

Defence Medical Services

RAF Scampton Medical Centre

Quality Report

RAF Scampton Medical Centre
Lincoln
LN1 2ST

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

Ratings

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

Summary of findings

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of RAF Scampton Medical Centre on 25 May 2017. The practice was rated as inadequate for providing safe and well led services, requires improvement for providing effective services and good for providing caring and responsive services. Overall the practice was rated as inadequate.

A copy of the report from our last comprehensive inspection can be found at:

<http://www.cqc.org.uk/what-we-do/services-we-regulate/defence-medical-services#raf>

Recommendations were made following the inspection in May 2017 and were in relation to: the managements of significant events; risk management systems; governance systems; training and staff competence; medicines management; staff support and leadership.

We carried out this announced comprehensive inspection on 1 February 2018. Overall the practice is rated as good.

Our key findings were as follows:

- There was a clear staffing structure and staff were aware of their role and accountabilities. Staff had defined lead roles in key areas.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal in the practice minimised risks to patient safety.
- There was a process in place to the monitoring of patients on high risk medicines.
- A system was in place for managing incidents and significant events. Staff understood their responsibility in relation to using the system.
- Processes for identifying and monitoring vulnerable patients and patients who could be subject to safeguarding procedures were in place.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Clinical care for patients was person-centred and well managed. Patient feedback suggested the care was of a high standard.
- Effective medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover.
- A pro-active approach to quality improvement, including a programme of clinical audit had been developed to drive improvements for patients.
- Staff had a good understanding of the Mental Capacity Act (2005) and how it applied in the

context of the service they provided.

- Results from the Defence Medical Services patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available.
- Staff said the leadership of service had improved. They felt engaged, supported and valued by management.
- Patient feedback systems were in place for patients to provide their views about the service.

The Chief Inspector recommends:

- Review the arrangements for the routine checks of equipment to ensure they are carried out in accordance with protocol.
- Review the threshold for identifying patients who are carers so the practice can accommodate and respond accordingly to their specific caring responsibilities.
- Embed and sustain the newly implemented governance systems to ensure that improvements continue to be delivered across 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.

Good



Are services safe?

The practice is rated as good for providing safe services.

- The practice prioritised safety. An effective system was in place for reporting and recording significant events. Significant events were reviewed at health governance and practice meetings so lessons were shared with the wider staff team.
- 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 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.
- Comprehensive protocols and guidelines in relation to medicines management 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.
- Equipment checks were not always taking place in accordance with protocol.

Are services effective?

Good



The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were good.
- Practice staff assessed needs and delivered care in line with

current evidence based guidance.

- A programme of clinical audit was in place to improve patient outcomes.
- Staff had the skills, knowledge, and experience to deliver effective care and treatment.
- Patients were supported to live healthier lifestyles through a proactive approach to health promotion and wellbeing.
- Registered patient records had been summarised.
- There was evidence of appraisals and personal development plans and support for all staff.

Are services caring?

Good 

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 was available.
- Systems were in place to maintain patient and information confidentiality.
- We received 24 comment cards from patients. All of the feedback was positive about the standard of care received.

Are services responsive?

Good 

The practice is rated as good for providing responsive services.

- The patient's individual needs were central to the planning and delivery of their care.
- The service was flexible to ensure patients' needs were met in a timely way.
- Patients found it easy to make an appointment and urgent appointments were available the same day.
- Telephone consultations were provided as an alternative to visiting the practice.
- Patients could select the gender of clinician they wished to be seen by.
- Referrals to the physiotherapy team were made by doctors and the average waiting time for an appointment was less than one week.
- Eye care and spectacles vouchers were available to service

personnel at the medical centre.

Are services well-led?

Good 

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

- The practice had developed a clear vision and strategy regarding the delivery of high quality care to promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- The leadership of the practice had been effectively strengthened and staff felt engaged, supported and valued. A whole-team approach had been adopted.
- Clinical and management led governance structures and systems had been strengthened. The new structure was working well especially as it had been revised in less than a year. There is a need to embed and sustain the newly implemented governance systems to ensure that improvements continue to be delivered across the practice.
- Regular practice and health governance meetings took place, which supported effective communication and shared learning within the team.
- The practice was aware of and complied with the requirements of the duty of candour.
- The practice sought feedback from staff and patients, which it acted on.
- There was a strong focus on continuous learning and improvement at all levels.

