Defence Medical Services

Brawdy Medical Centre

Quality Report

Cawdor Barracks
Brawdy
Haverfordwest
Pembrokeshire
SA62 6NN

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

Ratings

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

Summary of findings

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Brawdy Medical Centre on 22 March 2018. Overall, the practice is rated as inadequate. Our key findings across all the areas we inspected were as follows:

- Staffing levels at the practice were sufficient to meet the needs of the patient population.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal in the practice minimised risks to patient safety.
- High risk medicines were not being appropriately managed. Shared care agreements were not in place for patients on high risk medicines.
- The system for managing incidents and significant events was not being used in accordance with Defence Primary Health Care (DPHC) policy.
- Duty of candour principles had not been consistently adhered to.
- Clear arrangements were in place for infection prevention and control, the management of clinical waste and substances hazardous to health. Risk assessments in relation to health and safety were relevant and current.
- Mandated training could not be confirmed for all staff working at the practice. Clinical supervision and peer review were undeveloped.
- Effective medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Staff respected the privacy, dignity and confidentiality of patients.
- The governance of the practice was unclear particularly in relation to the operational management of the practice. Clinical leadership was weak. There was no evidence to demonstrate that a contact was in place for the GP service.
- Although there was evidence of quality improvement, clinical audit was lacking and underdeveloped.
- Lines of communication between the practice and units commanders regarding the fitness of service personnel were not effective.

The Chief Inspector recommends:

- That a contract is established for the GP service and formal contract monitoring arrangements are put in place. The contract should take account of: the working hours of the GPs;

responsibility for healthcare governance; provision of clinical leadership; engagement and communication with the unit Chain of Command; training needs in relation to military occupational health care; arrangements for mandated training and appraisal.

- The practice management arrangements for the day-to-day operational management of the practice should be reviewed and clarified.
- Formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision should be reviewed, strengthened, embedded and understood by all staff.
- A programme of relevant and targeted clinical improvement work should be developed to improve patient outcomes and care.
- The standing agenda for practice meetings is reviewed and revised to ensure it is in accordance with DPHC expectations.
- A suitable staff member is identified as the safeguarding lead for the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Inadequate

Are services safe?

The practice is rated as inadequate for providing safe services.

- A system was in place for reporting and recording significant events. The GPs were not using the system in accordance with DPHC policy.
- Effective monitoring arrangements were not in place for patients on high risk medicines. Shared care agreements were not in place.
- Effective arrangements were in place for health and safety, infection prevention and control, environmental cleaning and waste management.
- Staffing levels were adequate to meet the needs of the patient population.
- Facilities and equipment at the practice were sufficient to treat patients and meet their needs.
- Fire safety was comprised by the use of fire wedges to retain fire doors in an open position.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- Clinical quality improvement work was underdeveloped and the GPs had not undertaken any audits.
- Patients' records were not aways updated in a timely way.
- GP representation at the Unit Health Committee meetings was not consistent. This was important when discussing the downgrading of patients.
- Patients were actively supported to live healthier lifestyles through a targeted and proactive approach to health promotion and wellbeing.
- Summarisation of patient records was up-to-date.
- Evidence of mandated training, clinical supervision and peer

review was not in place for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Overall, the majority of patients told us they were treated with compassion, dignity and respect, and were involved in decisions about their care and treatment.
- The patient experience survey showed that patients were satisfied with the care and attitude of staff at the practice. A small number of patients were unhappy with the attitude of their GP.
- Information for patients about the service was available and accessible. Systems were in place to maintain patient and information confidentiality.
- We received 27 comment cards. Feedback from 25 patients was positive about the standard of care received.
- Interpretors were available for patients if they required this service.

Are services responsive?

Requires improvement

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

- Patients found it easy to make an appointment and urgent appointments were available the same day.
- Staff advised that GPs did not always work at the practice for the number of hours outlined in their contract.
- The arrangements for the transport of tissue samples limited the clinical activity of nurses and this in turn could delay patient care.
- Telephone consultations could be provided as an alternative to visiting the practice.
- Effective medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover.
- A rehabilitation team was based at the practice. Referrals to this service were made by the doctors and nurses; with the average waiting time for an appointment was less than one week.

Are services well-led?

