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.

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<th>Service Quality</th>
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Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Abingdon Station Medical Centre on 8 March 2018. Overall, the practice is rated as requires improvement. 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 absence of a Senior Medical Officer post had led to some leadership issues.
- The practice was not adhering fully to the principles of safe medicines management.
- Shared care agreements were not in place for patients on high risk medicines.
- An effective system was in place for managing incidents and significant events. It was clear there was learning in place from the outcome of investigations into these events.
- The practice worked to the regional infection prevention and control policies. The lead for infection prevention and control did not have the required training for the role.
- A cleaning contract was not in place.
- An alarm system was not in place for staff in the event of an emergency. After the inspection the practice confirmed personal alarms had been agreed for the team.
- The security of the premises was compromised by a large hole in a shattered pane of glass.
- Arrangements for the management of clinical waste were not effective.
- Processes for identifying and monitoring vulnerable patients and patients who could be subject to safeguarding procedures were in place.
- The practice was well equipped to treat patients and meet their needs.
- Mandated training for staff was up to date, including safeguarding training.
- Clinical care for patients was person-centred and well managed. Patient feedback suggested the care was of a high standard.
- Effective medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover.
- Clinical audit was taking place but not in a structured or consistent way.
- Staff had a good understanding of the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Results from the Defence Medical Services patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment. Patients we spoke with said they found it easy to make an appointment and urgent
appointments were available the same day. Information how to complain was available for patients.

- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- Staff respected the privacy, dignity and confidentiality of patients.
- Governance systems were underdeveloped specifically in relation to a formal senior management system. The practice was not effectively supported by regional headquarters.
- The practice was proactive in identifying opportunities for quality improvement.

We identified the following notable practice, which had a positive impact on patient experience:

The practice recognised the importance of quality improvement activity and sought every opportunity to improve on the patient experience. A quality improvement log was established that outlined the action taken and impact for each activity. Examples include, developing targeted and patient focussed information leaflets, reviewing the remit of an underutilised nurse clinic resulting in a better use of the resource and a more convenient and relevant service for patients.

The Chief Inspector recommends:

- 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.

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

The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

The practice is rated as inadequate for providing safe services.

- A system was in place for reporting and recording significant events. Significant events were reviewed at team meetings so lessons were shared with the wider staff team.
- When things went wrong patients were engaged and received reasonable support, relevant information and an apology.
- Effective arrangements were in place for child and adult safeguarding. Shared care agreements were not in place for patients on high risk medicines.
- Infection prevention and control (IPC), environmental cleaning and waste management arrangements at the practice were not sufficient.
- Staffing levels were adequate to meet the needs of the patient population.
- A panic alarm system was not in place for staff.
- There were gaps in the arrangements for managing medicines.
- Facilities and equipment at the practice were sufficient to treat patients and meet their needs.
- Security of the premises was comprised by a shattered window pane.
- Fire safety was comprised by the use of fire wedges to retain fire doors in an open position.

**Are services effective?**

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed that patients with high blood pressure and asthma had not been reviewed in a timely way.
- Practice staff assessed needs and delivered care in line with
current evidence based guidance.

- The practice was pro-active in identifying and implementing quality improvement initiatives.
- 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.
- There was evidence of appraisals for all staff

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

- Patients were treated with compassion, dignity and respect, and were involved in decisions about their care and treatment.
- The patient experience survey showed that patients were satisfied with the care and attitude of staff at the practice.
- Information for patients about the service was available and accessible. It was also available in other languages to meet the needs of the patient population.
- Systems were in place to maintain patient and information confidentiality.
- We received 45 comment cards and interviewed three patients. All of the feedback was positive about the standard of care received.
- Interpreters were available for patients if they required this service.

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

- Patients found it easy to make an appointment and urgent appointments were available the same day.
- 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 aligned with the practice. All referrals to this service were made by the doctors and the average waiting time for an appointment was less than one week.
Are services well-led?

