and demonstrated a commitment to improving outcomes for patients at the practice. Audits undertaken to date were cyclical and were relevant to the needs of registered patients. The practice had conducted 18 audits within the last 12 months. Some of these consisted of more than two cycles. We saw that learning points were taken from all audits; results and learning points were discussed at clinical meetings and healthcare governance meetings.
- We saw audits were conducted on a wide range of clinical treatments, which helped clinicians maintain and develop their knowledge. This was important in a practice that has a higher proportion of younger patients with lower rates of age related conditions.
- For example, an audit on lipid modifying medicines covered the correct prescribing protocol for these medicines, and over two cycles showed an increase in prescribing of the correct first line medicine, from 67% to 80%. The audit also highlighted that the alerts set on a patient record were easy to override. As a result increased tracking of these patients was targeted to reduce this practice.
- An audit on asthma patients and adherence to QOF indicators, showed improvement in care of these patients over two cycles of audit. Also results of the audit prompted the quicker recall of patients who had turned eight years old, for review of their condition to check for reversibility or variability in condition. We saw that analysis of audit findings also prompted the better use of clinical coding for effective management of patients with asthma.
- Audit of patients from high incidence countries for latent tuberculosis (T.B) showed these patients were identified quickly and referred for treatment without delay.
- An audit on minor surgery for post-surgical infections showed zero incidents of post procedure infection. This covered three doctors who performed a total of 33 procedures.
- An audit on prescribing interventions supported the management of safe and effective

prescribing across the practice. ATC Pirbright issued approximately 9,500 prescriptions in the six month period from 1 January 2017 to 30 June 2017. When checked, 258 interventions had been made by dispensary staff. This could be due to incorrect quantities of medicines prescribed (against prescribing guidance), changes to prescribing protocol or guidance, or where abbreviations have been used in patient direction labels on medicines. Overall the intervention rate was 2.7%, compared to a standard set by the practice of 2%. Audit findings were shared and discussed at practice meetings, with action points agreed to reduce the rate of intervention to below 2%. This audit supported our findings that communications on NICE guidance, updates to the Tri-Service Formulary and MHRA alerts were effectively shared and followed by staff.

- Monitoring exercises were in place to check that standard operating procedures continued to meet the needs of the practice and its patients.
- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. When we reviewed the CAF we saw that any areas requiring further action or updating were being managed effectively. We also noted that the practice had used this self-assessment tool effectively, which aided the proactive management of areas that required attention.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and adherence to Caldicott principles. Staff had access to and made use of e-learning training modules and in-house training.
- Staff had all received mandatory training in subjects such as fire, basic life support and infection control. In addition staff had received role-specific training. For example, the infection control lead had attended a relevant course and all clinicians had been trained around the application of Gillick competence (Gillick is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge). Staff who acted as chaperones had received training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training including an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes. The medical centre was Yellow Fever registered and the practice nurses were up to date with training for this.
- The nurses maintained their own continual professional development. The practice manager organised mandatory training and the practice nurses managed their own nursing update training. We were told there was no issue with being released for courses and or updates.
- We particularly noted that the detailed minutes of monthly meetings highlighted all training courses available to staff with links to how to apply for these training places. The practice was proactive in encouraging all staff to improve their knowledge and scope of practice; staff we spoke to confirmed that line managers encouraged them to attend courses relevant to their role

and future development.

- There were supervised placements available within the practice for medics, trainee pharmacy technicians and student nurses.
- The practice medics assessed “fresh cases” (patients being seen for the first time for a certain issue). Daily clinical oversight was in place to monitor and discuss decisions made and treatment given by medics. Eight medics were assigned to the practice.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. Information was shared between services, with patients’ consent, using a shared care record.
- From the sample of anonymised patient notes we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Information on any vulnerable adult or child was recorded appropriately. The necessary alerts were used to ensure clinicians were aware of who these patients were. Nurses who summarised patient records demonstrated they could effectively collate and order information to ensure that all clinicians had effective access to this, which promoted patient safety.
- When we made checks, we saw patient records were current and there was no backlog in summarising notes.
- The practice had ring-fenced the services of one full time nurse and 32 hours from part time nursing staff, who managed the flow and summarising of patient notes. The average turnover of patients (new recruits) was approximately 4,000 per year. The turnaround time on these notes, from receipt to full summarising and input onto the computerised patient record system was two days. In addition to this, the practice had 1455 permanent military patients and approximately 204 dependant patients. This added to the annual throughput of patients. There was no delay to summarising of civilian patient notes, with these taking typically two days to summarise and enter on the practice patient record system. The average time to summarise the notes of a new recruit was set at 45 minutes and slightly longer for civilian notes. As well as maintaining this throughput, the practice also took on summarising work from other practices who struggled to keep up with this work and summarised notes of reservist soldiers. When we reviewed the systems in place at the practice to facilitate this work, we saw they were highly effective.
- Reports were usually received from the OOH service within 48 hours of a patient having accessed treatment. These reports were scanned on to DMICP and alerts sent to a doctor to ensure they were read and appropriate follow up instigated if necessary. The reviewing doctor coded problems/conditions as necessary on DMICP. Patients seen by the out of hours service (OOH) were required to present to the practice, if practicable, the next day for review.
- When we reviewed patient registers we saw the standard of clinical coding and maintenance of accurate patient registers was of a high standard. All information required from the practice was available without delay. When reviewing information we saw that a mix of both clinical and

