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>
</tr>
</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Requires improvement</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>
</tr>
</tbody>
</table>
Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Chatham Medical Centre on 15 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 and a system in place for reporting and recording significant events. Staff had recently received refresher training and guidance on what constitutes a significant event and how this should be reported using the internal computerised reporting system.

- The assessment and management of risks was comprehensive. Staff had worked hard to ensure all risks were recognised and addressed, promoting safety within the practice.

- The handling of patient emergencies was under review at the practice. We saw how analysis of significant events informed review and prompted questions which made the service safe for patients.

- There was some evidence of clinical audit including regular reviews of the service, used to drive improvements in patient outcomes. This could be developed further.

- 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). The system for managing blank prescription forms could be further improved.

- 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. The appraisal arrangements for some staff required review.

- Results from the patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.

- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

- Patients we spoke with said they found it easy to make an appointment, but this may not be within the same week. Some staffing issues meant not all patients who needed to be seen on the same day, could be accommodated.

- The practice had good facilities and was well equipped to treat patients and meet their needs.

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

- The provider was aware of the requirements of the duty of candour. Examples we reviewed
showed the practice complied with these requirements.

The Chief Inspector recommends:

• A review of arrangements for ongoing care of any patient experiencing extended periods of illness, to ensure all GPs are aware of the needs of these patients and are able to respond appropriately.

• Further familiarisation training in the use of the practice electronic records system, DMICP. This should include use of templates by all clinicians to record interventions for patients with long term conditions to ensure all tests are recorded and recalls are set up appropriately.

• Improved management and monitoring of blank prescription pads.

• Development of clinical audit to include an annual antibiotic audit and audit of prescribing compliance, in line with the Tri Service Formulary.

• Review of appraisal arrangements for some staff, for example, the pharmacy technician, to ensure appropriate evidence of clinical oversight and input.

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

#### The five questions we ask and what we found

<table>
<thead>
<tr>
<th>We always ask the following five questions of services.</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are services safe?</strong></td>
<td></td>
</tr>
<tr>
<td>The practice is rated as good for providing safe services.</td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
</tr>
<tr>
<td>• Risks to patients were assessed and the practice managed to minimise risks to patient safety.</td>
<td></td>
</tr>
<tr>
<td>• Protocols and guidelines to cover the dispensing of medicines were in operation. Medicines were managed safely and effectively. The management of issue of prescription pads could be further improved.</td>
<td></td>
</tr>
<tr>
<td>• Sufficient numbers of staff were employed to meet the needs of the practice population.</td>
<td></td>
</tr>
<tr>
<td>• The practice had arrangements in place to respond to emergencies and major incidents.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Are services effective?</strong></th>
<th>Requires improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice is rated as requires improvement for providing effective services.</td>
<td></td>
</tr>
<tr>
<td>• Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were below NHS target figures.</td>
<td></td>
</tr>
<tr>
<td>• Practice staff assessed needs and delivered care in line with current evidence based guidance.</td>
<td></td>
</tr>
<tr>
<td>• Clinicians required further training and support in the use of DMICP templates. This is essential for recording interventions with patients with long term conditions, and to ensure all required checks and tests are conducted.</td>
<td></td>
</tr>
<tr>
<td>• Evidence showed that arrangements for the care of patients between clinicians required improvement, to ensure that the</td>
<td></td>
</tr>
</tbody>
</table>
practice GPs were aware of the needs of patients experiencing extended periods of illness.
• The vacant practice nurse post had placed a greater demand on GP time and appointments. Staff told us there was also a backlog of medical boards which required addressing.
• There was evidence of audit and quality improvement exercises, although this could be developed further.
• There were effective systems in place for receiving and circulating updates and alerts.
• Patients were actively supported to live healthier lifestyles. The practice gave access to health promotion information and support to all patients, including those only temporarily based at Brompton Barracks.
• All staff had received an appraisal and were aware of the scope of their duties. Effective support was in place for clinicians due for revalidation and to enable them to demonstrate continuous professional development. Appraisal arrangements for some clinical staff required review, for example, the pharmacy technician.