Inadequate

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

• The practice management arrangements were unclear and clinical leadership was weak. This had an impact on the effectiveness of the governance systems. • The GPs were not familiar with the terms of their contract and the contract we were provided with suggested they were not working in accordance with elements of the contract. We were unable to establish if the contract was being monitored at regional level. • The practice sought feedback from staff and patients, which it acted on. • A programme of clinical audit should be developed as part of a quality improvement process to improve patient outcomes and care. • Patients did not always receive reasonable support, relevant information and an apology when things went wrong. • Since November 2017 the practice team had made a number of positive changes to improve the practice.	

Our inspection team

Our inspection team was led by a CQC inspector. The team included two specialist advisors; a GP and practice nurse.

Background to Brawdy Medical Centre

Rurally located and a short distance from the village of Brawdy, the medical centre provides a routine primary care, occupational health and rehabilitation service to a military personnel population of approximately 500 some of whom are subject to operational deployment at any time. In addition to providing a service to three units, the medical centre also oversees the occupational health needs of a small reservist population.

Medical cover was provided under a contractual agreement by St Thomas Surgery, a local NHS primary care practice. Three GPs provided this service from 08:30 to 11:30 Monday to Thursday. The medical centre staff team comprised a band 6 nurse, a band 5 nurse, a practice administrator and two physiotherapists. There was no practice manager post established for the medical centre. Although not employed by the medical centre, the practice was supported by two combat medical technicians (referred to as medics) who were attached to the unit.

The medical centre was open from 08:00 to 17:30 Monday to Thursday and was closed on a Friday. The arrangements for access to medical care outside of opening hours were outlined in the practice leaflet and directed patients to contact NHS 111. Medical cover was provided by St Thomas Surgery when the practice was closed and before NHS 111 commenced.

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 General's office.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice.

During the inspection we:

- Spoke with a range of staff including the senior GP, an SMO from another practice who

provided support to the practice, a medic, the senior practice nurse, physiotherapist and the administrator.

- Patients were not available to speak with on the day of the inspection.
- Reviewed 27 comment cards completed by patients who shared their views and experiences of the service.
- Looked at information, including patient records and information the practice used to deliver care and treatment.
- Looked at information used to monitor the quality and safety of services.

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

The established system for reporting and managing significant events was not being used in accordance with Defence Primary Health Care (DPHC) policy.

- The standardised Defence Medical Services (DMS) wide electronic system (referred to as ASER) for reporting, investigating and learning from significant events, incidents and near misses was not being used by GPs. The GPs were not registered to use the system and the senior GP advised us it was because there were too many passwords to remember. Instead, any issues that needed to be reported were passed to the nurses or medics to report on behalf of the GP.
- The nurse and medic provided a number of examples of significant events, describing how they were managed in accordance with DPHC policy, including lessons learnt. We asked the senior GP about the outcome of significant events reported through the system since January 2018. They were unaware of any despite at least one significant event being related to their care and treatment of a patient. Staff confirmed that significant events were discussed with the GPs, and were discussed at practice meetings. The practice meeting minutes from January and March 2018 showed significant events were a standing agenda item. All staff had access to the meeting minutes.
- National patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the Department of Health Central Alerting System (CAS) were received to the group email. They were logged and forwarded to staff by email to doctors and nurses. Staff provided examples of alerts received to the practice. We noted that alerts were not a standing agenda item at practice meetings and the senior practice nurse (SPN) said they would update the standing agenda to include alerts.
- Unintended or unexpected safety incidents were not managed effectively. We were provided with a recent example which identified a patient had not received reasonable support, a verbal or written apology and were not advised by the GP about any action taken to improve processes in order to prevent the same thing happening again. The patient submitted a formal complaint which was being investigated at the time of our inspection.

Overview of safety systems and processes

Not all systems in place to keep patients safe and safeguarded from abuse were effective.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Information was displayed and included contact details of designated safeguarding teams in the local area. Regular staff working at the practice were trained in child safeguarding to level

three. In the absence of a practice manager or manager responsible for monitoring the contract at regional headquarters (RHQ), we were unable to ascertain whether the GPs had completed safeguarding training and to what level. The senior GP was identified as the safeguarding lead for the practice. Given that they only worked at the practice for a limited numbers of hours each week, we indicated that this arrangement was not suitable. The Senior Practice Nurse (SPN) said they would look into identifying an alternative lead.