administrative staff had an excellent understanding of how the practice computer system worked. This contributed to the quality exchange of patient information both onwards following recruits initial training and on discharge of those patients who did not progress beyond basic training.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment. When providing care and treatment for young recruits, many of whom are aged between 17-18 years, staff carried out assessments of capacity to consent in line with relevant guidance. We saw that any parental or guardian involvement in patients' care or treatment was with the consent of the patient.
- The process for seeking consent was monitored through patient record audits.

Supporting patients to live healthier lives

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

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- All new patients were asked to complete a proforma on arrival. The practice nurse followed up any areas of concern, such as raised blood pressure.
- The practice offered basic sexual health advice including the issue of free condoms and referred on to local clinics in the community for more comprehensive services.
- Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50-64 years who were entitled to breast screening. The 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. All patients over 50 who had not had cholesterol check in the past five years were called in to be tested.
- 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 296 out of 338 eligible women. This represented an achievement of 88%. The NHS target was 80%.
- There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available.
- The practice were able to give us data on rates of childhood immunisation. Childhood immunisation rates for the vaccinations given to children under 12 months was 84%. For children under two years old this was 84% and for five year olds was 87%. We do not have any regional or national comparative data across DPHC practices for rates of childhood

immunisation.

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 June 2017 provides vaccination data for patients using this practice:

- 93% of patients were recorded as being up to date with vaccination against diphtheria compared to 94% regionally and 95% for DPHC nationally.
- 93% of patients were recorded as being up to date with vaccination against polio compared to 94% regionally and 95% for DPHC nationally.
- 71.5% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 80% regionally and 83% for DPHC nationally.
- 95% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 91% regionally and 94% nationally.
- 93% of patients were recorded as being up to date with vaccination against Tetanus, compared to 94% regionally and 95% for DPHC nationally.
- 51.5% of patients were recorded as being up to date with vaccination against Typhoid, compared to 54% regionally and 53% for DPHC nationally.

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



Are services caring?

Our findings

Kindness, dignity, respect and compassion

- During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The practice could offer patients the services of either a female or a male GP, when patients expressed a preference. For any intimate examinations that were to be performed by a GP at the practice, a chaperone was always available.
- There was an accessible toilet in the waiting area. A room was available for baby changing and/or breastfeeding.
- We were able to speak with two patients briefly. They told us they were very satisfied with the care provided by the practice and said they were able to get an appointment when needed.
- Patients commented in feedback provided on CQC comment cards that they felt involved in decision making about the care and treatment they received. They commented that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- We saw many compliments and letters received by the practice from patients. Some of these described the very personal experiences of young recruits joining the service, and how clinicians and professionals had helped them during their basic training, both physically and emotionally. Examples we saw demonstrated the very high level of commitment of all staff to their patients at the practice.
- Results from the latest practice Patient Experience Survey showed patients felt they were treated with respect and felt involved in decisions about their care. For example:
 - 94% of patients said the practice was good at involving them in decisions about their care.
 - 100% of patients said they would be happy to recommend the practice to a friend or family member.
- We did not receive any comparator data to compare patient feedback with other GP practices. However the views of patients expressed on CQC comment cards and those from patients we

spoke with, aligned with the views above.

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

Care planning and involvement in decisions about care and treatment

- The clinicians and staff at the practice, under the leadership of the Senior Medical Officer, demonstrated that they recognised at all times that the junior soldiers they provided care and treatment for, could be making decisions about treatment themselves for the first time. Staff demonstrated how they gauged the level of understanding of patients, avoided overly technical explanations of diagnoses and treatment and encouraged and empowered young patients to make decisions based on sound guidance and clinical facts.
- When we spoke with patients they told us the GPs took the time for example, to explain why an injury may be slow to heal and what they could do to improve the healing process. We saw this type of engagement and involvement across all treatment and in handover between GPs, nurses and physiotherapy staff.
- The young patients at the practice were treated in an age-appropriate way and recognised as individuals.
- When reviewing patient records, we saw that clinicians, nurses and medics made themselves available outside of normal working hours, for example at weekends, for appointments with any patient with learning difficulties. For example, patients with ADHD could avoid falling behind with practical courses or more formal learning, by having their medical appointments at the weekend.
- The Choose and Book service was used to support patient choice as appropriate (Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).
- Information leaflets were available in reception and a computer was also available to access health information.

