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

We carried out an announced inspection at Chester Medical Facility on 9 March 2018. Overall, the practice is rated as requires improvement. 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. Awareness of matters that should be reported could be developed further, along with the confidence of staff to report incidents autonomously.

- From the incidents reported we could see that investigations had been carried out appropriately and lessons learned, discussed and applied. The lessons learned required recording in the electronic reporting system.

- There were clear systems in place for the receipt, cascade and sharing of patient safety alerts and updates to clinical practice.

- The practice had clearly defined systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- There was evidence of audit although many of the audits were made up of initial cycle only, and we observed there were limited learning points established or applied.

- There was no effective mechanism in place to ensure that the two long term locums at the practice, had access to the same training opportunities as civilian medical practitioners.

- We found a clinician required further training relevant to their role to enable them to perform all duties expected of them.

- The newly appointed practice manager had not received any training in medical practice management.

- We found staff that had been away from the practice for longer periods of time required refresher training, for example, in how to access and effectively use the electronic incident reporting system and in full use of the electronic patient record system DMICP.

- 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). Systems for management of blank prescription forms were in place and adhered to by all at the practice.

- Although the practice was clean, tidy and provided sufficient space to meet the needs of patients, some improvements were required to fully meet infection control guidance. The facility was located in an older building and is due to be closed in 2023.

- Nursing staff were responsive to patient demand and delivered clinics at other sites across the
North West region, Wales and Northern Ireland to meet patients’ needs.

- Registers of any vulnerable patients and patients who were carers were kept by the practice.
- The practice did not have a policy on home visits; there was no information in the practice leaflet for patients on home visits.
- There was a lack of senior leadership within the practice. The absence of the Regimental Medical Officer when the regiment deployed, meant that GP services were provided by two locums who had regularly worked at the practice for a number of years. No consideration had been given to who should act as Senior Medical Officer (SMO) in the absence of the RMO. There was no evidence of oversight by Regional Managers, into the distribution of leadership duties in the absence of the RMO.

The Chief Inspector recommends:

- Staff should do all that is reasonably practicable to mitigate risks to patients. This includes completing significant event reports for all events, including evidence of emerging risk that could be shared more widely across DPHC.
- Ensure premises used to provide care and treatment are properly maintained and are fit for purpose.
- Assess, monitor and improve the quality and safety of the services provided, through continuous improvement exercises. This should be a clinical audit made up of completed cycles.
- Assess, monitor and mitigate the risks relating to the health, safety and welfare of patients. This includes but is not limited to giving patients and staff access to a policy on home visits and share this information with patients; by attendance of GPs at Unit Health Committee meetings to discuss the medical downgrading of some patients; by providing new patient medicals or formal registration of new patients to the practice, to ensure those requiring closer monitoring are captured; and by maintaining a formal register of patients on high risk medicines.
- Ensure persons employed receive appropriate support, training, supervision and appraisal to enable them to carry out the duties they are employed to perform.

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

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

We always ask the following five questions of services.

**Are services safe?**

Describe the findings in response to this question, with the following points:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. Awareness of matters that should be reported could be developed further.
- Although significant events were recorded and records of discussion of incidents were kept, lessons learnt were not recorded. Staff did not appear confident to autonomously report incidents, with some staff preferring to discuss incidents at meetings before going on to report them. Some incidents that had occurred, even though the practice was not directly involved, were not reported to enable effective management of emerging risks by DPHC HQ.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. All staff, including non-clinical staff were trained in safeguarding to the appropriate level for their role.
- The practice did not conduct new patient medicals or ask patients to register with the practice when they were transferred to this military site. Patients who required closer monitoring due to their course of treatment would not automatically be picked up, which could represent risk to patients.
- The arrangements for managing medicines, including emergency medicines and vaccines in the practice, minimised risks to patient safety.
- Upgrade work was required in some parts of the practice to aid compliance with infection control standards, for example, the removal of carpets, fabric covered notice boards and some vanity unit handwashing sinks.
- Systems were in place to receive, share and discuss any medical alerts and updates to clinical practice.
- The practice had arrangements in place to respond to
emergencies and major incidents.