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

- The practice had a vision and strategy to deliver high quality care and promote good outcomes for patients.
- Governance systems in terms of senior management systems, meeting/communication structures and audit, were underdeveloped.
- The practice was not effectively supported by regional headquarters.
- The practice was aware of and complied with the requirements of the duty of candour. A culture of openness and honesty was promoted at the practice.
- The practice sought feedback from staff and patients, which it acted on.
Our inspection team

Our inspection team was led by a CQC inspector. The team included four specialist advisors; a GP, practice nurse, pharmacy technician and a practice manager.

Background to Abingdon Station Medical Centre

Located on the outskirts of Abingdon in Dalton Barracks, the medical centre provides routine primary care to service personnel. The registered patient list was 1400 with an annual turnover of 1000 patients. The age range of the population was from 18 years upwards. Dependents of personnel are not registered at the medical centre and are signposted to a number of local NHS GP services.

In addition to routine doctor services, the medical centre offers emergency appointments each day, occupational medicals, an immunisation clinic, smoking cessation, well-person checks and sexual health promotion are available. The physiotherapy team was located in a nearby building.

At the time of the inspection, the medical centre staff team comprised a full time acting civilian Senior Medical Officer (SMO), one civilian GP, a locum GP, three practice nurses and a pharmacy technician. A full time military practice manager was responsible for the day to day operation of the medical centre supported by a team of four administrators. Although not employed at the medical centre, the practice was supported by combat medical technicians (CMT) who were attached to the units.

The medical centre was open from 08:00 to 16:30 Monday, Tuesday and Thursday, Wednesday 08:00 to 13:30 and Friday 08:00 to 15:30. The 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 arrangements were in place for when the practice was closed and 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.

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

- Spoke with a range of staff including the SMO, one GP, CMT, the practice manager, physiotherapist, two nurses, the pharmacy technician and an administrator.
- Spoke with three patients who were attending the practice during the inspection.
- Reviewed 45 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?
Are services safe?

Our findings

Safe track record and learning

There was an established system in place for reporting and managing significant events (SE) and all staff knew how to report events using this system.

- The senior medical officer (SMO) was the lead for risk, including SEs. The standardised Defence Medical Services (DMS) wide electronic system (referred to as ASER) was used for the reporting, investigation and learning from SEs, incidents and near misses. Staff provided numerous examples of incidents and SEs that that had been effectively managed and discussed at practice meetings, and had led to positive change. We were provided with three examples of how an SE led to a quality improvement. For example, the SMO developed a guidance note for staff as a result of a SE in relation to the management of blood results.

- We reviewed safety records and national patient safety alerts, including the minutes of meetings where these were discussed. 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 mail box, which was monitored daily. They were logged and staff said they were discussed at either the weekly diary meetings or practice meetings.

- Unintended or unexpected safety incidents were managed effectively. We were provided with two examples, both of which illustrated that patients received reasonable support, truthful information, a verbal and written apology and were advised about any action taken to improve processes in order to prevent the same thing happening again.

Overview of safety systems and processes

Not all systems to keep patients safe and safeguarded from abuse had been effectively developed.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Information was displayed and included contact details of designated safeguarding teams in the local area. Two members of staff were identified as the safeguarding leads and had competed the required training for this role. All staff had received safeguarding training in accordance with Defence Primary Health Care (DPHC) policy. The staff we spoke with demonstrated they understood their responsibilities in relation to safeguarding. They provided a good example of how they had engaged with other professionals when a safeguarding concern was identified.

- Processes were in place to identify if patients were vulnerable, including a register and placing an alert on the patient’s record. The SMO attended Unit Health Committee meetings each month and concerns in relation to safeguarding or vulnerability of patients were discussed at this forum, which was also included a representative from the welfare team. The SMO also
attended case conferences arranged at unit level.

- Information was displayed advising patients that a chaperone was available if required. The practice had clear guidelines in place and only clinical staff acted as chaperones. Chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Shortly after the inspection the SMO sent us a chaperone training package they had developed with other members of the staff team and with reference to organisational and national guidance. They advised us that the training was mandated for all staff acting as chaperones.

