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.

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Good</th>
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<tbody>
<tr>
<td>Are services safe?</td>
<td>Requires improvement</td>
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<tr>
<td>Are services effective?</td>
<td>Good</td>
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<tr>
<td>Are services caring?</td>
<td>Good</td>
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<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good</td>
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<tr>
<td>Are services well-led?</td>
<td>Good</td>
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Summary of findings

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at RAF Valley on 30 January 2018. Overall, the practice is rated as good. 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.
- The assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff. However, medical safety alerts were not fully processed and managed.
- We saw several examples of collaborative working and sharing of best practice to promote better health outcomes for patients.
- There was evidence to demonstrate that quality improvement was embedded in practice, including clinical audits 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 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 provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- The layout of the building did not meet the privacy and confidentiality needs of patients, although the practice did all it could to mitigate this. In addition, the building was in a poor state of repair with damp, mould and flooring which was buckling and rotten. The flooring was replaced with chipboard and made safe to walk on the day of the inspection. However, this was not conducive with good infection control practice.
- There was a clear leadership structure and staff felt supported by management. However, some elements of the leadership team were not fully engaged with the rest of the practice.
We identified the following notable practice, which had a positive impact on patient experience:

Practice staff worked hard to find alternatives to safe and responsive care for their patients when possible, for example;

- In Wales there are prolonged waiting times for some secondary care services which exceed a year in some instances proving a challenge for the management of patients. There was evidence that, where possible, the clinicians worked hard to find alternative providers or resources to help get the patients the care they needed.

- We saw the practice was proactive in learning and sharing good practice. For example the practice nurse met with other nurses from local practices and had formed an informal network whereby they shared current practice and learning. This was done in their own time, then shared with colleagues at the practice and training sessions delivered.

The Chief Inspector recommends:

- Develop a system to ensure that the actions required to respond to MHRA alerts are clearly allocated to a clinician to oversee / undertake as required.

- Action is needed to secure new premises and ensure the building is fit for purpose.

- Ensure all leaders understand and contribute equally to the clinical leadership throughout the practice.

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

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

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

- The practice prioritised safety. An effective system was embedded for reporting significant events and all staff knew how to raise and report an incident and were fully supported to do so.
- When things went wrong patients were engaged and received reasonable support, relevant information and a written apology. They were advised about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined systems, processes and practices in place to keep patients safe and safeguarded from abuse. All staff, including non-clinical, staff were trained to the appropriate level for their role.
- Risks to patients were assessed and well managed to minimise risks to patient safety. However the system to deal with medicine, medical device and patient safety alerts was not always actioned appropriately to ensure patient safety.
- 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.
- The building was in a poor state of repair with notable damp, mould and buckled flooring in the corridors. This had been reported to Regional Headquarters by the practice and temporary arrangements and repairs had been made. A new medical centre was planned to be built in the future. However the current state of the building did impact on patient safety including infection control.
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. Staff were proactive in extending and pursuing their own personal learning needs and then sharing with the wider practice group.
- Audits and other quality initiatives demonstrated that staff embraced quality improvement to enhance patient outcomes.
- The practice valued and encouraged education for all practice staff giving them the skills, knowledge, and experience to deliver effective care and treatment.
- Patients were actively supported to live healthier lifestyles through a targeted and proactive approach to health promotion and wellbeing.
- 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.

- Comment cards, completed by patients before our inspection, indicated that they felt practice staff treated them with compassion, dignity and respect and they were involved in decisions about their care and treatment. Patients told us on the day that they felt the care was good and they were treated with kindness. The practice kept a record of compliments received, this showed high levels of satisfaction from patients.
- Information for patients about the services available was accessible.
- Prescriptions were collected by the practice from the local pharmacy if the patient was unable to do so themselves.
- The practice provided services to families and dependants, and recognised that patients may have some caring responsibilities for their relatives. There were no registered carers at the time of our inspection.
- Systems were in place to maintain patient and information confidentiality. However, the fabric and layout of the building was not ideal to support patient privacy at all times.
### Are services responsive?
The practice is rated as good for providing responsive services.