Are services caring?
The practice is rated as good for providing caring services.
• Comment cards, completed by patients before our inspection, indicated that they felt practice staff treated them with compassion, dignity and respect and they were involved in decisions about their care and treatment.
• Information for patients about the services available was accessible.
• Systems were in place to maintain patient and information confidentiality.
• Our observations of staff throughout the inspection day, demonstrated that all practice staff were patient focussed and treated patients in a caring and compassionate manner.

Are services responsive?
The practice is rated as good for providing responsive services.
• We saw that it was easy to make an appointment and appointments were available to pre-book in advance.
• At the time of our inspection, we saw that the waiting time for a routine appointment was approximately seven working days. Review of records showed that in isolated incidents, where a patient needed to be seen on the same day, this had not been possible.
• Physiotherapists were employed within the practice. All
referrals to this service were made by the GPs and the average waiting time for an appointment was approximately three days.

- 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.
- Shoulder cover arrangements were in place. However, the travelling time to the covering practice was an hour or more. Patients would also need to book transport to travel to an alternative medical centre, which would add to the time taken to get to see a doctor.
- The practice were planning to ‘on-board’ all patients who were based at the barracks for 30 days or more. This was to make sure all patients received medical care promptly. However this may require a review of staffing arrangements.

### Are services well-led?

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

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- The practice manager and Senior Medical Officer provided guidance, support and leadership for all staff at the medical centre.
- A clear governance structure including management processes, meetings, updates and briefings was in place. This supported staff in delivery of their duties.
- Staff said they felt supported by leaders, and that they were inclusive in their leadership style.
- 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, and nurse specialist advisor and a practice manager specialist advisor.

Background to Chatham Medical Centre

Chatham Medical Treatment Facility is located in Brompton Barracks, Chatham, Kent. The treatment facility offers care to forces personnel. At the time of inspection, the patient list was approximately 540 patients. The practice also provides care to any of the students who are at the barracks on a temporary basis whilst on educational and specialist courses, if they require this. These students are not registered as patients at the practice. Occupational health services are also provided to personnel.

In addition to routine GP services, the treatment facility offers physiotherapy services and travel advice. An NHS sexual health clinic in Chatham was available for patient self-referral, or patients can be referred to a sister practice in Maidstone, Kent. Family planning advice is available, with referral onwards to NHS community services. Maternity and midwifery services are provided by the NHS practice in Gillingham and community teams, who hold clinics at the practice in Gillingham on a weekly basis.

At the time of our inspection, the facility had two full time GPs, (both male) one part time practice nurse (female), one pharmacy technician who worked in the practice dispensary, and three reception and administrative staff. Attached to the practice was one exercise rehabilitation instructor and two locum physiotherapy staff. These were supported by a receptionist. The facility was led by a practice manager, who was the only member of military staff based at the practice.

The facility was open from Monday to Thursday each week, between 0800 and 1630 hours and from 0800 to 1600 hours on Friday. The facility was closed daily for lunch between 1230 hours and 1330 hours, and closed on Tuesday afternoons. On Monday, Wednesday and Thursday of each week between 1700 hours and 1830 hours, and on Tuesday afternoon patients were referred by telephone message to Pirbright surgery. After these hours, patients were diverted to out of hour’s services provided by NHS 111. Throughout this report, Chatham Medical Treatment Facility 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 15 February 2018. During our visit we:

• Spoke with a range of staff, including the practice manager, pharmacy technician, the part time practice nurse, two administrative staff and the lead GP who was the Senior Medical Officer. We were able to speak with two patients who used the service.
• Reviewed comment cards completed by patients who shared their views and experiences of the service.
• Looked at information the practice used to deliver care and treatment plans.
• Conducted a 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.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice’s computer system.
- The practice manager supported and led the investigation and analysis of significant events. Senior staff understood their roles in discussing, analysing and learning from incidents and events.
- Staff would complete a significant event record form. The event would be discussed at a practice meeting, which took place weekly, and information and learning would be made available to all staff and discussed at practice meetings.
- Recent training of all staff in the reporting and recording significant events had increased the instance of reporting.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient’s welfare. There was a lead member of staff for safeguarding and this was a GP who worked full time at the practice. Deputising arrangements were in place however not all staff, including the deputy for safeguarding, realised they were nominated for this role.
- Staff 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. The practice were able to demonstrate how they would maintain an accurate and up to date register of
patients subject to safeguarding arrangements and patients deemed to be ‘at risk’. Staff could describe how they would use the alert facility within DMICP (Defence Medical Information Capability Programme) to ensure that risks showed clearly when the medical record was opened.

