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

### Ratings

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

We carried out an announced inspection at HMS Raleigh on 19 February 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. All staff knew how to raise and report an incident and were fully supported to do so. We saw some inconsistencies with the management of significant events with no clear indication that a root cause analysis had been completed and actions identified to address what had occurred, or actions put in place to reduce the likelihood of re-occurrence.
- 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.
- There was evidence to demonstrate that quality improvement was embedded in practice, including clinical audits, however these were limited.
- 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.
- 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 Chief Inspector recommends:

- Ensure significant event reporting is completed including evidence that actions have been identified, recorded and shared with all staff to prevent reoccurrence.
- Develop a system to monitor each clinical member of staff’s registration status with their regulatory body.
• Continue with the implementation of the rolling programme of improvement work and clinical audit to drive the best possible clinical outcomes for patients.

• Develop a log of patient safety alerts.

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. A system was in place for reporting significant events and all staff knew how to raise and report an incident and were fully supported to do so. Incidents were discussed with the practice team at practice meetings and all staff were made aware of them. However, we saw some inconsistencies with significant events management and recording. We saw that root cause analysis was not always conducted and lessons to address what had occurred and to reduce likelihood of re-occurrence were not applied.

- 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.

- 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.

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 comparable to regional averages.
• Practice staff assessed needs and delivered care in line with current evidence based guidance.

• There was evidence of quality improvement including clinical audit but this was limited. The audit programme was not up to date and planned audits had not been completed.

• 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.

• Patients were treated with compassion, dignity and respect, and were involved in decisions about their care and treatment.

• The patient’s experience survey demonstrated that patients were satisfied with the care and attitude of staff at the practice.

• Information for patients about the service available was accessible.

• Systems were in place to maintain patient and information confidentiality.

• We received 78 comment cards and spoke with two patients. All of the feedback was positive about the standard of care received.

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

• The patient’s individual needs were central to the planning and delivery of their individual care.

• The service was flexible to ensure patients’ needs were met in a timely way. For example, vaccinations were given opportunistically as well as at planned clinics to ensure patients were adequately covered from illness.

• Patients found it easy to make an appointment and urgent appointments were available the same day.

• Patients could select the gender of clinician they wished to be seen by.

• Three physiotherapists were employed within the practice.
Patients were able to self refer to this service and the average waiting time for an appointment was less than two days.

- 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 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.
- There was a clear leadership structure and staff felt supported by management.
- The practice had policies and procedures to govern activity and held regular multi-disciplinary 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.
Our inspection team

Our inspection team was led by a CQC inspector. The team included a GP specialist advisor, one nurse specialist advisor, a practice manager specialist advisor and another practice manager (shadowing the inspection).

Background to HMS Raleigh

HMS Raleigh Medical Centre provides primary care and occupational health to Royal Navy Phase 1 recruits and the unit's permanent members of staff. It also provides care to patients who are stationed at the base for the duration of a short course. An average of 60 new patients (recruits) arrive each week to commence training and join the practice. There is a high turnover of the patient population, which on the day of the inspection was approximately 1400, made up of 900 recruits and 500 more permanent staff.

The medical centre has two full time military GPs and three civilian GPs (some are part time), which equates to a full time equivalent of four. There are also four nurses; two military and two civilian, nine medical assistants, four administrative staff, a pharmacy technician, three civilian physiotherapists and two exercise remedial instructors (ERI).

In addition to routine GP services, the treatment facility offers physiotherapy and rehabilitation services. The PMO runs a weekly women’s health clinic offering the full range of contraceptive options. Maternity and midwifery services are provided by NHS practices and community teams. Mental Health referrals are made to HMS Drake located approximately 2 miles away.

The practice has a 14 bed overnight observation facility, situated on the upper floor of the practice. This is run by the practice staff who provide 24 hour a day cover.

The practice is open from Monday to Friday, between 0700 and 1830. Outside of these times, patients were referred to NHS 111 or local out of hours services. The nearest accident and emergency unit is located at Derriford Hospital which was approximately 22 miles away.