- We saw that it was easy to make an appointment and urgent appointments were available the same day. Appointments were available to pre-book in advance.
- There was good engagement with the community midwives and health visitors who were invited and attended multi-disciplinary meetings every month at the practice. Mental health referrals were made for service personnel to Donnington situated 126 miles away.
- Two physiotherapists were employed within the practice. All referrals to this service were made by the GPs and the average waiting time for an appointment was three days.
- A physiotherapist visited each squadron every Wednesday and held a clinic, this could be pre-booked or patients could just turn up on the day to be seen.
- Patients could select the gender of clinician they wished to be seen by.
- Eye care and spectacles vouchers were available to service personnel at the medical centre.
- Transport for patients to hospital appointments was available if needed.
- The practice had an effective system in place for handling complaints and concerns. Complaints were discussed with the whole team and at practice meetings and actions put in place to prevent reoccurrence.

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

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- The practice had policies and procedures to govern activity and held regular MDT meetings.
- 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. We saw evidence the practice complied with these requirements.
- There was a clear leadership structure and staff felt supported by management. However, some of the leadership team did not have full oversight of the clinical leadership of the practice which was evident from the lack of understanding
of some of the operating processes already in place. The rest of the clinical staff were able to clearly articulate these.
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 RAF Valley

RAF Valley Medical Centre currently has a population at risk (PAR) of 580 and provides primary and occupational healthcare to all service personnel and their entitled dependants posted to the station. Additionally they provide emergency medical cover for all air operations at RAF Valley and a nearby airfield (RLG Mona).

The medical centre has three GPs, two military and one civilian, two nurses, one military and one civilian, nine medics and two civilian administrators. The practice also has a Primary Care Rehabilitation Facility (PCRF) which is established for two physiotherapists, one military and one civilian post which is currently covered as a job share between two members of staff and one exercise rehabilitation instructor (ERI).

In addition to routine GP services, the treatment facility offers physiotherapy and rehabilitation services. Family planning advice is available, with referral onwards to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams. Mental Health referrals are made for service personnel to Donnington situated 126 miles away.

The facility was open from Monday to Friday each week, between 0800 and 1830 hours. The centre was closed on the last Thursday of each month for routine appointments, emergency cover was provided by duty staff at the practice on these days. After these hours patients were diverted to out of hour’s services provided by the local NHS, North Wales Out of Hours Service. Throughout this report, RAF Valley will be referred to as ‘the practice’.

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 30 January 2018. During our visit we:
• Spoke with a range of staff, including three GPs, the practice manager, one practice nurse, four medics, a physiotherapist and two administrative staff. Reviewed comment cards completed by patients who shared their views and experiences of the service.

• We visited the squadron with a physiotherapist and spoke with a trainee pilot.

• Looked at information the practice used to deliver care and treatment plans.

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

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

Our findings

Safe track record and learning

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

- The deputy practice manager was the dedicated lead to oversee significant events and staff said they would approach the lead if they were unsure of any issues in relation to significant events. Staff were familiar with policy and with using the standardised Defence Medical Services (DMS) wide electronic system the practice used to report, investigate and learn from significant events, incidents and near misses. They said there was a strong culture of reporting and learning from incidents at the practice. Thirteen significant events had been identified and managed over the last 12 months. Staff provided a number of examples and described how the incidents were managed. They highlighted any changes made as a result of the investigation and we saw good evidence of improvements made. However the written information submitted to the Defence Medical Services headquarters (DMS) was not always fully comprehensive and did not fully reflect the actions taken. The practice recognised this and was going to share this learning with the wider team.

- We saw meeting minutes from January 2018 showed a significant event in relation to documentation being printed out in the wrong location due to a printer setting not being correct. Following this all staff were reminded of the importance of printer settings and this information was in reinforced in all staff induction packages. Significant events were a standing agenda item at the monthly practice meetings where they were discussed with the wider staff team.

- We reviewed safety records and national patient safety alerts, including the minutes of meetings where these were discussed. MHRA alerts were monitored by the medical store’s staff and emailed to clinicians for action and were also shared with the local pharmacy. The email notification was recorded on the alerts spread sheet, but the actions taken were not always apparent. For example an alert regarding a faulty pacemaker had been made and the practice had not searched the patient list to see if they had any patients this would affect.