- Notices in the waiting room and consultation rooms advised patients that chaperones were available if required. Staff who acted as chaperones were trained for the role, and had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice had an infection control policy and lead who had attended appropriate infection control training. An Infection control audit was carried out by the new practice manager on arrival at the practice, and any areas requiring improvement had been addressed.

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

- Spillage kits were available and clinical waste was stored appropriately and securely and was collected from the practice by an external contractor on a fortnightly basis.

- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines.

- Prescription pads were securely stored and there were systems in place to monitor the issue of pads to each clinician. However, there was no log in place to check on their usage. For example, at the time of our inspection, prescription pads were issued to GPs by box full, rather than a batch. Batch numbers of prescription pads were not recorded. We explained how this system could be improved.

- In the practice dispensary, there were no security bars on the windows, to prevent intruder access to this controlled area.

- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

**Monitoring risks to patients**

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. A health and safety policy was available and a poster was displayed in the main corridor of the practice which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. The fire equipment was checked by an external contractor on a six 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, infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- The practice building was owned by the Defence Infrastructural Organisation and, alongside services provided by the Station Quarter Master, we saw evidence to confirm the practice was taking the necessary action to manage the maintenance of the practice. The station was responsible for the gas and electrical safety of the building. We saw the gas safety certificate on the day of inspection. The electrical safety certificate has been requested. The building had only been in use since November 2017.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients’ needs. The practice had been through a period of flux in relation to permanent staff at the practice, particularly GPs. The recent arrival of a second GP and the arrival of a new practice manager had helped to galvanise staff and promote a team spirit across the practice. Key functions that had previously been overlooked, such as a programme of regular meetings, clinical audit and review of performance data were now being addressed.

**Arrangements to deal with emergencies and major incidents**

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

- 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 plan included emergency contact numbers for staff. A copy of this plan was available in the practice and additional copies were kept off the premises.
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. Regular clinical meetings were held and we viewed minutes from meetings which confirmed that NICE guidance had been discussed. Peer review was being re-introduced following the successful appointment of a second GP at the practice. This would further ensure that guidelines were followed.
- 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. The GP we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.

Management, monitoring and improving outcomes for people

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 DPHC 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 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 of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control.
- For one diabetic patient, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- For two diabetic patients, the last blood pressure reading was 140/90 or less which is an indicator of positive blood pressure control. We noted that foot and eye checks had been done for these patients. However, no diary entry had been made or template annotated to ensure
recall for review took place at the appropriate times.

- There were twelve 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 of their blood pressure in the past nine months. Of these patients with hypertension, seven had a blood pressure reading of 150/90 or less which is a positive indicator of blood pressure control. We noted that some of these patients did not have a record of albumin creatinine ratio (ACR) recorded within their records.

- The number of patients who smoke and whose notes contained a record that smoking cessation advice or referral to a specialist service had been offered within the previous 15 months was 17 which is 70% of the smoking patient population. The NHS target for this indicator is 93%.

- There were four patients with a diagnosis of asthma. Of these, only one 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 five patients with a new diagnosis of depression in last 12 months. None had been reviewed within 10 to 35 days of the date of diagnosis.

- Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that the instance of patients with in date audiometric hearing assessment was 93%. This compares to a national DPHC average of 86%. 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).

There was some evidence of quality improvement including clinical audit. This could be developed further.

Some clinical audit was in place and demonstrated a commitment to improving outcomes for patients at the practice. Audits undertaken to date were cyclical and were relevant to the needs of registered patients. For example:

- We reviewed an audit on obesity. This identified that 6% (37) patients had a BMI greater than 30, and of those patients, six had a BMI greater than 35. The audit made recommendations that patients were managed through a weight and measuring clinic to support them in managing BMI more effectively. Further cycles were to be completed by GPs and the new, incoming practice nurse.