**Are services effective?**
The practice is rated as requires improvement for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes for some indicators were above NHS target figures. Two indicators were below NHS target figures.
- A patient was being prescribed a high risk medicine but there was no effective register for patients on high risk medicines, maintained by the practice.
- Practice staff assessed needs and delivered care in line with current evidence based guidance.
- Findings on the day of inspection showed some clinicians required further training and support in the use of the electronic patient records system (Defence Medical Information Capability Programme – DMICP) and associated templates. This is essential for recording interventions with patients with long term conditions, and to ensure all required checks and tests are conducted.
- Staff who had been away from the practice for long periods of time required refresher training in use of the system for recording significant events.
- Staff had not introduced self referral to physiotherapy services for patients, as per recently circulated DPHC guidance. The practice still operated a GP referral system for patients seeking physiotherapy services.

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

- 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.
- Systems were in place to maintain patient and information confidentiality.
- Feedback provided on CQC comment cards was highly positive. Patients said they had received high quality care from dedicated health professionals.
- Staff maintained a carers register and a register of any patients that may be vulnerable.
### Are services responsive?
The practice is rated as good for providing responsive services.

- Practice nursing staff delivered additional clinics to meet the needs of reservist soldiers. These were usually at different sites within the North West region, Wales and Northern Ireland.
- The practice did not have a policy on home visits and there was no information about home visits contained in the practice leaflet.
- A complaints policy was in place and any complaints received were handled in line with this policy.
- Feedback in CQC comment cards, completed by patients before our inspection, suggested that patients were able to access appointments without delay.
- The practice carried out patient surveys and acted on feedback to improve services if possible.

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

- The practice nurses and regular locum GPs, who were all civilian staff, provided stability for the practice patients when military clinicians and staff were deployed with the regiment.
- Some key areas of responsibility had been shared between staff. However, this didn’t cover all responsibilities in the absence of the Regimental Medical Officer (RMO) for example, attendance at Unit Health Committee meetings.
- There was a lack of oversight by Regional Managers, which meant that gaps in leadership were not addressed.
- A governance structure including management processes, meetings, updates and briefings was in place. This supported staff in delivery of their duties.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The majority of staff we spoke with were 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 a practice nurse specialist advisor.

Background to Chester Medical Facility

Chester Medical Facility is located approximately two miles from the city of Chester and serves a regular tri-service military population of approximately 630 patients. It also provides occupational health services for an additional 3,000 reservist personnel. The dependants and families of regular military personnel were served by local NHS GP practices.

The clinical lead for the practice is the Regimental Medical Officer, who deploys with the regiment as required. The practice is further supported by two full time, long term locum GPs, two civilian nurses and two administrative staff. One of the nurses has completed further study and training and is a qualified nurse prescriber. The practice is led by the military practice manager who has a deputy military practice manager. Both of these military staff are trained medics who are part of the practice staff complement meaning that they do not deploy with the regiment.

The medical facility is located in an older style building designed to operate as a medical centre. This presents the practice team with challenges. Also, capacity for IT capability is also limited by the age of the building.

The medical facility is open from Monday to Thursday, 0800 hours to 1630 hours, closing each day for lunch from 1230 hours to 1330 hours. The facility is open on Friday from 0800 hours to 1230 hours. Outside these hours, shoulder cover is provided by RAF Valley medical facility, which is approximately one hour away by car. Between 1830 hours and 0800 hours, at weekends and on bank holidays, patients are diverted by a telephone message to NHS 111 services. The practice does not have a dispensary facility and all prescriptions are outsourced to a local pharmacy, who will collect, fulfil and deliver prescriptions back to the medical facility. The nearest accident and emergency department is located within Countess of Chester Hospital, approximately two miles away. Throughout this report, Chester Medical Facility is referred to as ‘the practice’.