- Although an alert was used on electronic patient records to identify patients under the age of 18, an alert system was not used to highlight patients who were vulnerable. A register of vulnerable patients was maintained at the practice. Vulnerable personnel and the mental wellbeing of personnel was a standing agenda at the multi-disciplinary Unit Health Committee (UHC) meetings held each month. The welfare team were represented at these meetings. We were advised that that none of the GPs from the practice attended the meetings.
- Information was available advising patients that a chaperone was available if required. Although chaperones had received a Disclosure and Barring Service (DBS) check, they had not undertaken specific training in relation to chaperoning. 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.
- A process was in place for the management of tissue samples whilst they were being processed within the medical centre. The GPs then took the samples back to St Thomas NHS Surgery for transportation to the laboratory. Once the samples left the practice in this manner staff could not be assured as to whether they were being stored/transported in accordance with DPHC policy. This concern was identified on the risk register but no action had been taken.
- The SPN was the lead for infection prevention and control (IPC) and had undertaken additional training for the role of IPC lead. Regular staff working at the practice had completed mandated IPC training. We were unable to confirm whether the GPs were up-to-date with IPC training. An IPC audit was undertaken annually and the most recent was in January 2018 resulting in a compliance score of 91%. Effective arrangements were in place for environmental cleaning.
- Arrangements were in place to minimise the risk of legionella, including a legionella risk assessment (March 2018), monitoring of water temperatures and the flushing of water outlets. Arrangements for the management of waste, including clinical waste and sharps were effective. Consignment notes were in place and a pre-acceptance waste audit had been undertaken in January 2018.
- Arrangements were established for managing medicines, obtaining, prescribing, recording, handling, storing and the security of medicines. The SPN was the lead for medicines management. No controlled drugs were stored on the premises. Medication was outsourced to Lloyds Pharmacy and delivered to the practice for patients to collect. Medication was stored securely and appropriate documentation was maintained to ensure it was accounted for and the patient received it safely.
- The cold storage unit for medicines, including vaccinations was monitored daily to ensure temperatures were within the correct parameters. Measures were in place in the event of a break in cold store chain and this was indicated on the risk register. Ambient temperatures in rooms where medicines were stored were monitored. In accordance with the Defence Medical Services (DMS) policy, staff monitored the room where medicines were stored. They advised us medication had to be disposed of last summer as the temperature in the treatment room exceeded the upper range for the storage of medicines. A business case had been submitted by the practice for air conditioning to be installed.
- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer

medicines in line with legislation. The PGDs were signed and in-date.

- Some patients were prescribed high risk medicines, including disease-modifying anti-rheumatic drugs. We looked at an example and, although an appropriate Read code had been assigned, no alert was used on the patient's record to identify they were taking a high risk medicine. In the absence of shared care agreements, it was unclear who was responsible for undertaking medication reviews. In addition, we were unable to confirm that the patient had received a critical blood test required for regular monitoring to ensure an appropriate prescribed dose, and to minimise the risk of adverse effects.
- The full range of recruitment records for permanent staff was held centrally. However, the SPN could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure regular staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. A system was in place to monitor each clinical member of staff's registration status with their regulatory body. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice. Safe staffing levels were in place for the practice. In the absence of a practice manager or manager responsible for monitoring the GP contract at regional headquarters (RHQ), we were unable to confirm this information for GPs, including also their indemnity cover.

Monitoring risks to patients

Effective risk management processes were in place to minimise the risks to patients and others.

- Policies and procedures were in place in relation to the management of risks at the station, including a health and safety policy that took account of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The senior medic was identified as the lead for health and safety and they were suitably qualified for the role.
- Electrical testing, gas safety and portable appliance testing were all current. An equipment care inspection had been undertaken in March 2017. Specific equipment was cleaned daily and daily logs were completed. Single use items were stored appropriately and were within their expiry date. A range of recently updated risk assessments specific to health and safety of the medical centre were in place, including those in relation to needle stick injury, fire and slips, trips and falls.
- Arrangements to minimise the risk of fire were in place, including checks of the fire system and firefighting equipment. However, we did observe a number of fire doors wedged open which is not in accordance with fire regulations.

Arrangements to deal with emergencies and major incidents

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

- A resuscitation trolley was in place and records confirmed it was checked monthly and all items were in-date. It included the appropriate equipment and emergency medicines as described in recognised guidance, including oxygen. The SPN confirmed that all regular staff were in date for basic life support (BLS) training on an annual basis. Evidence that the GPs had completed this training was confirmed shortly after the inspection.
- A panic alarm system was located in consulting rooms for clinical staff to summon assistance should the need arise. The waiting room could not be observed by staff at all times. Before we

had completed the inspection the administrator had submitted a business case requesting funding for CCTV.