RAF Scampton Medical Centre

Detailed findings

Our inspection team

This follow-up review was carried out by a CQC Lead inspector. The team included a GP specialist adviser and physiotherapist specialist advisor.

Background to RAF Scampton Medical Centre

RAF Scampton medical centre provides routine primary health care to a practice population of approximately 400 service personnel and reservists. In addition, the practice provides occupational medicals and medicine, aviation medicine and emergency airfield cover. Women's health and travel medicine are also provided at the medical centre. Families and dependants of service personnel are not treated at the practice. Maternity services are provided at RAF Waddington by visiting NHS midwives. The nearest hospital is Lincoln County Hospital.

At the time of the inspection, the medical centre staff team comprised a Senior Medical Officer (three days per week), a full time practice manager, a part time advanced nurse prescriber and a part time non-prescribing nurse, four RAF medical technicians and a full time receptionist. A physiotherapist was available one day per week. A medical technician is a health care role unique to the forces. The role is similar to that of a health care assistant found in NHS GP practices but with a broader scope.

The practice is open from 08:00 to 17:00 Monday to Thursday and from 08:00 to 16:00 on a Friday. A medical technician triages calls when the practice closes and until 18:30. The CMT has access to a GP should that be needed. From 18:30 patients are directed to contact NHS 111. The medical centre is a two storey building with all patient facilities located on the ground floor. Patient facilities include a large patient waiting area, separate treatment and consulting rooms and a dispensary area. The practice has a contract with Lloyds pharmacy to provide dispensing services locally. Prescriptions are forwarded to the pharmacy and medicines are delivered to the practice for collection by patients.

Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. In this case CQC found shortfalls in the quality of services during the May 2017 inspection. We escalated these concerns to the Surgeon General's Office and the Inspector General's Office, prompting an action plan and support from the healthcare governance team.

How we carried out this inspection

Before visiting, we reviewed a range of information the practice provided us with. We carried out an announced inspection on 1 February 2018.

During the inspection we spoke with a range of staff including the SMO, three medical technicians, the practice manager, physiotherapist, the receptionist and two nurses. We reviewed 24 comment cards completed by patients who shared their views and experiences of the service. We looked at information, including patient records and information the practice used to deliver care and treatment. We also looked at information used to monitor the quality and safety of services.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Good



Are services safe?

Our findings

At our previous inspection on 25 May 2017 we rated the practice as inadequate for providing safe services. This was because the arrangements in respect of significant events, safety alerts, record summarisation, infection prevention and control, medicines management and medical emergencies were not adequate. We made recommendations in relation to these shortfalls and found significant improvements had been made when we inspected the service on 1 February 2018. The practice is now rated as good for providing safe services.

Safe track record and learning

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

- The Senior Medical Officer (SMO) was the dedicated lead to oversee significant events and staff said they would readily approach the SMO 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 (referred to as ASER). Locum staff did not have a log in to the ASER system or access to hardcopy significant event forms. The practice manager said they would ensure locum staff had the facility to personally report a significant event moving forward.
- Since May 2017 five significant events had been reported. Staff discussed specific significant events and described how they were managed. They highlighted any changes made as a result of the investigation. For example, staff told us about a Caldicott breach that was recorded as a significant event and managed in accordance with the Caldicott principles. The incident was discussed with staff at the health governance meeting in January 2018.
- The practice manager maintained and regularly monitored a tracker of significant events that was designed to support the analysis of any emerging themes and trends. The tracker was reviewed at both the health governance and practice meetings so all staff were involved. It provided good detail about each event, including the outcome of investigation and lessons learnt.
- A dedicated member of staff was the lead for managing patient safety notices and alerts that were received from Regional Head Quarters (RHQ). They were checked by the lead and practice manager and forwarded to the SMO to action. We noted from the minutes that all patient safety alerts were discussed at both the health governance and practice meetings. A register of alerts received at the practice was maintained.
- 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.