Patient and carer support to cope emotionally with treatment

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic was prominently displayed and accessible. For example, we saw posters which explained how to use a condom safely, on symptoms that may suggest a sexual health screening appointment would be useful, on access to contraception and on the importance of completing any prescribed course of treatment.
- The practice acted in a compassionate way toward any patient that had to be discharged from the training course on health grounds. We saw that the practice reassured these patients and signposted to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions.
- The practice proactively identified patients who were also carers. We saw that 23 patients were registered as carers, some of these children. Where patients identified themselves as carers, a

code was added to their records in order to make them identifiable and so that extra support or healthcare could be offered as required. The SMO (Senior Medical Officer) attended monthly welfare meetings with other professionals to discuss where extra support and care were needed.

- The practice had formed working links with community based groups that offered additional support for carers – both practical and financial. These organisations were Surrey Military Young Carers and Surrey Independent Living Council. Any person that was a carer could be referred to these organisations for support.
- Patient information leaflets and notices were available in the patient waiting area which informed patients how to access a number of other support groups and organisations.
- Clinicians were aware of those patients that may have entered the army from foster care or other local authority care. We saw that the practice played a strong pastoral role in the care of these recruits and worked with welfare services within the army to ensure these patients had somewhere to go, should they be discharged from the army due to being unsuitable for military life.
- Doctors and nurses were highly supportive of young mothers who used the practice. We were told that patients often struggled to adjust to the life of a military spouse or partner, particularly when they were living a considerable distance from their own extended family. Clinicians ensured that these patients had access to the support networks they required and offered follow up appointments to ensure that services provided met their needs.

Are services responsive to people's needs?

(for example, to feedback)

Good



Our findings

Responding to and meeting people's needs

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

- A wide range of clinics were available to service personnel and their dependants, for example, minor surgery services, health checks, travel advice, well woman clinics and family planning advice. Pre and post-natal clinics were held at the practice every week. Patients were able to receive travel vaccines when required. The practice was a Yellow Fever centre and nurses had received training to support this.
- Patients could have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse. Patients requiring them could book a double GP appointment of 30 minutes.
- Same day appointments were available for those patients who needed to be seen quickly.
- Physiotherapists were employed within the practice for use by service personnel and recruits. All referrals to this service were made by the GPs and the average waiting time for an appointment was less than one week. Physiotherapy services for dependants were community based and available on referral from a GP at the practice.
- There were accessible facilities which included interpreter services when required. Transport for patients to hospital appointments was available if needed.
- Eye care and spectacles vouchers were available to service personnel from the medical centre. Optician services were available in the local town for dependants.

Access to the service

- The practice was open from Monday to Friday each week, between 08:00 and 16:00. For military patients, access to the practice was between 07:30 and 19:00, Monday to Friday. The telephone is manned 24 hours a day. After these hours, between 17:00 and 18:30 civilian patients were advised to contact Woking Community Hospital Walk in Centre. Outside these hours all patients were diverted to NHS 111. This arrangement did not give all patients' access to a GP between the hours of 17:00 and 18:30.
- The practice leaflet gave clear directions on local accident and emergency unit access. The nearest accident and emergency department was located at Frimley Park Hospital.
- Results from the practice Patient Experience Survey showed that overall patient satisfaction levels with access to care and treatment were good. For example:
 - 100% of patients said they were able to obtain an appointment when they needed

one.

- 100% of patients said this appointment was at a convenient time.
- Patients told us on the day of the inspection that they were able to get appointments when they needed them and that access to doctors at the practice was good.
- We saw from minutes of meetings that access to services by dependants was discussed at practice meetings, including the number of patients who did not attend appointments, which increased during Autumn/Winter 2016. We noted that the practice took a caring approach to investigating this, looking at any barriers there may be for people using the medical centre, for example, young mothers with infants visiting the practice during bad weather. From this we saw that all staff were both compassionate and flexible in trying to meet the needs of all patients at the practice.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Defence Primary Health Care had an established policy and the practice adhered to this.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.
- We spoke with two patients who told us that they felt comfortable and knew how to complain if the need arose. They confirmed that military rank would not be a barrier to them raising issues with the practice.
- There had been seven complaints raised since October 2016. We saw that there were processes in place to share learning from complaints. Complaints were audited through the Common Assessment Framework (CAF). This was used to focus on improvements to the service and to ensure that designated standards were being met on the handling of complaints.

Are services well-led?