The practice has a dispensary which is open from 0800 to 1200 every morning, 1330 to 1530 on Tuesdays and Thursdays and 1330 to 1430 on Mondays. The dispensary is closed on a Wednesday afternoon. Any medicines that are not immediately available within the dispensary can be collected on prescription from Lloyds Pharmacy, who have a contract to dispense medicines for Defence Primary Healthcare (DPHC) sites. Throughout this report, HMS Raleigh 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 19 February 2018. During our visit we:

- Spoke with a range of staff, including two GPs, the practice manager, deputy practice manager, two practice nurses, three medical assistants, a pharmacy technician and three administrative staff.
- Reviewed 78 comment cards completed by patients who shared their views and experiences of the service. We were able to speak with two patients who used the service.
- Looked at information the practice used to deliver care and treatment plans.
- Conducted a visual inspection of the premises.

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 Principal Medical Officer (PMO) 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.

- Twenty 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. For example, we saw that a new patient had requested a repeat prescription for a medicine that required regular monitoring including blood tests. This had been instigated by a secondary care provider but no shared care agreement was in place to support this, (a shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of a medicine can be shared between the specialist and general practitioner). The practice took the appropriate steps to ensure the patient had a blood test and an appropriate code put on their clinical notes to ensure safe recall in the future. However, the evidence and investigation that was shown on the day of inspection was not captured within their significant events reporting.

- Significant events were a standing agenda item at the monthly practice meetings where they were discussed with the wider staff team. However, we saw some inconsistencies with significant events management and recording. We saw that root cause analysis was not always conducted and that actions to address what had occurred, or to reduce the likelihood of re-occurrence were not applied. The practice were aware of this and had completed an audit in January 2018 about the management of significant events. The outcome showed that more training was required by all staff to ensure a full, accurate and comprehensive account was recorded and held meaning.

- We reviewed safety records and national patient safety alerts, including the minutes of meetings where these were discussed. MHRA alerts were received via the automated system from DPHC HQ. There were multiple staff with access to the alert emails. All alerts were printed out in hard copy and checked against equipment registers and DMICP (Defence Medical Information Capability Programme) patient records/stock reports. Alerts were shared with practice staff as appropriate and documented in meeting minutes. However, there was no log maintained of alerts received within the practice.

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

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 the deputy principal medical officer (DPMO). Effective deputising arrangements were in place.
- There was a whistleblowing policy in place and information about whistleblowing displayed in the waiting area. We were given an example where this was used effectively.
- New recruits were required to complete an emotional health questionnaire which asked if they had any emotional issues they would like to discuss, for example, eating disorders, bereavement, self-harm, or if they had any caring responsibilities. This information was considered by the GP who then, if concerned, shared this information, with the patient’s consent, at the weekly welfare meeting. The practice held a register of patients subject to safeguarding arrangements and patients deemed to be ‘at risk’ or particularly vulnerable. Staff used the alert facility within DMICP 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 chaperone service was on display in reception and the waiting area and recruits were briefed on the availability as part of their induction and joiners medical within two days of arrival at HMS Raleigh. Only clinicians were utilised as chaperones.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The infection control lead nurse undertook a monthly inspection of the practice to check that good standards of cleanliness were upheld. The practice had an infection control policy and the lead staff member had attended annual infection control refresher training. The last infection control audit was undertaken in January 2018 and it showed some areas requiring improvement, including handwashing and the management of sharps bins. We saw actions were in place to improve, and further information was added to induction packs to ensure compliance was maintained at all levels throughout the practice.
- 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 vaccines, 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 antibiotic 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 full range of recruitment records for permanent staff was held centrally at Regional Headquarters (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. The practice did not however monitor 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.

• There was a good system in place for the monitoring of laboratory results.

• Military DMICP records were transferred in/out the practice electronically. Recruit’s records came either in paper form or electronically from the recruitment company. These were summarised by GPs who were allocated time each week with a set number of notes to complete. Recruits’ notes were summarised in advance of the patient attending for medicals. This system had highlighted several recruits whose previous medical history showed concerns but had not been recorded, these patients were sent back for further pre-screening. All other military notes were complete and had been summarised.

• 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).