- A comprehensive process was in place for the management of tissue samples, this involved a specimen register, a sticker system for identification, a signature from the driver taking the sample and a signature from the laboratory receiving the sample. This was an example of a quality improvement initiative introduced by the practice.

- The senior practice nurse was the lead for infection prevention and control (IPC). They had completed basic online mandatory IPC training but additional IPC training for the lead role was not available to them. They were however experienced and skilled in IPC matters. The IPC role was not outlined in the terms of reference for the nurse. All staff had completed mandated IPC training. The practice worked to the regional IPC policies and staff had access to these on the shared drive. A register was located on the shared drive confirming the status of staff vaccinations.

- An IPC audit was undertaken in January 2018 resulting in a compliance score of 93%. An action plan was in place with timescales for completion and this had been discussed at the practice meeting. Actions in relation to the infrastructure had been escalated, most notably in relation to the cleaning contract. There was no cleaning contract in place resulting in an absence of cleaning schedules, which was the responsibility of the station. A weekly cleaning log was undertaken by medics. Spillage kits were available.

- An internal legionella risk assessment was in place. Evidence was in place to show the practice manager had tried, albeit without success, to obtain a full premises risk assessment undertaken at station level. Arrangements to minimise the risk of legionella were in place for the practice, including the monitoring of water temperatures and the flushing of water outlets.

- Arrangements for the management of waste, including clinical waste and sharps were incomplete. Not all consignment notes were available and a pre-acceptance waste audit had not been undertaken.

- The SMO and pharmacy technician were the medicines management leads for the practice. Elements of overall medicines management processes to keep patients safe were undeveloped, including arrangements for obtaining, prescribing, monitoring, storing and the security of medicines. A pharmacy risk audit had been carried out by a member of the regional team on 14 February 2018. The practice was found to be compliant but the audit had not picked up the issues we did.

- Ratified by the pharmacy technician, standard operating procedures (SoP) were in place for the management of medicines. The pharmacy technician had clear arrangements in place for the monitoring of prescribing patterns and prescriptions, including those not collected by the patient. Safe measures were established for the monitoring and management of repeat prescriptions. A clear audit trail for prescriptions issued or changes to a patient’s medication made by out-of-hours clinicians or secondary care was in place. Prescription pads were securely stored and there were systems in place to monitor their use. Effective measures were in place for stock control, storage and temperature control of the fridge for vaccines and other medicines requiring cold storage. The DPHC had a policy in place for the monitoring of ambient
temperatures and this policy was not being followed. There were occasions when the ambient temperatures were outside the parameters for the safe storage of medicines and no action had been taken. There was no safe storage identified for the storage of medical gases.

- Arrangements for the safe holding and monitoring of controlled drugs (CD) were not in accordance with the Controlled Drugs Regulations 2013. Stored in the dispensing office, CDs were contained in a safe that was not secured to the wall. In accordance with policy, practice arrangements were not in place to allow for the signing out of keys/release of door codes. For audit and accountability purposes, a record of who had entered the dispensary was not available to dispensary staff at the beginning of each routine shift. Evidence provided stated that the admin staff also had access to the keypress which was held within reception and that no local protocol was in place regarding the security and access to the dispensary room keys/CD keys out with normal working hours. Both the pharmacy technician and an administrator held the code for the safe. Checks of CDs were carried out by two members of staff. The SMO was not routinely involved with these checks, which is not in accordance with best practice. Shortly after the inspection the SMO developed a protocol confirming that a monthly check of CDs would be undertaken by the medical officer with overall responsibility for medicines.

- Five patients were prescribed high risk medicines. The pharmacy technician advised us that alerts were placed on the patient’s record to remind the GPs if blood checks were due. Reviews in relation to high risk medicines were not taking place at the practice. In the absence of shared care agreements, it was unclear who was responsible for undertaking medication reviews. Shortly after the inspection the SMO send us information demonstrating that they had looked into the matter, developed a high risk medicines register, had invited patients in for a review and were pursuing shared care agreements with secondary care services.