- A comprehensive business continuity plan was in place and accessible to all staff. We noted from an internal governance review it was due for a review.

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

Inadequate 

Our findings

Effective needs assessment

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

- Practice nurses were aware of evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE). They received NICE and other guidance updates by email and through the monthly newsletters circulated to practices by the DPHC. The senior GP was uncertain about recent NICE guidance. Although it was not a standing agenda item at practice meetings, the SPN confirmed NICE and other guidance was logged when received and discussed at the meetings. We noted from the log that guidance about prescribing for an acute sore throat was reviewed in February 2018.
- Nurses had effective systems in place to monitor long term conditions. They referred to NICE for chronic disease management.

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 DMS practices, we are not using NHS data as a comparator.

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

- There were three patients registered at the practice with diabetes. For one of these patients the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For all three patients the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were seven patients recorded as having high blood pressure. All had a record of their blood pressure being recorded in the past nine months. Four had a blood pressure reading of 150/90 or less.
- There were seven patients with a diagnosis of asthma. Of these, four had received 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 three new 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 instance of audiometric hearing assessment was above average compared to DMS practices regionally and nationally. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data from December 2017 showed:

- 100% of patients had a record of audiometric assessment, compared to 100% regionally within DMS and 99% for DPHC nationally.
- 99% of patients' audiometric assessments were in date (within the last two years) compared to 92% and 86% for DPHC nationally.

The audit register confirmed that two first cycle clinical audits had been completed by nurses in the last 12 months; a yellow fever audit and a cytology audit. The GPs had not completed any clinical audits through their work at Brawdy Medical Centre.

Effective staffing

Evidence was not in place to confirm all staff had the skills and knowledge to deliver effective care and treatment.

- The SPN had developed an effective and detailed induction package that covered all roles. A completed induction was in place for the most recently appointed member of staff. The induction programme included mandated training, such as safeguarding, health and safety and information governance. There was also a specific induction and training for new staff depending on their role. Staff had access to e-learning training and in-house training on a Wednesday afternoon.
- A staff database was used to monitor the status of staff mandatory training. Evidence was in place to confirm regular staff were up-to-date with mandated training. The SPN was unable to confirm whether the GPs had completed the full range of mandated training. Staff had undertaken update training relevant to their role, such as cytology and phlebotomy. The SPN also ran cytology clinics at St Thomas surgery to maintain their skills.
- The clinical skills of the medics were not being used effectively. They were undertaking an administrative role as they had had not been assessed to confirm their competence with clinical procedures, such as taking blood and vaccinating patients. The advisory SMO for the practice told us that they planned to carry out the competency based assessments with the medics in the near future.
- Opportunities were in place for nurses to participate with continued professional development. Links were in place with the local health board and nurses had attended local NHS study days. The SPN identified clinical supervision and peer review as areas for development. The regional nurse lead post was 'gapped' so the nursing team had not received clinical supervision for some time. Shortly after the inspection the SPN confirmed that the GPs were up-to-date with their NHS appraisals.
- Although aware of the Gillick competence, we were unable to confirm whether GPs had received training regarding 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.

Coordinating patient care and information sharing

Systems to ensure effective coordination of patient care were not effective.