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. However, where CQC finds shortfalls in the quality of services during inspection, we will report them by making a recommendation for action to the Surgeon...
How we carried out this inspection

Before visiting, we reviewed a range of information sent to us by the practice before the inspection.

We carried out an announced inspection on 8 March 2018. During the inspection, we:

- Spoke with staff at the medical facility, including the practice manager, two practice nurses, the Regimental Medical Officer, two locum GPs and administrative staff.
- Reviewed records at the medical facility, including a sample of anonymised patient records.
- Collected 38 CQC comment cards, completed by patients before our inspection.
- Conducted a tour of the building, carrying out visual checks.
- Collected data on the day of the inspection and in the days following our inspection, on patient outcomes.

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. However, some staff lacked the confidence to report autonomously, preferring to discuss incidents first at practice meetings, before officially recording and reporting incidents.

- The practice carried out a thorough analysis of the significant events. Staff understood their roles in discussing, analysing and learning from incidents and events.

- Significant events were discussed at a practice meeting, which took place monthly.

- Review of significant events required improvement to ensure any lessons learned were applied and formally recorded as required.

- Staff had not reported some events because the practice had not been directly involved. Some adverse events had not been acted on at practice level. This presented risk to some patient groups. Where issues had been reported, there was scope to consider these more widely across Defence Primary Health Care (DPHC) and any impact this may have on patient care.

- We noted that although investigations that had been conducted were clearly recorded and findings shared at practice meetings, lessons learned were not formally recorded in the health care governance record.

- We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. The practice were able to demonstrate that safety alerts and incident reports were dealt with in line with DPHC guidance.

- 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 clearly defined systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Safeguarding arrangements that reflected relevant legislation and local requirements. Policies were accessible to all staff; we saw that staff were familiar with and understood these policies. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient’s welfare. There was a lead member of staff for safeguarding and this was a GP who
worked full time at the practice. Effective deputising arrangements were in place.

- Staff 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, although the practice did not treat families and dependent children.

- The practice demonstrated how they maintained an accurate and up to date register of patients subject to safeguarding arrangements and patients deemed to be ‘at risk’. Staff used the alert facility within DMICP to ensure that risks showed clearly when the medical record was opened.

- The practice did not conduct new patient medicals or ask patients to register with the practice when patients were transferred to this military site. This meant patients who required closer monitoring would not automatically be identified, which could represent risk to patients.

- 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 an enhanced level 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). However when asked about providing chaperone services, staff who had been away from the practice for some time, incorrectly identified administrative staff as chaperones. These staff had not been trained and may not have undergone the required standard of DBS check.

- The practice was visibly clean and tidy. Practice staff ensured that standards of cleanliness and hygiene were maintained. The practice had an infection control policy and lead who had attended annual infection control training. Infection control audits were carried out at least annually. These audits had highlighted the need for further upgrade work at the practice, if the facilities were to comply fully with infection control standards. This would include the removal of carpets in clinical areas, the removal and replacement of fabric covered seats and notice boards, and the replacement of vanity hand wash basins, with approved, compliant standard hand wash basins. We were advised that some of this work would be carried out in the near future.

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

- Spillage kits for bodily fluids were available and clinical waste was stored appropriately and securely. A contract was in place for this to be collected from the practice on a fortnightly basis. We saw that the practice had records of all clinical waste, including consignment notes. A pre-acceptance audit for clinical waste had also been completed. This showed that all staff were managing clinical waste safely and in accordance with Department of Health guidance.

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

- There was an appointed medicines management lead within the practice. At the time of our inspection, this was the senior nurse who was a qualified prescriber.

- The practice had carried out an audit of the small dispensary area, where over the counter medicines could be provided to patients who needed them, if they could not access the local pharmacy service. No prescription only medicines were dispensed by the practice. The audit showed that all stock held was stored correctly, and that records were in place to support the safe management of medicines kept in the dispensary.

- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow one of the practice nurses
to administer medicines in line with legislation. Patient Specific Directions were used appropriately.