- The nurses and medics had completed training in travel health. The nurses worked in accordance with Patient Group Directions (PGD) that had been ratified by the SMO. A PGD is a recorded prescriber instruction for the administration of a medicine without the need to refer back to the doctor for an individual prescription. A meeting had taken place in January 2018 between the nurses and the SMO to monitor PGDs. A PGD audit had not been undertaken. Arrangements for the supervision and monitoring of medics working to Patient Specific Directions (PSD) were clearly established. PSDs differ from PGDs in that a PSD is a recorded prescriber instruction for a medicine specifically prescribed for a named patient.

- Medication was outsourced to Lloyds Pharmacy and we were informed of discrepancies in relation to the provision of service that were not in accordance with the contractual arrangement. For example, Lloyds was not delivering medicines to the practice, which meant patients had to self-present at the pharmacy to collect their medicines. These incidents would have benefited from being treated as SEs to ensure they were escalated and effectively managed.

- The full range of recruitment records for permanent staff was held centrally. However, the practice manager could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. A system was in place to monitor each clinical member of staff’s registration status with their regulatory body. They confirmed all clinical staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice. Safe staffing levels were in place for the practice.

**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 barracks, including a health and safety policy that took account of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager 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. In addition, arrangements to minimise the risk of fire were up-to-date. An equipment care inspection had been undertaken in February 2018. Specific equipment was cleaned daily and daily logs were completed. Single use items were stored appropriately and were within their expiry date. Staff were aware of their role in the reporting and management of incidents, including how to report in accordance with a range of risk assessments specific to health and safety of the medical centre were in place. We observed a number of fire doors wedged open which is not in accordance with fire regulations.

- Although we were advised that no lone working took place, we observed the layout of the building meant staff often worked in isolation when in contact with patients and others, most notably the pharmacy technician. Due to a shortage of clinical rooms, the SMO on rare occasions had consultations with patients in their office on the first floor. This office was isolated from the main activity within the medical centre. The risk in relation to lone working was compounded by the absence of a staff alarm system in the building. This was a temporary location for the medical centre as it was due to move to a refurbished building that had a staff alarm system in place. Shortly after the inspection the practice manager confirmed the regional team provided assurance personal alarms would be supplied for all staff.

- We observed an external window had been shattered and the large hole was covered with a sheet of plastic. This window had been broken for over a year. The practice manager had formally made a request for the window to be fixed but a date for its fixture had not been agreed by the station. This posed a risk to security, in particular the security of medicines stored in the building and patient records.

- The risk register in place was underdeveloped as it did not show the majority of risks we identified and that staff also recognised. Shortly after the inspection the practice manager sent us a newly devised and more comprehensive risk register that included the risks we highlighted from the inspection.

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 staff training records provided assurance that all staff received basic life support training on an annual basis.

- Due to limited consulting rooms, the SMO occasionally had consultations with patients in their office on the first floor. This was not safe as there was no call system and the emergency trolley was located downstairs. There was only stair access to the first floor.

- A comprehensive business continuity plan was in place and accessible to all staff. We noted it was on the risk register as it was due for a review.
Are services effective?
(for example, treatment is effective)

Our findings

Effective needs assessment

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

- Clinical staff were aware of evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE). They received NICE and other guidance updates by email and through the monthly newsletters circulated to practices by the Defence Primary Health Care (DPHC) service. Staff told us, and we confirmed from meeting minutes, that NICE and other guidance was not discussed at practice meetings.

- Nurses had effective systems in place to monitor long term conditions (LTC). They referred to NICE for chronic disease management. We were provided with an example of how a patient with an LTC was managed in accordance with NICE guidance.

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 two patients the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

- There were 14 patients recorded as having high blood pressure. Eight had a record of their blood pressure being recorded in the past nine months. Of these patients with hypertension, eight had a blood pressure reading of 150/90 or less.