- When unintended or unexpected safety incidents happened patients received 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, a patient was given a vaccine that had breached the cold chain storage and off license authority, (there are clinical situations when the use of unlicensed medicines or use of medicines outside the terms of the license may be judged by the prescriber to be in the best interest of the patient on the basis of available evidence). The practice took necessary action by informing and apologising to the patient, offered them a copy of the complaints procedure and advised them of the changes and improvements made to prevent a similar incident happening again. The practice had also informed their Regional Pharmacist, who assisted with the investigation and in advising the patient, to ensure safety.
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:

- The staff we interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level three.

- 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 permanent civilian GP who worked part time at the practice, effective deputising arrangements were in place. The practice held a register of patients subject to safeguarding arrangements and patients deemed to be ‘at risk’. Staff used the alert facility within DMICP (Defence Medical Information Capability Programme) to ensure that risks showed clearly when the medical record was opened. There were no patients under safeguarding action currently; meetings were held with the health visitor and the midwife to ensure that processes were ready for if that happened. There was one ‘looked-after’ child and their notes were appropriately annotated to draw attention to their potential health needs.

- 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 within the limitations of the building itself. We observed the premises to be clean and tidy. The infection control lead nurse undertook a weekly inspection of the practice to check that good standards of cleanliness were upheld. The practice had an infection control policy and lead staff member who had attended annual infection control refresher training. The infection control audit undertaken in October 2017 showed that the medical centre only had partial compliance (81%), it was recognised that there were areas within the practice that could not be improved as it related to the infrastructure of the building. We saw six issues that had been identified and actioned, for example the introduction of cleaning schedules for toys and the water cooler in the waiting room, updated sharps training for all staff and an update and review of the pandemic flu plan which had been completed.

- 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.

- 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 for example an anti-biotic audit, 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 medics to administer vaccinations after specific training when a doctor or nurse were on the
• The full range of recruitment records for permanent staff was held centrally at RHQ. However, the practice manager could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. They also monitored each clinical member of staff’s registration status with their regulatory body. The practice manager confirmed all staff had professional indemnity cover. Information was in place to confirm practice staff had received all the relevant vaccinations required for their role at the practice.

Monitoring risks to patients

Risks to patients were assessed and well managed.

• The practice conducted regular medicine audits, for example, antibiotic prescribing audit, repeat prescribing audit and medicines management risk assessment audit.

• The practice was being proactive about asking secondary care providers for shared care agreements. This made sure that patients on high risk medicines were receiving safe care.

• There was a process for ensuring that the monitoring of high risk medicines occurred. The GP would enter the code onto Defence Medical Information Capability Programme (DMICP) for monitoring of shared care drugs and the practice nurse ran a monthly search for these patients which was kept on a register. They were then discussed at the clinical meeting monthly. The patients were seen and reviewed before each prescription was issued and the medications and bloods monitoring reviewed by a GP.

• There was a good system in place for the monitoring of laboratory results. There had been a recent incident where there had been a significant delay in reviewing a swab result. This had resulted in a delay in prescribing the antibiotics the patient needed. This was reviewed as a practice and it was noted that as the nurse who usually moved results into individual inboxes was not at work, and there was no other member of staff deputising for this task. This meant results were left unseen. New measures have now been put in place to ensure that the duty doctor reviews all results daily with the aspiration that there are not delays in reviewing results.

• The practice recognised the importance of managing sick chits (temporary sickness absence notes) to ensure the safety of patients and other military personnel. They had adopted a system to email the Chain of Command if a patient had been signed off from a certain task. This is important where the safety of the patient or their colleagues might be compromised where someone is temporarily unfit to perform a duty e.g. pilots. The clinical detail remained confidential between the GP and the patient, so adherence to Caldicott principles was maintained.

• There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and carried out regular fire drills. The fire equipment was checked by an external contractor on 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. 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).

• 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 and monitored their training. Staff had a flexible approach towards managing the day to day running of the practice.

- The medical centre is in a state of poor repair. There are plans underway for a new build. A number of issues were indicated that impacted on hygiene requirements and safety throughout the building meaning that it was very difficult to maintain infection control standards. The building was damp with visible mould, the flooring in the corridors was buckled and dangerous (this was replaced with ply wood on the day of the inspection). There was only one toilet for male and female patients; there was no accessible toilet for patients with disabilities, no baby changing facility other than the one in the staff toilet.

- The layout of the building was poor in relation to maintaining confidentiality mainly in the reception, and treatment rooms.