- An audit on the prescribing of Zopiclone had been carried out, measuring prescribing during the period January 2017 to January 2018. This showed prescriptions for Zopiclone had fallen considerably from two previously audited six month periods, from 11 and 20 prescriptions respectively, to just five prescriptions in the year January 2017 to January 2018. This is a positive finding. Zopiclone is an opioid based medicine which can be addictive if not managed correctly.

- We reviewed an audit on hypertension and the monitoring of all patients with a systolic blood pressure reading greater than 140mmHg and also those with a diastolic blood pressure of greater than 90mmHg. This set out a structured recall and review process for all patients identified as being within this group, who were based at Chatham, including those who had moved on to other bases (Chatham is a phase three training centre with a high turnover of patients). This had positive benefits as when patient notes were sent on to medical centres receiving those patients, they would have highlighted the need for review of blood pressure at the earliest opportunity for these patients.
• An audit on management of patients with diabetes showed that these patients were managed effectively. However, a key recommendation was made, that all diabetic reviews should include the use of the DMICP template, to ensure that all relevant information is captured and stored appropriately, to aid information gathering.

• The standard audits we would expect to see had not been carried out. For example, an audit on antibiotic prescribing and an audit on prescribing in line with the Tri Service Formulary.

• 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 honestly, which aided the effective management of areas that needed attention.

**Effective staffing**

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

• The practice had an induction programme for all newly appointed staff. This included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and Caldicott accountability. Staff had access to and made use of e-learning training modules and in-house training. The induction pack for GPs had been updated and developed by the new practice manager, to ensure this met the needs of GPs and nurses joining the practice.

• Staff had all received mandatory training in subjects such as fire, basic life support and infection control. In addition staff had received role-specific training. For example, the infection control lead had attended a relevant course and all clinicians had been trained around the application of Gillick competence (Gillick is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge). Staff who acted as chaperones had received training.

• Staff administering vaccines had received specific training including an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes.

• The nurses maintained their own continual professional development. The practice manager organised mandatory training and the practice nurse 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. However, the appraisal arrangements in respect of the nurse and pharmacy technician required review. This had been done previously by an area manager who did not have the clinical experience to gauge the safety of performance of these individuals.

• The practice had been through a period where responsibility for clinical leadership had fallen to one GP who was working permanently at the practice. Although the practice is a two GP practice, the post of the second GP had been filled by a series of locums. This had placed a strain on the lead GP. At the time of our inspection, the second GP post had been filled. This had brought stability to the practice. However, the full time post of a practice nurse was vacant,
and this post had been vacant for some time. We were made aware that a new nurse was due to start as a locum at the practice, with the hope that they may become a permanent member of staff. During the period that the full time nursing post had been vacant, this had placed a higher demand on GP time and for GP appointments, from patients. There was also a back log of medical boards (where the downgrading of patients due to their medical condition was discussed) which needed to be addressed.

- We were made aware of instances where the needs of patients had not been fully met at the practice. This appeared to be due to staffing resource issues. In one case, staff were unable to offer a patient a home visit, which may have prevented a hospital admission. We also saw that when a patient needed to be seen as an urgent case, this was not accommodated. We reviewed the waiting time for an appointment with a GP. At the time of our inspection, this was approximately seven working days, or 10 calendar days, which is unusual for DMS GP practices although well within acceptable parameters compared to the NHS. During the practice presentation on the day of inspection, the practice manager told us of their wish to register any personnel based at the barracks for more than 30 days. This was to ensure that these patients had access to the clinical care needed, and to negate the need for patients to visit the practice they were registered at, which could be a considerable distance away. This may require a review of the staffing currently in place at the practice, and a more in depth analysis of the types of appointments being requested by the current patient register.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. Information was shared between services, with patients’ consent, using a shared care record. Any patients on high risk medicines had the appropriate alerts set on their patient record. When we reviewed anonymised records we saw that these patients had a record of regular blood tests which ensured that continued use of these medicines was safe.