- Arrangements for adult and child safeguarding reflected relevant legislation and local requirements. The child protection policy was last reviewed in September 2017. Policies were accessible to all staff. A quick reference guide to the safeguarding procedure was located in the office and clinical areas. Safeguarding policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The SMO was the lead member of staff for safeguarding and a deputy was identified in the absence of the SMO.
- The staff we spoke with demonstrated they understood their responsibilities regarding safeguarding and had received training in relation to safeguarding children and vulnerable adults. Staff had received safeguarding training to a level relevant to their role. The SMO was trained to level three in child safeguarding.
- The practice had a system in place to maintain an accurate and up to date register of patients subject to safeguarding arrangements, and patients assessed to be 'at risk'. Safeguarding was a standing agenda item at health governance meetings. The SMO attended the weekly meetings with unit commanders at the station and concerns about vulnerable patients were discussed at this forum. In addition, the SMO met with the welfare team each month. An alert facility within the patient record system; Defence Medical Information Capability Programme (DMICP) ensured any risks showed clearly when the medical record was opened.
- Notices throughout the premises 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.
- An infection prevention and control (IPC) policy was in place. A dedicated IPC lead and deputy were identified and they had completed training relevant to the role. All staff had completed IPC mandated training. IPC audits were carried out on a six monthly basis and the last audit was completed in August 2017. It was discussed with the staff team at the health governance meeting in November 2017. The practice manager confirmed that all actions identified from the audit had been addressed.
- Appropriate standards of cleanliness and hygiene were in place. Throughout the inspection we noted the premises were clean and tidy. A cleaning contract, cleaning schedules and cleaning checklists were in place and these were monitored by the practice manager. Confirmation was in place that high level cleaning had been carried out in September 2017. An environmental cleaning audit was undertaken in November 2017 and the practice received a score of 100% compliance.
- All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. Spillage kits were available.
- The practice manager was the dedicated lead identified for the management of waste. Waste was appropriately stored, including healthcare, sharps and domestic waste. Healthcare waste was stored securely. Waste was collected from the practice by an external contractor and appropriate documentation was in place to support effective waste collection, including a clinical waste register. A waste audit was undertaken in November 2017 and the practice received of 95% compliance. A healthcare waste pre-acceptance audit was undertaken in January 2018.

- Effective arrangements for managing medicines and vaccines were established to keep patients safe. The SMO was the medicines management lead for the practice. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines. Controlled drugs were subject to regular checks and we found no discrepancies or gaps in the checking system. The cold storage unit for medicines were regularly monitored to ensure temperatures were within the correct parameters.
- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The processes in place were comprehensive demonstrating that PGDs were well managed.
- The SMO had undertaken a peer review of the prescribing practices of the advanced nurse prescriber (ANP) when they first joined the practice and this had confirmed the ANP was safe to prescribe. The ANP advised us their prescribing was subject to an annual audit. Medical technicians had received the appropriate training, competency checks and supervision to carry out their clinical roles in relation to medicines management.
- The practice carried out medicine audits to ensure medicines were managed and prescribed in line with best practice guidelines. A Tri-Service Formulary prescribing audit was undertaken annually and it last took place in May 2017. It showed safe prescribing was taking place at the practice. A regional medicines audit had taken place shortly before our inspection but the documentation was not yet available for this. The practice manager advised us that no concerns had been identified from the audit. A high risk medicines register was in place that took account of review dates and whether an alert was on the system indicating the patient was on a high risk medicines.
- The practice manager provided evidence to demonstrate that all patient records had been summarised.
- 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 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 were procedures in place for monitoring and managing risks to patient and staff safety, including a health and safety policy. A health and safety poster was displayed at the practice office which identified local health and safety representatives. The practice manager was the lead for health and safety and had completed relevant training for the role.
- Staff were aware of their role in the reporting and management of incidents, including when to report in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Such incidents were reported through the DMS-wide electronic incident reporting system.
- A risk register was established for the practice and risk management was a standing agenda item at the health governance meetings. For example, the minutes from January 2018

demonstrated that patient safety and workload was reviewed in relation to the reduced staff numbers