- The leaders of the practice were working to mitigate the risks associated with the building. We were advised that a new medical centre was planned to start in February 2018.

**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 alarm system in all the consultation and treatment rooms which alerted staff to any emergency.

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

Our findings

Effective needs assessment

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients’ needs. We looked at the minutes of a recent clinical update meeting and saw that sepsis and endometriosis were discussed and acted upon. NICE guidance was a standard agenda item at these meetings. 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.

Management, monitoring and improving outcomes for people

- There was a robust chronic disease management plan and this was managed by the senior practice nurse. Patients were recalled appropriately and patients received effective, individually personalised care. There is a comprehensive and extensive chronic disease management register. The management was tailored to individual patients needs and outcomes were good with the patients well-known to the clinicians.

- The clinicians provided personalised effective care. An example of this was that all patients on medicines that need monitoring were reviewed face to face or on the telephone before all new prescriptions were issued. Staff could name those patients without reference to the spreadsheet although the spreadsheet was available; it was up to date and used to confirm blood testing was undertaken on time. The clinicians were diligent and dedicated in their work with the patients.

- 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 13 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, eight had a blood pressure reading of 150/90 or less which is an indicator of good blood pressure control.

- There were 24 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. Of these, 23 had an asthma review in the preceding 12 months which included an assessment of asthma control using the 3 Royal College of Physicians questions. This indicated that these patients were well managed.

- 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 97% regionally and 99% for DPHC nationally.
  - 98% of patients’ audiometric assessments were in date (within the last two years) compared to 83% regionally and 86% for DPHC nationally.

There was evidence of quality improvement including clinical audit:

- There was evidence of completed audit cycles. There was not strong evidence that these had demonstrated quality improvement, but a partial cause of this was the initial cycles already showed positive results. There was no cohesive direction for which audits had been chosen in the recent past. There was a new plan to address this; audits would be done based on new and recent NICE guidance updates, to check that guidance had been followed and to assure that patients were receiving the correct treatment and following designated care pathways. Examples of completed clinical audits and non-clinical audits we looked at included:
  - Clinical records audit - The findings of this audit found that the clinicians were meeting the required criteria set out in the audit and that no further cycles of the audit were required. All clinicians were to undertake regular peer reviews to ensure continued quality of medical record keeping.
  - An antibiotic prescribing audit completed in January 2017 exceeded the DPHC target of 90%. Despite the high score, action points were identified for doctors in relation to the use of FeverPAIN Score.
  - Referrals Audit – A further cycle of the audit undertaken in August 2016 identified that the quality improvement put in place following that audit had been effective and that all referrals were chased up and accounted for within six days.
  - Obesity Audit – this was a further cycle of an audit first carried out in 2013/14 and again in June 2017. This audit highlighted that there had been a considerable improvement in the documentation of BMI between 2013 and 2014. The 2017 audit demonstrated that this increased rate of recording was sustained, and had also improved. Audit results were also discussed at a clinical meeting to highlight the importance to all clinicians to reweigh patients with a BMI over 30. These are ongoing and would be assessed again next year when the audit was due for a repeat.

- 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 to aid effective management of areas that need 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 including locum staff. This included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and Caldicott accountability. Staff had access to and made use of e-learning training modules and in-house training.
- Staff had all received mandatory training in subjects such as fire, basic life support and infection control. In addition staff had received role-specific training. For example, the infection 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 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 saw the practice was proactive in learning and sharing good practice. For example the practice nurse met with other nurses from local practices and had formed an informal network whereby they shared current practice and learning. This was done in their own time, then shared with colleagues at the practice and training sessions delivered.
- 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.

- We found the practice shared relevant information with other services in a timely way. For example, one of the administrators managed and monitored the progress of referrals to secondary care services. The spreadsheet they maintained and monitored for referrals was used to indicate urgent and non-urgent referrals, and to highlight when the patient had received an appointment. They had set up a robust referral checking service which involved checking a referral had been received, and following this up at regular intervals to ensure an appointment has been made or ascertaining where the patient was on the waiting list. Recently the practice were made aware that there was an NHS electronic referral system in Wales that the practice did not have access to. They were in negotiations to gain access to this to improve the referral
process for their patients.

- From the sample of anonymised patient notes we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

- Patient records were current and there were a small number of notes requiring summarising (13). There was a strategy and routine to undertake this work on a weekly basis.