- There was a practice log which recorded all samples sent, results received and requests for referral. This acted as a failsafe checking system. At the time of our inspection, staff used patient names. It was recommended that DMICP patient numbers be used in future, to further uphold patient confidentiality.

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

- Patient records were current and there was no backlog in summarising notes.

- Reports were usually received from the out of hours (OOH) service within 48 hours of a patient having accessed treatment. These reports were scanned on to DMICP and alerts sent to a doctor to ensure they were read and appropriate follow up instigated if necessary. The reviewing doctor coded problems/conditions as necessary on DMICP. Patients seen by the OOH service were required to present to the practice, if practicable, the next day for review.

Consent to care and treatment

Staff sought patients’ consent to care and treatment in line with legislation and guidance.
• Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

• Where a patient’s mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient’s capacity and recorded the outcome of the assessment. When providing care and treatment for young recruits, many of whom are aged between 17 and 18 years, staff carried out assessments of capacity to consent in line with relevant guidance. We saw that any parental or guardian involvement in patients’ care or treatment was with the consent of the patient.

Supporting patients to live healthier lives

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

• Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

• All new patients were asked to complete a proforma on arrival. The practice nurse followed up any areas of concern, such as raised blood pressure.

• The practice offered basic sexual health advice including the issue of free condoms and referred on to local clinics in the community for more comprehensive services including family planning.

• The practice had completed an obesity audit. As a result all patients with a BMI reading of over 30 or 35 were followed up, and their records annotated to ensure medical centres that these patients were transferred to, recalled these patients to continue providing support.

• The practice contributed to and took part in initiatives to promote good health within their local community. This included outside agencies providing stalls at health fairs, to work together to give advice and information on topics such as healthy eating and weight management.

• 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 over 65.

• 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 three. This represented an achievement of 82%. The NHS target was 80%.

• There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters. All female patients were referred to a neighbouring practice where a qualified female clinician was available to provide this service.

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 December 2017 provides vaccination data for patients using this practice:

• 98% of patients were recorded as being up to date with vaccination against diphtheria
compared to 93% regionally and 95% for DPHC nationally.

- 98% of patients were recorded as being up to date with vaccination against polio compared to 93% regionally and 95% for DPHC nationally.

- 96% of patients were recorded as being up to date with vaccination against tetanus compared to 93% regionally and 100% for DPHC nationally.

Current guidance states DMS practices should offer the typhoid vaccination to personnel before deployment and not to routinely vaccinate the whole population. As this practice serves a training centre where personnel are not immediately deployed from, we did not receive figures for typhoid vaccination rates. Vaccination in respect of Hepatitis A and B is only given before deployment. This is reflected in the figures we received:

- 65% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 91% regionally and 94.5% nationally.

- 62% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 74% regionally and 83% nationally.
Are services caring?

Our findings

Kindness, dignity, respect and compassion

- During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Curtains were provided in consulting rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The practice offered patients the services of two male GPs. For any intimate examinations that were to be performed by a GP at the practice, a chaperone was always available.
- Arrangements were in place for women to access a female GP at either Maidstone or Gillingham medical practices, and for access to family planning and maternity clinics in the community.
- There was an accessible toilet at the practice for use by any person with restricted mobility. A room was available for baby changing and/ or breastfeeding.
- We were able to speak with two patients. They told us they were satisfied with the care provided by the practice and said they were able to get an appointment when needed.
- Patients commented in feedback provided on CQC comment cards that the service they received was of a high standard; GPs and nurses explained treatment options clearly and included them in discussions on how their conditions could be treated. 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.
- Results from the practice’s Patient Experience Survey, carried out in December 2017 showed patients felt they were treated with compassion, dignity and respect. For example:
  - 77.5% of patients said the practice was good at listening to any compliments, comments or complaints.
  - 85% of patients said they felt involved in decisions about their care.
  - 95% of patients said the health professional they saw was good at listening to them.
  - 93% of patients said if family, friends and colleagues could use the practice, they would recommend it to them.
  - 95% of patients said they found the receptionists at the practice helpful and friendly.
• We did not receive any comparator data to help interpret the above patient survey results. However the views of patients expressed on CQC comment cards and those from patients we spoke with, aligned with the views above.