- The number of patients with long term physical or mental health conditions, who smoke and whose notes contained a record that smoking cessation advice or referral to a specialist service had been offered within the previous 15 months, was six which is 100% of the smoking patient population.
The NHS target for this indicator is 90%.

- There were 12 patients with a diagnosis of asthma. Of these, eight 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 no patients with a new diagnosis of depression in last 12 months.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that instance of audiometric hearing assessment was above average compared to DMS practices regionally and nationally. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data from July 2017 showed:

- 100% of patients had a record of audiometric assessment, compared to 100% regionally within DMS and 99% for DPHC nationally.

- 96.4% of patients’ audiometric assessments were in date (within the last two years) compared to 86% and 86% for DPHC nationally.

We confirmed that four audits had taken place in the last 12 months; three completed by doctors and one undertaken by a nurse. They included a prescribing audit, low back pain audit, asthma audit and yellow fever audit. They were relevant, referenced national best practice and included actions for improvement. An audit of clinical records was also undertaken following a complaint. A cytology audit was in progress at the time of the inspection.

A QIA log was in place indicating the issue, improvement made and impact. Ten quality improvements in the last 12 months were identified on the log and they were developed from significant events, views of staff, national guidance and feedback from patients. For example, the underutilisation of a nurse clinic was reviewed and the remit expanded, leading a more convenient and relevant service for patients.

**Effective staffing**

Overall, evidence reviewed showed staff had the skills and knowledge to deliver effective care and treatment.

- The practice had a generic induction programme for all newly appointed staff that included the 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, and a separate induction for locum staff. Staff had access to e-learning training and in-house training.

- The practice manager monitored the status of staff mandatory training and updates were provided at practice meetings. Besides IPC training for the IPC lead (refer to the safe domain), we noted staff had completed update training relevant to their role, such as cytology (nurse), immunisation (medic). Relevant competency checks were undertaken before staff engaged in practice or a procedure that was new to them.

- Protected time was in place for training and continual professional development (CPD). Peer review and CPD opportunities were available for doctors in the form of internal and external events. Formal clinical supervision arrangements were not in place for nurses at the practice although they did participate in clinical supervision with another medical centre. Arrangements were in place to supervise the work of medics.

- Doctors 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. Staff who acted as chaperones had received training.

- The learning and support needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

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

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice’s patient record system and their intranet system. The DMICP system was used for managing patient records. 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. The sample of anonymised patient notes we looked at was of a very high standard. Notes included risk assessments, care plans, consultation records and investigation/test results. There was an appropriate summary screen of patients’ health needs on DMICP. 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.

- The SMO and physiotherapist attended unit health committee (UHC) meetings with commanders each month, a forum to review the health and fitness and welfare of military personnel including a discussion about downgraded personnel. The rehabilitation team were also represented at these meetings.

- The practice had a pro-active approach to monitoring the status of vaccinations. The medic undertook regular searches of DMCIP to establish the status of force protection. Any outliers in terms of vaccine uptake were sent to the units and discussed at the unit health committee meetings.

- 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.

- Processes were in place for managing and monitoring the progress of referrals to secondary care services. One of the administrators was the lead for referrals. 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. One of the nurses was identified as the health promotion lead. They, along with the SMO and physiotherapist, attended quarterly station health and wellbeing meetings. Strong links were established with the Community Mental health Department and local organisations, such as MIND and Turning Point.

• Health promotion briefings were held twice a year for military personnel and often involved guest speakers. A rolling health promotion programme was established that took account of matters, such as sexual health, smoking and alcohol use. The health promotion lead ensured promotion material and displays were up-to-date at the practice.

• The pharmacy technician facilitated a smoking cessation group and one of these sessions was taking place during the inspection. One of the administrators had designed a smoking awareness poster that was based on a well-known social media meme. A meme is an idea, behaviour or style that spreads from person to person within a culture. This was an original use of a meme that the patient population could relate to in order to promote smoking awareness.