- Reports were usually received from the OOH service within 48 hours of a patient having accessed treatment. These reports were scanned on to DMCIP and alerts sent to a doctor to ensure they were read and appropriate follow up instigated if necessary. The reviewing doctor coded problems/conditions as necessary on DMCIP.

**Consent to care and treatment**

- Staff sought patient’s 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. For example a patient who had given consent for a procedure was seen by the nurse and the nurse was concerned that the patient was not of the right disposition at that time to have the procedure undertaken. With the agreement of the patient they cancelled the appointment, spent some time talking things through and made a referral to the GP.

**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.
  - New patients have an arrival consultation with the practice nurse or GP as appropriate. All new patient questionnaires were reviewed by the nurse and all notes were summarised by the clinicians. New patients were invited in for an appointment if any issues were identified.

- The Senior Medical Officer (SMO) attended a Senior Executive meeting and discussed with the wider station how to establish a safe system in notifying the chain of command (CoC) regarding pilots/aircrew being unfit to fly. A new system had been developed of emailing the line manager with consent of the patient and this was working well.

- The practice offered sexual health advice and referred on to local clinics in the community for more comprehensive services including family planning.

- The practice had a health promotion calendar to promote specific issues relevant to the service population and its requirements.

- Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50 to 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. Flu vaccinations had been offered to all patients who were eligible.

- A dedicated cytology clinic was held every week. The number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 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.
- Childhood immunisation rates were above the DMS average. For example, childhood immunisation rates for the vaccinations given to under two year olds was 100% and 97.5% for five year olds.

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 October 2017 provides vaccination data for patients using this practice:

- 99% of patients were recorded as being up to date with vaccination against diphtheria compared to 96% regionally and 99% for DPHC nationally.
- 99% of patients were recorded as being up to date with vaccination against polio compared to 96% regionally and 95% for DPHC nationally.
- 89% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 82% regionally and 81.5% for DPHC nationally.
- 96.5% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 94% regionally and 92% nationally.
- 99% of patients were recorded as being up to date with vaccination against Tetanus, compared to 96% regionally and 95% for DPHC nationally.
- 16.5% of patients were recorded as being up to date with vaccination against Typhoid, compared to 55% regionally and 53.5% 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

Evidence we secured confirmed that the practice approach was to deliver the best service for their patients that they could.

- 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. However although consultation and treatment room doors were closed during consultations, conversations taking place in these rooms could be overheard due to the fabric and structure of the building of the building. Every effort was made by staff to not have patients in rooms next to each other at the same time if at all possible. Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

- The practice offered patients the services of either a female or a male GP. For any intimate examinations that were to be performed by a male GP at the practice, a chaperone was always available. A chaperone policy was in place and was displayed in the waiting area. Only trained staff were used as chaperones.

- We received 34 CQC comment cards from patients that described their care and treatment in a highly positive way. They said 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. They said staff were kind and respectful.

- Results from the latest patient experience survey showed patients felt they were treated with compassion, dignity and respect. For example:
  - 89% of patients said the practice was good at listening to any compliments, comments or complaints

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

- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities. 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 young patients at the practice were treated in an age-appropriate way and recognised as individuals.

- Data received from the Defence Medical Services (DMS) patient experience survey, February to May 2017 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:
  - 89% of patients said they felt involved in decisions about their care.

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

- The practice provided a service to patients from different countries and some of these patients did not have English as a first language. Staff told us that interpreter services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with treatment

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

- The practice proactively identified patients who were also carers, there were none registered at the time of the inspection. There were systems in place which when 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 attended monthly welfare meetings with other health professionals to discuss where extra support and care were needed.
Are services responsive to people’s needs?  
(for example, to feedback)

Our findings

Responding to and meeting people’s needs

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

- A wide range of services and clinics were available to service personnel and their dependants. For example, a cytology clinic, over 40’s health screening, physiotherapy and travel advice.
- Telephone consultations were available.
- Patients could have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse or longer if needed.
- Home visits could be arranged if required.
- Same day appointments were available for those patients who needed to be seen quickly.
- There were accessible facilities which included interpretation 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.
- The practice was proactive in being part of wider engagement with the whole base. For example;
  - The Mountain Rescue Team (MRT) was also stationed at RAF Valley. Two medics were regularly on call and attended training every month.
  - The practice maintains strong links with the Jon Egging Trust, this trust was set up to inspire and support young people in memory of a Red Arrows pilot who lost his life. The practice nurse delivers first aid training to local children involved with the trust at the base.
- In Wales there are prolonged waiting times for some secondary care services which exceeded a year in some instances proving a challenge for the management of patients. There was evidence that, where possible, the clinicians worked hard to find alternative providers or resources to help get the patients the care they needed. An example was a patient needing an anterior cruciate ligament repair who was expected to wait in excess of a year in the local NHS for treatment. The locum GP was working hard to find alternative sources of funding and it was expected to be successful in the near future.