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

Care planning and involvement in decisions about care and treatment

• The clinicians and staff at the practice, under the leadership of the Senior Medical Officer, demonstrated that they recognised at all times that some soldiers they provided care and treatment for, were under 18 years of age and could be making decisions about treatment themselves for the first time. Staff demonstrated how they gauged the level of understanding of patients, avoided overly technical explanations of diagnoses and treatment and encouraged and empowered young patients to make decisions based on sound guidance and clinical facts. When we spoke with patients they told us the GPs took the time for example, to explain why an injury may be slow to heal and what they could do to improve the healing process. We saw this type of engagement and involvement across all treatment and in handover between GPs, nurses and physiotherapy staff.

• The young patients at the practice were treated in an age-appropriate way and recognised as individuals.

• The Choose and Book service was used to support patient choice as appropriate (Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).

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

• Information leaflets were available in reception. Staff were also very knowledgeable and could signpost patients to services via the HIVE network.

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 information that was age appropriate and relevant to the patient demographic. This was prominently displayed and accessible. For example, we saw posters which explained how to use a condom safely, on symptoms that may suggest a sexual health screening appointment would be useful, on access to contraception and on the importance of completing any prescribed course of treatment.

• The practice acted in a compassionate way toward any patient that had to be discharged from the college on health grounds. We saw that the practice reassured these patients and signposted to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions.

• The practice proactively identified patients who were also carers and two patients were on the practice carers register. Where patients identified themselves as carers, a code was added to
their records in order to make them identifiable and so that extra support or healthcare could be offered as required. The SMO (Senior Medical Officer) attended monthly 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 clinics were available to service personnel, for example, physiotherapy, health checks, travel advice, and family planning advice. Pre and post-natal clinics were held at a neighbouring practice every week. Patients were able to receive travel vaccines when required. The practice was a Yellow Fever centre and the nurse had received training to support this.

- Patients could have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse. Patients requiring them could book a double GP appointment of 30 minutes.

- Generally, same day appointments were available for those patients who needed to be seen quickly. However, we were aware of examples where patients who needed to be seen quickly could not be accommodated.

- Physiotherapists were employed within the practice. All referrals to this service were made by the GPs and the average waiting time for an appointment was approximately three days.

- There were accessible facilities which included interpreter services when required. Transport for patients to hospital appointments was available if needed. All patients travelling to hospital appointments, under the age of 18, were provided with transport to and from those appointments.

- Eye care and spectacles vouchers were available to service personnel from the medical centre.

- Following some negative patient feedback on waiting times following arrival at the practice for an appointment, a survey had been conducted to establish whether patients were waiting for longer than 20 minutes to see a GP, after arrival at the practice. This survey was comprehensive and audited patient arrival times for their appointment, the time of the booked appointment, and the time recorded in the consultation of the patient actually seeing the GP. This showed 82% of patients were seen within 10 minutes of their appointment time; 16% of patients were seen within 20 minutes of their appointment time. Results showed that only one patient, which equated to 2%, was seen after a wait of 20 minutes after their appointment time. The number of patient consultations reviewed was 41. Research by the practice team showed that waiting for longer than 20 minutes was unusual. However, they encouraged patients to let reception staff know if they had been waiting longer than 20 minutes to see a GP.

Access to the service

- The practice was open from Monday to Friday. On Monday, Wednesday and Thursday of each
week, opening hours were from 0800 hours to 1630 hours. On Tuesday the practice opening hours were from 0800 hours to 1230 hours. On Friday the practice was open from 0800 hours to 1600 hours. The practice closed each day for lunch from 1230 hours to 1300 hours. ‘Sick parade’ (an opportunity for patients to attend the practice for advice in person) took place at 0800 hours.

- The practice provided GP clinics each day. Nurse clinics were available each morning and afternoon. At the time of our inspection, nurse clinics were limited due to the vacancy for a full time practice nurse, who supported the part time practice nurse. This had placed a further demand on the GP for some appointments, which impacted the availability of appointments with a GP. When we checked the waiting time for a routine appointment with a GP was seven working days, or 10 calendar days.