- We reviewed two staff 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 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 and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice kept records of water temperature checks and records of pipe flushing to support the management of legionella risk.
- We saw evidence which confirmed the practice was taking the necessary action to manage the maintenance of the practice. The practice manager was able to produce gas and electrical safety certificates in respect of the building.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients’ needs. This took account of the periods when the Regimental Medical Officer would be deployed with the regiment. To offer stability and continuity of care for patients, the practice retained the services of two, full time locum GPs who had worked at the practice for a number of years. Staff demonstrated a flexible approach to the running of the practice. There were a considerable number of responsibilities being held by the two practice nurses, which would normally sit with the SMO. This had an impact on nursing hours available to patients.
- The Senior Medical Officer (SMO), who was the Regimental Medical Officer, had recently returned to the practice following a lengthy deployment and resettlement leave. The SMO had not had the opportunity to familiarise themselves with all of the lead responsibilities that needed to be handed back to them. A number of these remained with nursing staff.

**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 had personal alarms.
- All staff received annual basic life support training and there were emergency medicines held
securely in one of the treatment rooms. All the medicines we checked were in date and fit for use.

- The practice had a defibrillator available on the premises and oxygen with adult masks.
- A first aid kit and accident book were available.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Copies of the plan were held in the medical centre and in other locations off site to ensure it could be retrieved if access to the building was restricted.
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. All 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 reviewed minutes from meetings which confirmed that NICE guidance had been discussed.

- 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 staff we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice. For example, we saw that patients had been contacted in response to an alert issued about some types of asthma inhaler.

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 no patients on the diabetic register. We noted the practice did not routinely carry out new patient screening, when patients transferred to Chester. Therefore, it was unclear as to whether the diabetic register would be accurate. Clinicians were able to describe the relevant care pathway for patients which reflected current NICE guidance.

- There were 11 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. Of these patients, 11 had a record of their blood pressure in the past nine months. Of these patients with hypertension, three had a blood pressure reading of 150/90 or less which is a positive indicator of blood pressure control.

- The number of patients who were recorded as smokers was 184. Those whose notes contained
a record that smoking cessation advice, or referral to a specialist service had been offered within the previous 15 months was 91 which is 49.5% of the smoking patient population. The NHS target for this indicator is 90%. This had been identified as an area for improvement by the clinical team.

- The number of smokers with a long term condition was 22; 100% had received smoking cessation advice or referral to a specialist service.

- There were 10 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, 10 (100%) had had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

- There were 10 patients with a new diagnosis of depression in last 12 months. All 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 95%, compared to 92% regionally and 85.5% nationally for DPHC. 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 evidence of quality improvement including clinical audit. This could be developed further, for example, by completing second cycles of audit to give results of any measurable improvement. The practice staff told us that ten audits had been completed in the last 12 months. When we reviewed audits, some were made up of data review or discussion of latest NICE guidance in relation to recommended care pathways, for example, in relation to hypertension.

Audits that had been completed by the practice included an audit on care for patients with asthma. This was the initial cycle, conducted in August 2017. Recommendations made from the result of audit was that all clinicians were to use the appropriate template in DMICP for asthma review and intervention in relation to asthma, to ensure that all recommended care actions are correctly recorded. The audit demonstrated that overall, care for asthma patients was effective. No patients had experienced an exacerbation of their asthma that resulted in transfer to or admission to secondary care facilities. All patients had received a full asthma review at least annually.

An audit had been completed on patient records. This audit checked the quality of notes made by clinicians and that clinical record keeping met the standards set by the Royal College of General Practitioners (RCGP). Results of the audit showed that records of patient consultations held electronically were of a good standard. One of the recommendations was that all clinicians should use standard DMICP templates where appropriate, as these prompt the collection and recording of information at each consultation. Again, this was a single cycle audit. The recommendation was that the audit was repeated again in 12 months.