• The practice maintained a rota for the inpatient facility and the duty doctor. The current staffing establishment was adequate and provided a good mix of staffing skills and experience. It was supplemented by clinical staff from other Plymouth medical establishments when required. 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 and completed the necessary checks and monitored their training. 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 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 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 practice had an infectious disease outbreak policy in place.
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 suspected cancer and sepsis guidelines were discussed and acted upon. We saw an example where a patient had presented at the practice acutely unwell and was promptly diagnosed as having sepsis. An ambulance was called but due to the location of practice this meant a possible delay of up to an hour. The practice responded by giving immediate treatment in line with NICE guidance and kept the patient comfortable and stable until the emergency services arrived.

- NICE guidance was a standard agenda item at weekly clinical 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.

Management, monitoring and improving outcomes for people

- There was a good 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 practice had funding available to provide swift access for patients needing diagnostic procedures, for example specialist X-ray. This was used to enable recruits to be seen and diagnosed quickly and their treatment plan initiated without delay.

- 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 26 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.

- There were 15 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, 13 (82%) had had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions. The other two patients were due to be recalled.

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 comparable 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:

- 95% of patients had a record of audiometric assessment, compared to 97% regionally and 99% for DPHC nationally.
- 75% of patients’ audiometric assessments were in date (within the last two years) compared to 75% regionally and 86% for DPHC nationally.

There was evidence of quality improvement including clinical audit. There was a programme in place but of the 10 audits planned in January and February 2018 only two had been completed.

- There was evidence of five clinical audits in the past 12 months, one had a completed second cycle.
- A second cycle of an antibiotic prescribing audit completed in September 2017 showed better compliance with national standards than of the first audit in the summer of 2016. However, it showed there were reoccurring areas of poor compliance. For example, it was identified that there was a marked variation in individual clinicians’ prescribing habits. Actions were put in place for this to be discussed at the next medical officers meeting and another audit scheduled for the end of the autumn term. This had not been completed to date.
- An audit on the raising of significant events was undertaken to look at a 12 month period of report raising within HMS Raleigh and look at issues identified for improvement. We saw actions identified including training for all staff. This was planned for the near future.
- 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
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.

The practice had an agreement in place with the local GP practice nearby whereby staff from HMS Raleigh ran clinics there every Friday morning. This enabled staff to keep their skills updated within NHS work and allowed continued access to treating children and older adults and in turn a wider variety of ailments than those witnessed in a military setting.

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 assistants (MA) and nursing team triage and ran fresh case clinics three times per day for recruits and twice daily for any other patients. This was overseen by the duty GP daily, who screened the MA’s consultations and any concerns with standards were addressed with further training given.

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.

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.

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

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients’ needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. Information was shared between services, with patients’ consent, using a shared care record. We saw that parents or guardians were involved in the care of patients between 16 and 18, only with the consent of the patient.

Patients that were inpatients in the bedding down unit were coded on DMICP so that they were known not to be fit to continue training and were supported whilst unfit.

The practice was aware of those patients who were joining the armed forces after being in care or foster homes. This information was noted by clinicians.

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 patients’ consent to care and treatment in line with legislation and guidance.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Where a patient’s mental capacity to consent to care or treatment was unclear, the GP or practice nurse assessed the patient’s capacity and recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice did not have any dependants or children of recruits registered with the practice.

- The practice identified patients who may be in need of extra support and signposted them to relevant services. For example, those requiring advice on their diet, smoking and alcohol cessation. The practice also gave sexual health advice, offered free condoms and referred to a sexual health clinic when required. Advice on prevention of musculoskeletal injury was also available from physiotherapy staff at the practice, as well as the GPs providing services.
- New patients had on arrival a consultation with the GP. Prior to this the patients’ notes were checked to ensure they were up to date with immunisations and any shortfall was addressed at the consultation.
- Chlamydia screening was available with test kits and forms made available in the waiting area.
- 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.
- 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 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 71%. The NHS target was 80%.
- The practice had an education initiative ‘back of the loo door’. This was where information was posted to heighten patient’s awareness of their own healthcare for example the use of long acting reversible contraception which could be fitted at the practice.