- The station was responsible for the electrical safety of the building. Portable electrical equipment was checked on a regular basis to ensure the equipment was safe to use. The last portable electrical check was undertaken in July 2017. An electrical installation condition report dated July 2013 was within the five-year required timeframe.
- A fire risk assessment was undertaken in October 2017. Records demonstrated that safety checks of firefighting equipment, fire doors, emergency lighting, the fire alarm and escape routes took place each month. The last fire drill took place in January 2018.
- A process was in place to check equipment each day to ensure it was in line with DMS policy, in working order and appropriately calibrated. We noted that some daily checks had been missed and had not been identified through monitoring or audit processes.
- A range of risk assessments were in place, including those in relation to the environment, use of equipment and lone working. Risk assessments were also in place in relation to the control of substances hazardous to health and infection. All internal risk assessments had been reviewed in January 2018. A building legionella risk assessment review was undertaken by an external contractor in November 2017, who also checked the temperature of the water outlets on a regular basis. Legionella is a term for a particular bacterium which can contaminate water systems in buildings. Water outlets were flushed for two minutes if they had not been used for more than seven days. This was undertaken in January 2018 after the practice was closed for the Christmas period.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice was not working to its full staff complement on the day of the inspection. For example, one of the medical technicians was working out-of-area and the post of an exercise rehabilitation instructor was awaiting approval. The SMO was working two days at RAF Waddington Medical Centre as part of a quality initiative to work in partnership with a larger primary care team. Staff shortages were managed with locum staff and/or support from RAF Waddington medical Centre. Feedback from patients and staff suggested there had been minimal impact on clinical care and its timeliness with the reduced staff team. A triage system was in place for patients who presented without an appointment and a duty doctor and nurse were available throughout the day for patients with urgent health care needs.

Arrangements to deal with emergencies and major incidents

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

- There was an emergency button in all the consultation and treatment rooms which alerted staff to any emergency.
- An emergency kit, including a defibrillator, oxygen with adult masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of their location. A first aid kit and accident book was available. Routine checks were in place to ensure the required kit and medicines were available and in-date. Medicines we checked were in-date. A laminated information booklet was available with the emergency kit which we deemed to be very good practice.
- The staff training records provided assurance that all staff received basic life support training on an annual basis. Equally, the training required for medical technicians responding to emergencies on the airfield was up-to-date.
- The practice had a comprehensive business continuity plan in place for major incidents such as

power failure or building damage. The plan included emergency contact numbers for staff. A copy of this plan was available on the staff intranet and additional copies were kept off the premises. Shortly before our inspection there had been a major incident. The practice manager described how the incident had been effectively managed in accordance with the business continuity plan.

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

Good



Our findings

At our previous inspection on 25 May 2017 we rated the practice as requires improvement for providing effective services. This was in relation to staff training and competence. In addition, cover for clinical tasks in the absence of clinical staff was not effective. We made recommendations in relation to these shortfalls and found significant improvements had been made when we inspected the service on 1 February 2018. The practice is now rated as good for providing effective services.

Effective needs assessment

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

- Clinical staff were aware of evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE). Staff referred to this information to deliver care and treatment that met patients' needs. They described how updates on NICE and medicines management were outlined in a newsletter circulated to clinical staff by the Defence Primary Health Care (DPHC) Team each month.
- Evidence based practice was a standard agenda item at the health governance meetings, including discussions about NICE guidance. For example, minutes of the meeting held in August 2017 indicated guidance in relation to diabetes was discussed and what staff needed to do to ensure the guidance was followed. The DPHC newsletter was also discussed at the practice meetings.

Management, monitoring and improving outcomes for people

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

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

- There were two patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. For both patients, the

last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For both patients the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

- There were 12 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. Six had a record of their blood pressure in the past nine months. Of these patients with hypertension, six had a blood pressure reading of 150/90 or less.
- There were no patients identified with long term physical or mental health conditions who smoke.
- There were four 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, two had had an asthma review in the preceding 12 months which included an assessment of asthma control using the 3 Royal College of Physicians questions.
- There were no patients with a new diagnosis of depression in last 12 months.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that instance of audiometric hearing assessment was above average compared to DMS practices regionally and nationally. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data from January 2018 showed:

- 100% of patients had a record of audiometric assessment, compared to 99.9% regionally and 99.2% for DPHC nationally.
- 97.5% of patients' audiometric assessments were in date (within the last two years) compared to 92.8% regionally and 85.5% for DPHC nationally.