Other audits completed by the practice included a full, infection control audit; a clinical waste pre-acceptance audit; a pharmacy check audit; audit on the effectiveness of SMS messaging when used to remind patients of appointment times, and an audit on over 40’s health checks at the practice. We noted gaps in the audit work undertaken, for example, there was no audit on antibiotic prescribing or 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 to aid the effective management of areas that needed attention.

**Effective staffing**

Evidence reviewed showed that not all 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. A new military practice manager had been placed with the practice. This staff member had no experience of running a clinical practice. We understand that a training course had been offered to them, but they were unable to attend this course. No further course dates had been offered.

- An induction pack for locum GPs was available. This was updated regularly to ensure this met the needs of GPs and/or nurses joining the practice.

- Staff had all received recommended 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.

- It was noted that one staff member struggled to locate and access the military wide on-line system for reporting and recording significant events (ASER), and to use and confidently navigate themselves around the electronic patient record system. This could impact on the effective recording of clinical details, and the recording of any significant event report, that required the input of this clinician.

- Locum GPs did take on some lead responsibilities. However, they did not take on all duties expected of a Senior Medical Officer. For example, neither of the locum GPs attended Unit Health Committee meetings, where the down-grading of active work status of patients was discussed. It was unclear how this was managed in the absence of the Regimental Medical Officer (RMO), or what the impact on patients would be.

- 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 practice manager organised mandatory training and the practice nurses managed their own nursing update training. We were told there was no issue with being released for courses and or updates.

- One of the GPs at the practice was unable to confirm that they had received update training on identifying possible cases of Sepsis.

- There was no mechanism in place to ensure locum clinicians had access to training that may otherwise be available to permanent, civilian medical practitioners.

- The learning needs of most permanent staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.
Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff through the practice’s patient record system and their intranet system. However, we found some patient records were incorrectly coded, or did not have Read codes applied, making them more difficult to navigate.

- Care and risk assessments, care plans, medical records and investigation and test results were held on each patient record. Information was shared between services, with patients’ consent, using a shared care record.
- The practice had a patient who was prescribed high risk medicines. This patient had the appropriate alerts set on their patient record. When we reviewed anonymised records we saw that patients who required it had a record of regular blood tests which ensured that continued use of high risk medicines was safe. However, there was no register kept by the practice, of patients on high risk medicines. Although all GPs were aware of this patient, the system in place did not provide quick effective access to the names of patients on high risk medicines, which could be needed if a new locum working at the practice required this information.
- DPHC had rolled out a system of self-referral of patients to physiotherapy services. The practice had not introduced this at the time of our inspection.
- The practice maintained a log which recorded all samples sent, results received and requests for referral. This acted as a failsafe checking system. DMICP patient numbers were used to 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.
- There was no backlog in summarising notes.
- Reports were usually received from the OOH service within 48 hours of a patient having accessed treatment. These reports were scanned on to DMICP and alerts sent to a doctor to ensure they were read and appropriate follow up instigated if necessary. Patients seen by the out of hours service (OOH) 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.
- The practice did not have any patients under the age of 18 years registered with them. However, all staff were able to explain Gillick competence and how this would be applied in their daily work.
- The process for seeking consent was monitored through patient record audits.
Supporting patients to live healthier lives

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

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

- New patients did not present to register with the practice, and were not asked to complete a new patient proforma when posted to the barracks in Chester. This meant staff had no effective mechanism in place to screen patients to ensure they were added to appropriate disease registers as required, for example, asthma or diabetes register. This also meant that some registers may be inaccurate.

- 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.

- 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 28 out of 28 eligible women. This represented an achievement of 100%. The NHS target was 80%.

- There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available.

- The practice had measures in place to ensure that the low numbers of female patients at the practice, did not impact on the quality checks on required for effectiveness of cytology screening. The practice nurse also represented the military on the local Clinical Commissioning Group cytology practice and quality assurance group.

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 March 2018 provides vaccination data for patients using this practice.

- 95% of patients were recorded as being up to date with vaccination against diphtheria compared to 96% regionally and 95% for DPHC nationally.

- 95% of patients were recorded as being up to date with vaccination against polio compared to 96% regionally and 95% for DPHC nationally.