• 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. There was only one patient identified for a screening programme at the time of our inspection.

• 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 95 out of 101 eligible women. This represented an achievement of 94%. The NHS target was 80%. The system for promoting cytology uptake was strong, involving the use of a system alert, reminder letters and a follow up phone call.

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 September 2017 provides vaccination data for patients using this practice:

• 100% of patients were recorded as being up to date with vaccination against diphtheria compared to 100% regionally and 100% for DPHC nationally.

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

• 89% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 81% regionally and 82% for DPHC nationally.

• 88% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 94% regionally and 92% for DPHC nationally.

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

• 42% of patients were recorded as being up to date with vaccination against Typhoid, compared to 34% for DPHC nationally and 56% 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.
- Clinic room doors were closed during consultations. Curtains were provided in clinic rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.
- Patients had the option of having a chaperone, particularly important for female patients as no female doctors were available. Chaperone uptake was monitored and a log maintained.
- The layout of the reception area and the seats in the waiting area meant that conversations between patients and reception could not be easily overheard. If patients wanted to discuss sensitive issues or appeared distressed practice staff could offer them a private room to discuss their needs.
- The building was not wheelchair user-friendly and facilities were not in place to accommodate access for people with a disability. We were advised that the building was temporary and the practice was due to move to a refurbished and more appropriate premises. No date had been confirmed for the move. 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 had the opportunity to speak with three patients during the inspection. They told us they were satisfied with the care provided by the practice and said they were treated with dignity and respect. All told us they could get an appointment when they needed one. Results from the Patient Experience Survey (collated in February 2018) showed patients valued the care at the practice. From a sample of 61 patients, 83% said they would recommend the practice to friends, family and colleagues.
- We received 45 completed comment cards prior to the inspection and feedback about treatment and care was very complimentary. Patients said that they felt involved in decision making about the care and treatment they received. Comments indicated that patients felt listened to and supported by staff, and they had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

**Care planning and involvement in decisions about care and treatment**

- The feedback provided by patients indicated that clinical staff took the time to explain their condition or injury and treatment plan.
• Data received from the latest DMS patient experience survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. From a sample of 61 patients, 78% said they were involved in decisions regarding their care.

• We looked at questionnaires (raw data) received by the practice from patients in December 2017 and January and February 2018. Out of 46 questionnaires, three patients said they would not recommend the medical centre, one patient said they did not feel listened to and one patient said they were not involved in decisions about their care. The form was tick box in nature and did not prompt patients to give reasons for their choices. This meant the practice had minimal information to follow up on this negative feedback.

**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. At the time of our inspection there were no patients registered who had caring responsibilities. The station welfare team attended the unit health committee meetings support for patients with caring needs could be discussed at these meetings.
Responding to and meeting people’s needs

- A range of services were available to patients. These were either available at the practice or patients were signposted to other services. Over-40’s health screening, audiology screening, physiotherapy and travel advice were provided.

- Access to a doctor was good for patients; most patients were seen within two to three days of requesting an appointment. 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 another defence medical centre. All the nurses were female and could act as chaperones if patients requested this. All referrals to the rehabilitation team were made by the doctors and the average waiting time for an appointment was less than one week.

- Identifying a patient need for information regarding certain issues, the SMO developed detailed and thoughtful patient specific information leaflets. These examples of quality improvement initiatives included: Information for your referral (to specialist services); downgrading? What next? FAQs on being downgraded; DCMH – referral to the Community Mental Health Team – What happens next?

Access to the service

- 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 in place for times when the practice closed and NHS 111 commenced.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- The practice manager was the designated responsible person who handled all complaints in the practice. They and the staff team adhered to the 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.

- We spoke with three patients who told us that they would feel comfortable with making a
complaint and knew how to complain if the need arose.

- Seven complaints since July 2017 were identified on the complaint log, which included a summary, outcome and lessons learnt from each complaint. Four of these complaints were clinical in nature. We looked in detail at two complaints and were satisfied that they had been thoroughly investigated and managed in accordance with policy.