The practice nurse was the dedicated lead for clinical audit. The minutes of the monthly health governance meetings showed that clinical audit was a standing agenda item. An audit register was maintained that included relevant dates, frequency of each audit, link to previous audits and a brief overview of the impact the audit had on practice. At the time of the inspection there were 21 clinical audits identified; either completed or in progress. Audits undertaken were in relation to: audiometry; blood results; use of antibiotics; use of terbinafine; cytology; asthma; Tri-Service Formulary and hypertension. Three or four of these audits were on their second cycle.

The practice manager was the lead for quality improvement in particular audit activity. The minutes of the monthly healthcare governance meetings showed that quality improvement was a standing agenda item. A quality improvement register was maintained that took account of how the improvement needed was identified, the outcome and the impact on practice. Monitoring exercises were in place to check that standard operating procedures continued to meet the needs of the practice and its patients.

An internal quality assurance tool, the 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. The CAF we were provided with was completed in March 2017 which pre-dated the last CQC inspection.

Effective staffing

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

- The practice had a generic induction programme for all newly appointed staff. This included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and Caldicott accountability. There was also a specific programme and training for new staff depending on their role, and a separate induction for locum staff. For example, a specific induction pack and personal development plan was in place for medical technicians
- Staff had access to e-learning training modules and in-house training. Relevant competency checks were undertaken before staff engaged in practice or a procedure that was new to them. Specific training was in place for medical technicians (referred to as Trade Training). Given that the medical technicians were facilitating walk-in clinics, we queried the sufficiency of their training. We did note that the Trade Training programme for 2018 was more comprehensive than the 2017 programme. The SMO assured us that they reviewed the medic's patient consultation notes, ensured they received clinical supervision and were available to answer any clinical queries they may have.
- The practice manager organised mandatory training. Records confirmed all staff, unless there were mitigating circumstances, were up-to-date with mandatory training in areas such as fire, basic life support and infection control and this training was refreshed in accordance with organisational policy. Equally, the required emergency care training for medical technicians was in-date. Staff who acted as chaperones had received training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training including an assessment of competence. They could demonstrate how they stayed up to date with changes to the immunisation programmes.
- Nurses and doctors told us they maintained their own continual professional development (CPD). They said they attended external forums, conferences, engaged with peer review and attended both internal and external training events. This was confirmed by one CPD file we looked at. From our discussions with staff we determined they had a detailed knowledge relevant to their lead roles and shared their knowledge when relevant with the wider staff team.
- The learning and support needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

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

- Reports were usually received from the out-of-hours service (OOH) service within 48 hours of a patient having accessed treatment. These reports were scanned on to DMCIP and alerts sent to a doctor to ensure they were reviewed and appropriate follow up instigated if necessary. The reviewing doctor coded problems/conditions as necessary on DMCIP.
- A protocol was in place for samples sent to the laboratory. A system was in place to monitor the progress of results and any outstanding results were followed up. Results received at the practice were logged, dated, stamped and scanned onto the patient's record by the administration team. They were then passed to the doctor to review.
- Effective communication systems were in place with other teams and health professionals, such as physiotherapy and the community mental health team. The SMO attended weekly meetings

with the commanders for the units.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Where a patient's mental capacity to consent to care or treatment was unclear, the doctor or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- When providing care and treatment for young people, some of whom may be aged between 16 and 18 years, staff carried out assessments of capacity to consent in line with relevant guidance.