Access to the service

- The practice was open from Monday to Friday each week, between 0800 and 1830 hours. The centre was closed on the last Thursday for routine appointments, emergency cover was
provided by duty staff at the practice on these days. After these hours patients were diverted to out of hour’s services provided by the local NHS, North Wales Out of Hours Service.

- Results from the patient experience survey showed that overall patient satisfaction levels with access to care and treatment were high. For example:
  - 80% of patients said their appointment was at a convenient location.
  - Patients comment cards we received confirmed that patients were happy with the appointment system and had good access to clinicians.

**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. There had been two complaints raised since February 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)

Good

Our findings

Vision and strategy

- The SMO and practice management team had developed their own vision, in addition to that of DPHC’s, which was more a reflection of what they already did rather than something they aspired to and this vision was clearly evident throughout the practice: ‘Always do our best for the patient at all times’. This was simple and effective and allowed new staff to quickly appreciate the ethos that was expected of them. It was clear that staff achieved this.

- Staff we spoke with throughout the day could identify this mission statement, and 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.

- All staff we spoke with were content with their working environment. Staff also acknowledged that their opinions, observations and views were valued.

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 national framework were implemented and were available to all staff. These were updated and reviewed regularly.

- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment 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. Learning needs were discussed at practice meetings and appropriate training was requested and delivered through this forum. 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. This 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.

- In addition, regular health care governance meetings were held and minutes were produced of all matters discussed. Monthly meetings were held to discuss vulnerable and at risk patients.

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

- A comprehensive programme of quality improvement was used to monitor quality and to drive
improvements. For example;
  o Introduce a locum clearing protocol, this had been actioned
  o Patient Participation Group (PPG), this was ongoing with another meeting planned in the near future.

- 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

- 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.
- The practice manager had a clear direction that the staff could follow and presented a positive and enthusiastic example for the staff to emulate. However, some aspects of the leadership team did not have a firm grasp of the clinical leadership of the practice which was evident from not clearly understanding some of the processes which occurred. Following the practice we were advised that this was being addressed. The rest of the clinical staff were able to clearly articulate these.
- All staff were involved in discussions about how to run and develop the practice. Staff told us the practice held regular meetings. Every Monday morning a meeting of clinicians was held to discuss the week ahead and make any plans as needed. 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.
- Staff indicated they felt well-supported by the management team and that they were approachable.
- The practice held regular force development activities, approximately every other month where up to half of the staff went away on training and development events. This fostered enhanced team cohesion and development of working relationships. They ensured that patient care was still delivered on these days.
- There were clearly allocated responsibilities in the practice with named deputies for cross coverage and resilience in the event of absence from the practice.
- 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 surveys and from any individual patient feedback received.

• The practice had worked hard to set up a Patient Participation Group and had held a meeting inviting patients to come along and be involved, however no patients had attended. Another meeting was scheduled to try again.

• 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.

• The practice had a ‘happy board’. This was where staff were able to stick a post it note up on a board to thank, praise or just make positive contributions to each other. These were shared at staff meetings.

• 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 within the practice. The practice team was forward thinking and from minutes of meetings we reviewed we saw that the leaders of the practice were open to learning opportunities from all sources. For example, at the present time the practice was striving to achieve direct access for patients needing physiotherapy.

• Over the next two years the PAR is expected to rise to around 1000 with the arrival training aircraft from other bases. With the increased PAR and the planned new building, the practice had aspirations of becoming a GP training practice, the new build would have capacity for a general duties medical officer (GDMO) and a GP registrar. It was planned towards the end of 2018 that the practice manager and CMP would attend the GP training course to enable them to make progress towards this goal as soon as the new building was complete.