- Ensuring the fitness of service personnel was paramount for unit commanders. Multi-disciplinary Unit Health Committee (UHC) meetings were held each month. These structured meetings took into account seven pillars: injury prevention, mental wellbeing, oral health, sexual health, nutrition, substance misuse and smoking prevention/cessation. In military settings the SMO for a medical practice would usually attend these meetings to discuss patient's needs. The senior GP for the practice had not attended the meetings for six months citing that they had not been invited. We were advised that the advisory SMO for the practice sometimes attended. As the SMO had not seen or treated the patients, they discussed the occupational needs of patients by access and reference to the patient's medical records.
- UHC meeting minutes from July 2017, August 2017 and January 2018 showed no GP or SMO representation at the meetings. It was noted from the minutes that the absence of a GP/SMO limited discussion and decision making. This was evident in relation to discussions about weight management/healthy eating initiatives and mental ill health rates/trends (January 2018). In addition, medics were not routinely attending the UHC meetings despite being expected to as they were attached to the units.
- Concern about the high rate of downgraded personnel was an emerging theme noted in the UHC minutes. We were advised that APP9 forms completed by the GPs regarding the 'deployability' (whether staff are fit to carry out certain roles) of personnel lacked consistency, detail and meaningful data. This concern was recorded in the minutes of the three UHC meetings with a query as to whether the GPs needed training (August 2017). There was no formal process in place for the practice to monitor downgraded patients. Shortly after the inspection the SPN advised us they had developed a spreadsheet for downgraded patients.
- Information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient electronic record system. We were advised by staff that GPs did not always update patient records in a timely way or refer to the records of other professionals when reviewing a patient. This meant there were delays with patients receiving prompt or appropriate care. We were shown an example on the system of when this had happened. The physiotherapist had started to put alerts on individual patient records to prompt the GP to read the notes. They also kept a spreadsheet of patients who were downgraded and receiving treatment from the rehabilitation team. The physiotherapist regularly checked the spreadsheet alongside patient records. An audit of patient records had not been undertaken.
- The practice had a pro-active approach to monitoring the status of vaccinations. The medic undertook regular system searches to establish the status of force protection. Any outliers in terms of vaccine uptake were sent to the units and discussed at the UHC meetings.
- Read coding, a system used to support clinical coding of patient details, including diagnosis, was used by all clinical staff with access to patient records. When patients moved or were deployed their medical records were transferred electronically. Summarisation of records was the responsibility of the nurses and was up-to-date.
- We found the practice managed information from other services in an efficient way. For example, any external correspondence, such as NHS 111 feedback, laboratory results and secondary care letters were scanned onto the system and sent to the doctor to review and code accordingly.
- When the administrator took up post in November 2017 they set up a system for managing and monitoring the progress of referrals to secondary care services. A register was maintained that was regularly checked and any delays followed up. Equally, laboratory samples sent were logged and

checked and results followed up if not received in a timely way.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. Where a patient's mental capacity to consent to care or treatment was unclear, the clinician assessed the patient's capacity.

Supporting patients to live healthier lives

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

- New patients were subject to checks and screening for lifestyle behaviours such as smoking and alcohol use. Family history was taken into account as part of the screening process.
- The practice demonstrated a pro-active and committed approach to health prevention and promotion. Relevant information leaflets and displays were up-to-date at the practice. The nurses facilitated weight management and smoking cessation clinics. The practice was represented at the station health fairs and quarterly health promotion meetings. Strong links were established with the Community Mental health Department.
- Patients had access to appropriate health assessments and checks. Searches were undertaken for 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. No patients were identified for a screening programme at the time of our inspection.
- Twenty seven patients were eligible for a smear test and three tests were outstanding. This represented an achievement of 89%. The NHS target was 80%.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis, polio and measles, mumps and rubella. The data below from December 2017 provides vaccination data for patients:

- 97% of patients were recorded as being up to date with vaccination against diphtheria compared to 96% regionally and 95% for DPHC nationally.
- 97% of patients were recorded as being up to date with vaccination against polio compared to 96% regionally and 95% for DPHC nationally.
- 88% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 78% regionally and 77% for DPHC nationally.
- 95% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 92% regionally and 91% for DPHC nationally.
- 97% of patients were recorded as being up to date with vaccination against Tetanus, compared to 96% regionally and 95% for DPHC nationally.
- 51% of patients were recorded as being up to date with vaccination against Typhoid, compared to 53% for regionally and 52% for DPHC nationally.

Good

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.
- Clinic room doors were closed during consultations. Curtains were provided in clinic rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Sound proofing was not very effective as conversations could be heard from the corridor in consulting rooms.
- Patients had the option of having a chaperone, particularly important for female patients as no female doctors were available. If patients wished to discuss sensitive issues or appeared distressed practice staff could offer them a private room to discuss their needs.
- The building had wheelchair access to the rear. Guidance was in place about how staff could access a translator should the need arise.
- A suggestion box for patients to leave feedback was located in the waiting area. Patients also were given the opportunity to participate in the patient experience survey.
- We did not have the opportunity to speak with patients during the inspection so relied on the patient experience survey and the 27 CQC feedback cards to understand the views of patients. Overall, feedback indicated patients were satisfied with the care provided by the practice. Themes included reference to friendly and helpful reception staff, diligent and professional nurses and good quality information provided.
- Results from the latest DMS Patient Experience Survey (collated in January 2018) showed patients valued the care at the practice. From a sample of 24 patients, 78% said they would recommend the practice to friends, family and colleagues. Two patients did not agree. The majority of comments were positive with patients highlighting that staff were approachable and support was excellent. A comment from a patient indicated the doctor was rude and not sympathetic to their needs.