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:

- 94% of patients were recorded as being up to date with vaccination against diphtheria compared to 94% regionally and 95% for DPHC nationally.
- 94% of patients were recorded as being up to date with vaccination against polio compared to 94% regionally and 95% for DPHC nationally.
- 80% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 81% regionally and 81.5% for DPHC nationally.
- 94% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 92% regionally and 92% nationally.
- 94% of patients were recorded as being up to date with vaccination against Tetanus, compared to 94% regionally and 95% for DPHC nationally.
- 78% of patients were recorded as being up to date with vaccination against Typhoid, compared to 80% 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

- 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. 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 clinical staff were used as chaperones.

- We received 78 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:

- 96% 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

Data received from the Defence Medical Services (DMS) patient experience survey, July to December 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. Interpreter services were available for patients who did not have English as a first language if required.

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 PMO (Principal Medical Officer) attended weekly 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. For example, a well woman clinic, physiotherapy and travel advice.
- Patients could have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse or longer if needed.
- Patients were able to self-refer themselves to physiotherapy and were typically seen within two days.
- Patients were able to receive travel vaccines when required. The practice was a yellow fever centre.
- 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 has a 14 bed overnight observation facility, located on the upper floor of the practice. This was run by the practice staff that provided 24 hour a day cover.

Access to the service

- The practice is open from Monday to Friday, between 0700 and 1830. Outside of these times, patients were referred to NHS 111 or local out of hours services. The nearest accident and emergency unit is located at Derriford Hospital which was approximately 5 miles away.
- The practice held ‘fresh case’ clinics three times a day. All patients were triaged by medics who referred on to a nurse or GP as required (a military medic delivers healthcare similar to a healthcare assistant in the NHS but has a greater scope of duties).
- Clinicians referred patients recovering from injury to physiotherapy teams when appropriate. These were based at the medical centre and we saw good working relationships in place that supported patients back to full physical health.
- The practice has a dispensary which was open from 0800 to 1200 every morning, 1330 to 1530 on Tuesdays and Thursdays and 1330 to 1430 on Mondays. The dispensary was closed on a Wednesday afternoon. Any medicines that are not immediately available within the dispensary could be collected on prescription from Lloyds Pharmacy, who had a contract to dispense
medicines for DPHC sites.

- Results from the patient experience survey showed that overall patient satisfaction levels with access to care and treatment were high. For example:
  - 94.5% 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 one complaint raised in the past year. 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)

Our findings

Vision and strategy

The practice had a clear vision and strategy to deliver high-quality care and promote good outcomes for patients.

- Consistent, safe, and effective care was clearly at the forefront of the strategy and vision for the practice and this was clearly projected to and adopted by the staff team. All staff we spoke with were content with their current working environment. The practice worked to the DPHC mission statement: “Safe Practice by Design”

- The aim of the service was to provide the highest quality of care to all patients regardless of their background; to treat every patient holistically, looking at social, psychological, and physical reasons when dealing with their problems; to continuously strive to improve the quality of care provided as a team by being a ‘learning organisation’ and to be involved in the teaching and training of other health professionals. The practice also had their own mission statement which was ‘to enable personnel to complete their training in the shortest possible time, in the best possible health’.

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.

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during busy clinic times and periods of staff sickness. This approach supported staff with learning about how the performance of the practice could be improved and how each staff member could contribute to those improvements. Minutes were comprehensive and were available for practice staff to view.

- 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 a lead member of staff responsible for the audit programme. However, they were posted away and there were no deputising arrangements in place. A comprehensive programme of quality improvement was in place to monitor quality and to drive improvements. However, this had not been kept up to date with audits not being completed.
- 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.

**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.
- 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. Staff indicated they felt well-supported by the management team and that they were approachable.
- The practice was a positive training organisation supporting multiple learners in different career pathways, for example, student nurses and nurses on a returning to work programme. The practice were seeking accreditation as a training practice for GPs and they were expecting this to be undertaken in the summer.
- The practice had established good links and co-working with a local NHS practice. The PMO worked one morning every week at the NHS practice and regularly took medics and student nurses with them to experience all aspects of primary care and not just that of the military.
- 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.
- 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 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 the training ethos shared by all staff throughout the practice.