Supporting patients to live healthier lives

- The practice identified patients who may be in need of extra support and signposted them to relevant services.
- All new patients to the practice were asked to complete an assessment form on arrival. The practice nurse followed up any areas of concern such as raised blood pressure. At the annual medicals patients were screened by the nurse for signs of mental health issues. Lifestyle choices were also elicited, such as cigarette and alcohol use.
- A dedicated lead for health promotion was identified for the practice. A health promotion schedule had been developed that took account of national campaigns, specific issues relevant to the service population and seasonal health concerns, such as the flu, alcohol use, national obesity. Patients had access to advice on weight management and smoking cessation.
- The practice participated in the station health fairs, which were held periodically to promote good health and lifestyle amongst the service personnel population
- Patients had access to appropriate health assessments and checks. Searches were undertaken for all patients aged 50 to 64 years who were entitled to breast screening. Two patients were identified and both were in-date for screening. The practice also took account of national screening programmes, such as bowel cancer and abdominal aortic aneurysm (AAA) screening programs. They had no patients eligible for either of these screening programmes.
- Nurses carried out regular searches of patients eligible for a cervical smear. 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 33 out of 33 eligible women. This represented an achievement of 100% The NHS target was 80%.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The most recent vaccination data for patients using this practice is:

- 98% of patients were recorded as being up to date with vaccination against diphtheria compared to 95.5% regionally and 95% for DPHC nationally.
- 98% of patients were recorded as being up to date with vaccination against polio compared to 95% regionally and 95% for DPHC nationally.
- 88% of patients were recorded as being up to date with vaccination against Hepatitis B

compared to 84% regionally and 83% for DPHC nationally.

- 97% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 94% regionally and 94.5% for DPHC nationally.
- 98% of patients were recorded as being up to date with vaccination against Tetanus, compared to 95.5% regionally within DMS and 93% for DPHC nationally.
- 81% of patients were recorded as being up to date with vaccination against Typhoid, compared to 88% regionally and 90% 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.

Good



Are services caring?

Our findings

At our previous inspection on 25 May 2017 we rated the practice as good for providing caring services. That rating remained unchanged from this inspection.

Kindness, dignity, respect and compassion

- During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations.
- The layout of the reception area and the seats in the waiting area meant that conversations between patients and reception could not be easily overheard. Reception staff said that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Results from the most recent Patient Experience Survey showed patients felt they were treated with compassion, dignity and respect. For example:
 - 99% of patients said their privacy and dignity was respected and maintained throughout their visit to the practice.
 - 98% of patients said they were seen by the most suitable practitioner to meet their need.
 - 88% of patients said there was clear information available about services for patients and how to obtain them.
 - 93% of patients said if family, friends and colleagues could use the practice, they would recommend it to them.
- We did not receive any comparator data 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. We received 24 completed comment cards prior to the inspection and feedback was very complimentary about the practice. Patients said that they felt involved in decision making about the care and treatment they received. Comments indicated that patients felt listened to and supported by staff, and they had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- 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.

Care planning and involvement in decisions about care and treatment

- The feedback provided by patients indicated that clinical staff took the time to explain their condition or injury and treatment plan.
- Data received from the latest patient experience survey 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 were given full information about any medicines that were prescribed for them, including their side effects.
- Comprehensive health promotion information leaflets were available for patients on notice boards throughout the medical centre. The practice leaflet had been revised and included details about the management of common ailments, availability of test results and repeat prescriptions.
- The Choose and Book service was used with patients as appropriate. This is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in hospital.

Patient and carer support to cope emotionally with treatment

- Patient information leaflets and notices were available in the patient waiting area, which advised patients about how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic was prominently displayed and accessible.
- The practice had a register to identify patients who had caring responsibilities for a dependant. At the time of our inspection we were advised that there were no carers on the register. Yet during the inspection we heard of two patients who had caring responsibilities.

Are services responsive to people's needs? (for example, to feedback)

Good



Our findings

At our previous inspection on 25 May 2017 we rated the practice as good for providing responsive services. That rating remained unchanged from this inspection.

Responding to and meeting people's needs

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

- A range of services and clinics were available to service personnel. For example, a smoking cessation, over 40's health screening, sexual health and travel advice.
- Home visits were available but the majority of patients could attend the practice.
- Same day appointments were available for those patients with medical problems that required same day consultation.
- Patients were able to receive vaccines required for occupational health at the practice.
- Physiotherapy services were available at the practice and the clinicians at the practice worked closely with the physiotherapist. Referrals to the physiotherapy team were made by doctors and the average waiting time for an appointment was less than one week. The physiotherapist had completed the Military Aviation Medical Examiners course.
- Eye care and spectacles vouchers were available to service personnel at the medical centre. Transport for patients to hospital appointments was available if needed.
- An interpreter service was available for patients should the need arise.
- The practice offered patients the services of either a female or a male clinician. The doctor was male so if a patient specifically wished to see a female then this request could be facilitated at RAF Waddington Medical Centre. A female GP was due to take up post in April 2018. A chaperone was available for any intimate examinations that were performed by a clinician at the practice.