Care planning and involvement in decisions about care and treatment

- The majority of feedback from patients on the CQC comment cards indicated that staff took the time to explain their condition or injury and treatment plan. Two feedback cards out of 27 were negative and a comment suggested that the GP seemed disinterested and advice given was inadequate. The DMS patient experience survey showed that overall patients were satisfied with their involvement in decisions about treatment and care. However, we noted a patient comment indicating the patient was not confident with the GP's decision making.

Patient and carer support to cope emotionally with treatment

- Patient information leaflets and notices were available in the patient waiting area, which advised patients about how to access a number of organisations. We saw that information that was relevant to the patient demographic was prominently displayed and accessible.
- Measures were in place to support with identifying patients who were carers. We noted a patient with caring responsibilities had an alert to highlight this on their electronic record.

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

Requires improvement 

Our findings

Responding to and meeting people's needs

- A range of services were available to patients including, over-40's health screening, audiology screening, family planning, sexual health, physiotherapy and travel advice.
- Usually patients were seen on the same day for urgent and routine appointments. Patients could have 15 minute appointments. If needed, patients could book a double appointment of 30 minutes with the doctor. Telephone consultations were available with if the patient requested that option.
- Patients could request to see a specific doctor. No female doctors worked at the practice so if patients wished to see a female then they would be signposted to alternative medical centre. All the nurses were female and could act as chaperones if patients requested this. Referrals to the rehabilitation team were made by the doctors and nurses; with the average waiting time for an appointment was less than two weeks.

Access to the service

- The GPs working hours were from 08:30 to 11:30 Monday to Thursday. If they needed to see a GP outside of these hours then they could travel to St Thomas Surgery, some 12 miles away. The senior GP advised us they saw military patients infrequently at the surgery, approximately once a month. Arrangements for access to medical care outside of opening hours were outlined in the practice leaflet and directed patients to contact NHS 111. Shoulder cover was provided by St Thomas Surgery when the practice closed and before NHS 111 commenced.
- We were advised by staff that the GPs did not always work at the practice in accordance with their perceived contracted hours. Staff said they sometimes arrived late and/or left early. On the day of the inspection we noted the GP left the practice at 10:50.
- The SPN said it was difficult to carry out any clinical activity involving the taking of a tissue sample outside of the GP working hours, such as blood samples and cervical smear testing. This was due to the GP taking samples back to St Thomas Surgery so they could be transported to the laboratory. This arrangement meant nurses were restricted in terms of times when patients could attend the practice for clinical procedures that involved tissue sampling.
- The limited hours GPs were available at the practice was identified on the risk register specifically in relation to the practice's response to the need for occupation health in readiness for deployment operations or exercise.
- Results from the January 2018 DMS Patient Experience Survey showed 92% were happy with the practice opening times and that the telephone was answered promptly. Fifty eight percent of patients said they could get an urgent appointment and 17% disagreed.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- The SPN was the designated responsible person who handled all complaints in the practice. They worked to the DPHC's established policy on the management of complaints.
- Information was available in the waiting area to support patients' understanding of the complaints system. How to make a complaint was summarised in the practice leaflet.
- One complaint from March 2018 was recorded on the complaint log and it had been responded to effectively. We were advised that a complaint had been submitted just before our inspection that had not yet been added to the complaints log. The matter had also been reported as a significant event and was currently being investigated.
- Staff advised us that if there was any learning from complaints then this would be shared at the practice meetings. Staff advised us that complaints would be discussed at practice meetings. We noted from the practice minutes we looked at that complaints and patient feedback were not standing agenda items. Complaints were audited through the CAF.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Inadequate 

Our findings

Vision and strategy

The aim of the practice was to work to the DPHC mission statement outlined as:

> "To deliver a unified, safe, efficient and accountable primary healthcare service for entitled personnel to maximise their health and deliver personnel medically fit for operations."