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

Outstanding



Our findings

Vision and strategy

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Consistent, safe and effective care was clearly at the forefront of the vision for the practice and this was clearly projected to and adopted by all members of staff.
- All staff we spoke with were engaged and committed to the practice vision. Staff took pride in their work which contributed to a highly positive working environment.
- Staff acknowledged that their opinions, observations and views were valued.
- The practice followed the DPHC mission statement: “DPHC will deliver a unified, safe, efficient and accountable primary healthcare service for entitled personnel to maximise their health and to deliver personnel medically fit for operations.” The practice had also embraced their own local level mission statement – “Doing the right thing on a difficult day.”
- Staff we spoke with throughout the day could identify with these mission statements. The DPHC statement was displayed in the waiting areas and staff knew and understood the values and behaviours required to support this. The practice had a clear strategy and supporting business plan which reflected the vision and values and these were regularly monitored.

Governance arrangements

- The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas.
- Policies from the framework were implemented and were available to all staff. These were updated and reviewed regularly. A significant finding of our inspection was that governance processes were truly embedded at the practice and fully understood by staff. The effect of this was significant, in that when key figures were posted to other duties, the levels of governance were maintained. This contributed to the safe and effective running of this busy practice.
- An understanding of the performance of the practice was maintained. The practice manager used the Common Assurance Framework (CAF) as an effective governance tool. Practice meetings were held regularly and were used as an additional governance communication tool, for example to remind staff to complete all paperwork in respect of significant events and to draw the attention of all staff to learning opportunities available.
- Learning needs were discussed at practice meetings and appropriate training was requested for all staff as required. The meetings were also used for forward planning, for example, to ensure that patient needs were met during busy clinic times and periods of staff sickness. The

meetings provided an opportunity for staff to learn about how the performance of the practice could be improved and how each staff member could contribute to those improvements. Notably, we saw from minutes of these meetings, that all staff were aware of the changing priorities of individual departments, for example, in physio departments. The active exchange of information facilitated at these meetings increased the instance of leaders and staff, working together for the benefit of patients.

- A programme of clinical and internal audit was used to monitor quality and to make improvements. We saw that the practice used their audit work to identify learning and action points. We noted that a driver of successful audit had been the improved use of correct clinical codes by all staff within the practice. As a result of this, second and third cycle audit was more insightful whilst giving more accurate findings and enabling learning.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. This included plans developed each year that took account of manning levels at the practice due to deployment of some staff.
- We saw evidence from minutes of meetings, a structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

- On the day of inspection the leaders in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Everything we saw on the inspection day, and communications with the practice following the inspection, supported this.
- There was a clear leadership structure and staff felt supported by management. Staff told us the practice leaders were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run and develop the practice. We particularly noted the 'learning atmosphere' in the practice, which was promoted by leaders. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Following input from staff, leaders made decisions that delivered positive benefits for patient safety and the effectiveness of the service. For example, the decision to ring fence the working hours of one full time nurse and 32 hours of a part time nurse, to ensure that all patient note summarising was dealt with efficiently. Given the patient turnover at this practice, the achievement of summarising new patient notes within 48 hours is commendable.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included training for all staff on communicating with patients about notifiable safety incidents. The GPs 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 from:

- Patients through the practice Patient Experience Survey and from any individual patient

feedback received.

- 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.
- Completed CQC comment cards from patients supported our findings, that there was an open door policy when it came to patient input and feedback.

Continuous improvement

- There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and from minutes of meetings we reviewed we saw that the leaders of the practice focussed on improving the speed and quality of delivery of care for all patients. For example, the practice had developed effective, efficient systems for screening patients from higher incidence countries for latent tuberculosis. Those who require further testing were offered this without delay to check for active tuberculosis. The training schedule at Pirbright is tight and the patients were allocated time to attend the medical centre for vaccinations at week one, week five and week six. This required the test for tuberculosis (TB) to be accommodated around these vaccination dates. We saw the practice managed this effectively with recruits testing positive for latent TB referred to a specialist nurse at Frimley Park Hospital for treatment.
- Leaders and staff at the practice recognised they would not achieve the highest standards of clinical care for their patients alone. We saw several examples of local partnership working that brought real benefits to patients and to the wider community at Pirbright. For example, work with the specialist TB nurse at Frimley Park Hospital to reduce the possible spread of disease, and through doctors providing an extended on-call service to patients who phoned the practice outside of normal opening times. We also noted strong working links with external agencies, such as Surrey Military Young Carers and Surrey Independent Living Council, which brought both financial and practical help for carers, which contributed to the overall health and well-being of these patients. Doctors and nurses spent a considerable amount of time supporting patients at risk of isolation, for example, young mothers whose partners were away on military exercise.
- There was good evidence of quality improvement activity in many areas and the practice team focussed on improving outcomes for patients through scrutiny of audit which provided action points to achieve these improvements. For example, we saw that audit cycles carried out by GPs at the practice showed that there were zero incidents of post procedure infection. This standard has been maintained over one subsequent, full cycle of audit.