Access to the service

- The practice was open from 08:00 to 17:00 Monday to Thursday and from 08:00 to 16:00 on a Friday. A medic triaged calls from when the practice closed and until 18:30. The medic had access to a GP should the need arise. From 18:30 patients were directed to contact NHS 111.
- A new practice leaflet had been developed and was available to patients. It was comprehensive, including opening times, out-of-hours arrangements, a site map and staff details. It also provided useful information about treating minor ailments and the use of

antibiotics.

- Access to a doctor or nurse was good for patients; most patients were seen within 48 hours of requesting an appointment. Same day appointments were available for those patients who needed to be seen quickly. Patients could have 15 minute appointments with the doctor and up to 30 minute appointments with the nurse. If needed, patients could book a double appointment of 30 minutes with the doctor. Telephone consultations were available with a doctor if a patient requested that option. Patients could also be seen at the medic's walk-in clinic.
- The Patient Experience Survey showed that overall patient satisfaction levels with access to care and treatment were high (score of 75% or more). For example:
 - 95% of patients said the opening hours were convenient for them and their family.
 - 84% of patients said if they had an urgent problem they were able to see the doctor on the same day.
 - 89% of patients said they could normally get an appointment to see a doctor for non-urgent problems within two days.
 - 87% of patients said they were able to speak to a doctor or nurse by telephone for advice during the day.
- Medical technicians facilitated a walk-in clinic and triaged patients referring onwards to the SMO as appropriate.
- Midwife-led maternity services were delivered from RAF Waddington Medical Centre.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- The practice manager was the designated responsible person who handled all complaints in the practice. They and the staff team adhered to the Defence Primary Health Care's established policy on the management of complaints.
- We noted that information was available in the waiting area to support patients understand the complaints system. How to make a complaint was summarised in the practice leaflet.
- A complaints register was in place that provided a brief description of the complaint and took account of the action taken. Two written and one verbal complaint had been received since June 2017. None of the complaints were in relation to clinical care and all had been managed effectively. Clinical complaints would be forwarded to the SMO.
- Processes were in place to share learning from complaints. This was through the health governance and practice meetings. Compliments and complaints was a standing agenda item at the practice meetings. A log of compliments was maintained and four compliments had been received since September 2017
- 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

At our previous inspection on 25 May 2017 we rated the practice as inadequate for providing well-led services. This was in relation to underdeveloped governance arrangements and a lack of managerial oversight of processes. The long term absence of a practice nurse had not been effectively addressed. In addition, staff felt unsupported and their concerns were not acted upon. We made recommendations in relation to these shortfalls and found significant improvements had been made when we inspected the service on 1 February 2018. The practice is now rated as good for providing well-led services.

Vision and strategy

The practice had undergone a major period of change since the last inspection. A new Senior Medical Officer (SMO) joined the team in August 2017. A practice nurse was in post and a permanent practice nurse was to take up post from February 2018. A female GP was due to start also in February. In addition the practice manager was undertaking an academic course in management and leadership.

Staff we spoke with described a service that was now clearly defined, more structured and well managed. They said the practice was delivering high quality care and promoting good outcomes for patients. We found the team was working effectively to the DPHC mission statement of: "Delivering a unified, safe, efficient and accountable primary health care for entitled personnel to maximise their health and to deliver personnel medically fit for operations".

Governance arrangements

Since the last inspection the governance framework had been reviewed, developed and strengthened to support the delivery of safe and effective quality care. The following examples illustrate how governance arrangements had improved since the last inspection.