- After these hours, between 1630 hours and to 1830 hours shoulder cover was provided by Pirbright surgery, which was approximately one hour away. Beyond 1830 hours, patients were diverted to the NHS 111 service. When the practice closed on Tuesday afternoon for training purposes, patients were diverted to Pirbright surgery. In this way, the practice ensured that patients could directly access a GP between the hours of 0800 and 1830, in line with DPHC’s arrangement with NHS England.

- The practice leaflet gave clear directions on local accident and emergency unit access. The nearest accident and emergency department was located at Medway Hospital

- Results from the practice patient experience survey showed that overall patient satisfaction levels with access to care and treatment were good. For example:
  - 82% of patients said they were able to obtain a routine appointment when they needed one.
  - 84% of patients said medical staff listened to them.

- Patients we spoke with told us on the day of the inspection that they were able to get appointments when they needed them

**Listening and learning from concerns and complaints**

The practice had a system for handling complaints and concerns.

- Defence Primary Health Care had an established policy and the practice adhered to this.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.
- We spoke with two patients who told us that they felt comfortable and knew how to complain if they had to. They confirmed that military rank would not be a barrier to them raising issues with the practice.
- There had been one complaint raised in the last 12 months. We saw that there were processes in place to share learning from complaints. Complaints were audited through the Common Assessment Framework (CAF). This was used to focus on improvements to the service and to ensure that designated standards were being met on the handling of complaints.
Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Good

Our findings

Vision and strategy

- The practice had a vision to deliver high quality care and promote good outcomes for patients. Safe and effective care was at the forefront of the vision for the practice and this was projected by all members of staff. All staff we spoke with were content with their working environment. Staff also acknowledged that their opinions, observations and views were valued.

- The practice had a mission statement: “DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care service for entitled personnel to maximise their health and to deliver personnel medically fit for operations.”

- Staff we spoke with throughout the day could identify this mission statement, knew and understood the values and behaviours required to support this. The practice had a business plan which reflected the vision and values and these were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of good quality care. This ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and the practice nurse 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.

- Clinical and internal audit was being used to monitor quality and to make improvements. This could be developed further. We saw that the practice used the audit work they had done to identify learning and action points. For example, the effective follow-up of patients, which could be better managed through the use of templates on DMICP for recording patient interventions.
• There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. This included plans developed each year that took account of manning levels at the practice due to deployment of some staff.

• We saw evidence from minutes of meetings, a structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

• On the day of inspection the leaders in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure good care. They told us they prioritised safe, high quality and compassionate care. Everything we saw on the inspection day, and communications with the practice following the inspection, supported this.

• There was a clear leadership structure and staff felt supported by management. Staff told us the practice leaders were approachable and always took the time to listen to all members of staff.

• All staff were involved in discussions about how to run and develop the practice. We particularly noted the ‘learning atmosphere’ in the practice, which was promoted by leaders. We saw the practice held regular meetings and staff confirmed this. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.

• 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 Defence Medical Services surveys and from any individual patient feedback received.

• The practice were looking at the possibility of forming a Patient Participation Group (PPG) but were aware that limitations were inevitable due to the transient nature of the patient population.

• 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

• The arrival of the new practice manager in October 2017 provided a renewed focus on continuous learning and improvement at all levels within the practice. The practice team was
forward thinking and from minutes of meetings we reviewed we saw that the leaders of the practice focussed on improving the speed and quality of delivery of care for all patients. Improvements implemented regular full practice team meetings. Review of records showed that previously these had only occurred bi monthly. Staff commented that having staff meetings improved the feeling of team spirit and aided communication.

- The practice manager had driven improvements in the cleaning of the practice, following infection control and cleaning audits conducted on their arrival.

- There was a renewed focus on audit within the practice. Both clinicians and the practice manager had prioritised this as an area for improvement. The impending arrival of the new full time practice nurse would free up GP time, enabling both GPs to carry out continuous improvement activity.