- 80% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 78% regionally and 77% for DPHC nationally (there is currently a national shortage of Hepatitis B vaccine and routine vaccination has been suspended until supply increases.)

- 97% of patients were recorded as being up to date with vaccination against Hepatitis A,
compared to 92% regionally and 91% nationally. (There is currently a national shortage of Hepatitis A vaccine and routine vaccination has been suspended until supply increases.)

- 95% of patients were recorded as being up to date with vaccination against Tetanus, compared to 96% regionally and 95% for DPHC nationally.
- 82% of patients were recorded as being up to date with vaccination against Typhoid, compared to 53% regionally and 52% for DPHC 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 either a female or a male GP. For any intimate examinations that were to be performed by a male GP at the practice, a chaperone was always available. Arrangements were in place for women to access a family planning clinic in the community.
- There was an accessible toilet in the waiting area.
- Patients commented in feedback provided on CQC comment cards that they felt involved in decision making about the care and treatment they received. They commented that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Results from the practice’s 2017 Patient Experience Survey showed patients felt they were treated with compassion, dignity and respect.

- Of patients who responded, 42 out of 51 said the practice was good at listening to any compliments, comments or complaints.
- Of patients who responded, 43 out of 47 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 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 younger patients at the practice were treated in an age-appropriate way and recognised as individuals. We saw evidence that confirmed younger patients, for example, those between 18 and 25 years, were supported to make decisions about their care and treatment.

- 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).

- 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 with details of local hospital services and any specialist centres.

Patient and carer support to cope emotionally with treatment

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic. 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 proactively identified patients who were also carers and three were registered. 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 practice staff also kept a register of patients that may require additional support. For example those who had a relative or child undergoing treatment which meant it would be sensible for them to have a flu vaccination each year.
Are services responsive to people’s needs? (for example, to feedback)

Our findings

Responding to and meeting people’s needs

The practice staff told us they understood its population profile and had used this understanding to meet the needs of its population. However, the lack of new patient screening on patient transfer to Chester meant the needs of some patients may not be identified at the earliest opportunity. Our findings on the inspection day showed:

- A wide range of clinics were available to service personnel, for example, physiotherapy, health checks, travel advice, well man and well woman clinics. Any personnel requiring maternity services could be referred to a local NHS practice, where community midwives visited on a weekly basis.

- Patients were able to receive travel vaccines when required. The practice was a Yellow Fever centre and nurses had received training to support this.

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

- Same day appointments were available for those patients who needed to be seen quickly.

- Physiotherapists were employed within the practice. All referrals to this service were made by the GPs and the average waiting time for an appointment was less than one week. The practice had yet to introduce self-referral for physiotherapy services, which has been rolled out across DPHC nationally.

- There were accessible facilities which included interpreter services when required. Transport for patients to hospital appointments was available if needed.

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

Access to the service

The practice was open from Monday to Thursday, 0800 hours to 1630 hours, closing each day for lunch from 1230 hours to 1330 hours, and open on Friday from 0800 hours to 1230 hours. Outside these hours, shoulder cover was provided by RAF Valley medical facility, which was approximately one hour away by car. Between 1830 hours and 0800 hours at weekends and on bank holidays, patients were diverted by a telephone message to NHS 111 services. Patient feedback to the practice through surveys, complaints and compliments indicated that current opening hours and access arrangements were sufficient to meet patients’ needs.

The practice leaflet gave clear directions on local accident and emergency unit access. The nearest accident and emergency department was located at Countess of Chester Hospital,
approximately two miles away.

Results from the practice’s patient experience survey showed that overall patient satisfaction levels with access to care and treatment were high. For example:

- Of 43 patients that responded, 41 said their appointment was provided at a convenient location.
- Of 43 patients that responded, 41 said their appointment was at a convenient time.
- One of the practice nurses delivered additional weekend clinics, at various locations around the North West, Wales and Northern Ireland, to ensure that all personnel, including reservists, had access to occupational health and nursing services.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Defence Primary Health Care had an established policy and the practice adhered to this.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.