- The staffing structure and roles had been reviewed and developed. Staff were clearly aware of their own roles and responsibilities. Doctors, nurses and medical technicians had defined lead roles in key areas. A list of lead roles and deputies was visible in all areas of the practice used by staff. Terms of reference had been developed for lead roles and also for visiting GPs.
- Weekly 'stand-up' meetings had been introduced to ensure staff were aware of any issues both at practice and station level. Practice meetings continued to take place monthly. The SMO attended weekly meetings with unit commanders to review the health status of military personnel. The practice manager attended station health and safety meetings.
- The practice had developed and introduced a health governance workbook. Governance meetings were taking place monthly to discuss clinical matters. The agenda had been revised and items added. For example, significant events were a standing agenda item and were monitored through this forum to ensure they were effectively managed and lessons were being

learnt. Patient safety alerts were also a standing agenda item at the meetings.

- Summarisation of notes was being audited each month to ensure there was no backlog. With a practice nurse in post, monthly searches in relation to LTCs and screening were consistently taking place.
- Medicines management arrangements had been reviewed and strengthened. The SMO was identified as the lead. A high risk medicine protocol had been adopted and a register developed.
- A revised cleaning schedule had been developed to ensure compliance with national guidance on cleanliness. Internal infection prevention and control (IPC) audits were taking place monthly and an external IPC had also been undertaken. The arrangements for clinical waste management had been reviewed.
- Staff training was being closely monitored and any shortfalls addressed. A new Trade Training programme for medical technicians had been developed for 2018 and this was being shared with RAF Waddington Medical Centre.
- The risks in relation to clinicians working in isolation, often associated with a small or single-handed practice, were being addressed. The practice was working closely with RAF Waddington Medical Centre, including the rotation of staff and the sharing of systems. At the time of the inspection one of the medical technicians was on rotation and the SMO was working there two days a week. The SMO attended the practice meeting at Waddington.
- A scheme of peer review and clinical supervision had been introduced for clinical staff. The SMO and practice nurse reviewed the consultations medical technicians undertook with patients. 'Live' telephone GP supervision from Waddington had been introduced for the practice nurse at Scampton.

Leadership and culture

- On the day of inspection the SMO and practice manager working in partnership demonstrated that between them they had the experience, capacity and capability to run the practice and ensure high quality care. It was clear the approach to empower staff through a whole-team approach was having an impact.
- Staff told us they welcomed the changes that had been introduced since the last inspection. They described how the leadership was effective and a no blame culture was promoted. They felt valued and well supported in the work place.
- The practice nurse and medical technicians said they felt supported in their clinical roles. They described the SMO as a good communicator who responded promptly to clinical queries and always made time to listen to them. In particular, staff said they valued the clinical supervision they received from the SMO. Staff told us the practice manager helped them to understand and gain knowledge of the underpinning systems to support quality care.
- Systems were in place to ensure compliance with the requirements of the duty of candour and all staff had a good understanding of the matter. Duty of candour is a set of specific legal requirements that leaders of services must follow when things go wrong with care and treatment. This included ensuring all staff understood to communicate with patients about notifiable safety incidents. We found that the practice had systems to ensure that when things went wrong with care and treatment, patients were given reasonable support, information and a verbal and written apology.

Seeking and acting on feedback from patients, and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through the practice surveys and from any individual patient feedback received.
- A suggestion box for patients to leave feedback was located in the waiting area.
- Completed CQC comment cards from patients supported our findings that there was an open door policy when it came to patient input and feedback.
- Staff told us they would not hesitate now to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.
- There was no patient participation group or similar at the practice.

Continuous improvement

There was a focus on continuous improvement at all levels within the practice and this was evident throughout the inspection. Because staff now felt valued and included, they were inspired to share ideas. Improvements that had been implemented not only stemmed from the outcome of the previous CQC inspection and governance activity but from ideas staff had put forward. Some of the quality improvement initiatives included:

- A change in protocol as a result of a Caldicott breach when the delivering pharmacy inappropriately accepted a non-authorized signature for dispensed medicines.
- Tightening security of clinical registers to mitigate the risk of a Caldicott breach.
- An assigned lead for health promotion to ensure up-to-date and relevant patient information in relation to prevention and improving health.
- Development of a laboratory results protocol.
- Development of a protocol for the monitoring of high risk medicines.
- Introduction of walk-in medic led clinics.

We found that the practice had taken action since the last inspection and improved the service based on the recommendations made. The newly revised and implemented governance systems will need time to embed to ensure the improvements are sustainable and continue to be delivered across the practice.