- Effectively delivering a service in accordance with the mission statement was hampered by unclear and inconsistent management arrangements in relation to both clinical leadership and operational responsibility for the service. GP provision was provided under a Primary Health Care (PHC) contract from St Thomas Surgery, an NHS practice located some 10 miles away. The contract could not be located by the region during the inspection or by the newly appointed Regional Clinical Director after the inspection.
- In addition, practice management arrangements were ambiguous. Although the senior practice nurse (SPN) was identified on the practice information leaflet as the practice manager, this did not correlate with the terms of reference (ToR) for the SPN. The ToR, issued in February 2018, stated that the practice nurse was responsible to the SMO for all clinical practices and to the practice manager for management and administrative duties. There was neither an SMO nor practice manager in post at the practice.

Governance arrangements

Both the SPN and senior medic had assumed responsibility for jointly managing the service. We recognised the cogent commitment they gave to this role, and the developments they had made with the aim to provide a safe, responsive and effective service for patients.

- The SPN and senior medic used the organisational healthcare governance workbook to bring together and monitor key governance structures, including audit, complaints, significant events and the risk register. All staff had electronic access to this document.
- The common assurance framework (CAF), an internal quality assurance tool, was used to monitor safety and performance. The CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. The SPN reviewed the CAF in March 2018. The CAF showed areas of partial compliance across the domains. Our findings correlate with those of the CAF, demonstrating it was being used effectively at practice level to monitor the service. A management action plan (MAP) was in the process of being developed. The actions identified included the need to develop a quality improvement plan, increase audit activity and undertake clinical supervision and peer review.
- When a CAF assessment is undertaken by Regional Headquarters (RHQ) it is referred to as a

Health Governance Assurance Visit (HGAV). The last HGAV was undertaken October 2016. The SPN submitted a governance progress report to RHQ each quarter that included a CAF update.

- Despite numerous requests to RHQ throughout and after the inspection, we were unable to clarify the conditions of the GP contract or to establish what contract monitoring arrangements were in place.
- Practice meetings were held every four weeks with the purpose of ensuring effective communication within the practice. The physiotherapy team also attended these meetings. GPs had not routinely participated with practice meetings despite the meetings being held during the GP working hours. We were informed that they had started to attend and the most recent practice meeting in March 2018 showed the senior GP had been present. We noted that the meeting agenda did not include all the expected standard agenda items and the administrator said they would rectify this going forward. All staff had access to the minutes of the meetings. The practice meeting minutes showed that lessons learnt were discussed and shared following significant events and complaints.
- The approach to audit was underdeveloped. Insufficient clinical audit activity was taking place.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The senior medic was identified as the risk management lead for the practice and was undertaking this role effectively. However, medics are unit assets, not employed by the practice and subject to deployment or exercise. This could present a risk to the practice as they could be left without a lead for risk management at either short notice and/or for long periods of time.

Leadership and culture

- Staff said they felt part of the team. The nurses, physiotherapists and medics all confirmed they worked well together. They did highlight that the absence of clinical leadership at the practice had an impact, particularly with clinical decision making. An advisory SMO from another medical centre provided medical support to the practice, particularly in relation to military occupational health needs. The SMO advised us they received up to three calls a month from the nurses, physiotherapists and medics seeking advice about patient care.
- Systems were in place to support compliance with the duty of candour, and all staff we spoke with had a good understanding of what this meant and their responsibilities in relation to the requirements. Duty of candour is a legal requirement services must follow when things go wrong with care and treatment. An incident whereby duty of candour principles was potentially compromised had been reported as a significant event and was currently under investigation as the patient had also made a formal complaint.

Seeking and acting on feedback from patients, and staff

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

- Patient surveys and from any individual patient feedback received.
- The suggestion box available in the waiting area for patients to leave feedback.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

Despite the service limitations in terms of effective clinical leadership and clarity about the management of the practice, the practice team were committed to improving the service. The majority of the following improvements had been made since the SPN returned from extended leave in November 2017, which coincided with the appointment of an administrator. These included: the development of a referrals spread sheet (previously there was no way of tracking patient referrals); development of a new practice leaflet; development of new staff induction package and the development of a physiotherapy quality improvement plan for 2018.

Following the inspection, the SPN acted swiftly on the constructive feedback we gave them and within 48 hours provided us with evidence to demonstrate the changes they had made since the inspection. These included confirming GP appraisals were in-date, development of a spreadsheet for downgraded patients and a request for CCTV to monitor the waiting room.