There had been one complaint received by the practice in the past 12 months. This related to continuity of care from the Primary Care Rehabilitation Facility (PCRF), which is not covered as part of this inspection. However we did see that this was dealt with in line with the practice complaint policy.
Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Requires improvement

Our findings

Vision and strategy

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Consistent, safe and patient focussed care was clearly at the forefront of the vision for the practice and this was projected to and adopted by all members of staff. All staff we spoke with proud to work for the practice.

- The practice had a mission statement “To deliver a unified, safe, efficient and accountable primary healthcare service to maximise health and to deliver personnel medically fit for operations.”

- Staff we spoke with throughout the day could identify this mission statement, and knew and understood the values and behaviours required to support this.

Governance arrangements

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

- Policies from the national framework were implemented and were available to all staff. We were told these were updated and reviewed regularly. However, evidence on the day suggested some national DPHC policy updates were being missed by practice staff, for example, a recent notice on patient led self-referral to physiotherapy services had not been implemented as directed.

- 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. Learning needs and details of all available courses for staff were discussed at practice meetings. The meetings were also used for forward planning for example, to ensure that patient needs were met during periods of staff absence, and for example, when the Regimental Medical Officer (RMO) and medics may be deployed.

- These meetings also 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.

- A programme of clinical and internal audit was used to monitor quality and to make improvements. We saw that the practice used their audit work to identify learning and action points. For example, the GPs shared their findings on the quality of patient records, and highlighted areas for improvement.
Leadership and culture

- On the day of inspection the practice nurses and practice manager, demonstrated they had the capacity and capability to run the practice and ensure patient focussed care. However, there were gaps in leadership that had not been picked up by the SMO. A review of the distribution of clinical lead duties was required. The current arrangements, where nurses were leading in key areas, had an impact on the availability of nursing time. We did not see evidence of support and oversight by Regional Managers.

- The locum GPs had been at the practice for a considerable period of time, and were fully supportive of the practice team, taking on additional lead responsibilities when required. The Regimental Medical Officer (RMO) was the Senior Medical Officer (SMO) for the practice. There was no evidence that Regional Managers had considered SMO lead responsibilities and how these should be shared among the remaining clinicians when the RMO was deployed.

- Practitioners told us they prioritised safe and compassionate care. Everything we saw on the inspection day, and communications with the practice following the inspection, supported this.

- All staff were involved in discussions about how to run and develop the practice. 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 practice 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. However, one clinician required prompting when trying to explain the Duty of Candour.

- Overall, 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 told us they encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through the Patient Experience survey and from any individual patient feedback received. However, the practice were looking to develop the survey further, by setting questions that were clear and unambiguous.

- The practice had not formed a Patient Participation Group (PPG) but were aware that limitations were inevitable due to the transient nature of the patient population and deployable status of operational staff at the practice.

- 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. However, we did not see a level of involvement with Regional Management, that helped close gaps in leadership at the practice

- Completed CQC comment cards from patients supported our findings, that there was an open door policy when it came to patient input and feedback. In feedback in CQC comment cards, patients commented that they received a very good service from the practice.
Continuous improvement

- There was a focus on continuous learning at all levels within the practice. From minutes of meetings we reviewed we saw that the lead practice nurse and their immediate team, focussed on improving the quality and accessibility of care for all patients. For example, following analysis of numbers of reservists requiring access to clinics outside of standard working hours, one of the practice nurses had been delivering clinics at weekends, to meet the occupational health needs of reservist soldiers.

- The practice used data as a driver for improvements, which was discussed at clinical meetings. Recent examples included the review of patients who were smokers, their smoking status and offer of referral for smoking cessation advice. Also, a recent example of improvement had been the review of and treatment of patients with hypertension, in line with NICE guidance. This is reflected in the QOF figures for the practice.

- The lead practice nurse had links to the local CCG and shared any updates with staff at clinical meetings. This opportunity to network with peers was welcomed by the practice.