- Staff advised us that if there was any learning from complaints then this would be shared at the practice meetings. We noted complaints were a standing agenda item at the practice meetings. 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)

Requires improvement

Our findings

Vision and strategy

The practice was working to the DPHC mission statement:

“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.”

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

Governance arrangements

An overarching governance framework was in place to support the delivery of quality and safe care. We found some elements of this structure had been weakened by the current status of senior management arrangements. The SMO role was ‘gapped’ and had been for several months with no known date for a new SMO to be posted in. One of the civilian GPs was acting in this role. Our findings suggest that the absence of a senior military clinical lead at the practice may have had an impact, particular in relation to securing support from Regional Headquarters (RHQ) and the local health and safety unit. We consistently heard from staff that they did not feel supported in relation to concerns with the infrastructure, securing a date for the move to a refurbished building and pursuing a suitable cleaning contract. No regional nurse was in post so nurses sought support and advice from Brize Norton Medical Centre.

- 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. We were provided with a management action plan (MAP) that illustrated the practice was addressing any areas of non-compliance identified from the CAF. It mainly included actions related to administration and non-clinical activity.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Staff had lead roles in key areas.

- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.

- Practice meetings were held every eight weeks and were used as an additional governance communication tool. They were large ‘catch all’ meetings that all staff were invited to attend. There were no higher level management meetings taking place and the clinical meetings were
ad hoc, unstructured and did not include all clinical staff, such as a representative from rehabilitation and pharmacy. We found the absence of a clear meeting structure had led to staff feeling excluded, unable to share their views and not always up-to-date with activity at the practice. This was most evident in relation to clinical audit and links between pharmacy and the nursing team. Shortly after our inspection the SMO sent us a monthly structured schedule of meetings that was to be introduced. The SMO confirmed the aim was to increase the scope and focus of meetings between senior members of the team, and increase the effectiveness of communication and sharing information within the practice. The schedule took account of weekly, bi-weekly and monthly meetings, including a diary meeting, PCRF/PIM meeting, senior management meeting, clinical supervision, staff training and a practice meeting.

- Clinical meetings were undeveloped as just three had taken place in the last 12 months. Given there was no standing agenda and the meeting minutes lacked adequate detail, we were unable to determine the value and impact they were having on clinical care for patients. Attendance at the meeting included nurses and doctors. The pharmacy technician and physiotherapist had not attended. The SMO held weekly meetings with the physiotherapist.
- There was not a systematic or advanced planning approach to audit, including a central log to record the audits that had taken place, or to indicate what cycle they were on. Audit was being undertaken on an individual basis. Staff we spoke with were not always aware of audit activity their clinical colleagues were engaged with. They said audit was not a specific agenda item at the practice meetings so audit activity was not routinely discussed with the wider clinical team. Shortly after the inspection the SMO sent us a structured audit programme for 2018 with an audit identified to be undertaken each month.
- The practice was not using the organisational-wide health governance workbook (or similar) which lends itself to bringing all governance activity together. Staff can have access to this electronically and also can input to it. This workbook would ensure all staff had access to audit activity taking place at the practice.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. This included plans developed each year that took account of staffing levels at the practice due to deployment of some staff.
- The practice meeting minutes showed that lessons learnt were discussed and shared following significant events and complaints.

Leadership and culture

- Staff said they felt respected and valued at the practice. Some staff did not always feel they had opportunities to share their views in an appropriate forum. This possibly related to the current governance arrangements; most notably the absence of a structured meeting schedule to facilitate staff engagement at the relevant level.
- Systems were in place to ensure compliance with the requirements of the duty of candour and all staff 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. The practice had systems to ensure that when things went wrong with care and treatment, the practice gave patients reasonable support, information and a verbal and written apology.

Seeking and acting on feedback from patients, and staff

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

- Patient surveys and from any individual patient feedback received.
- The suggestion box available in the waiting area for patients to leave feedback.
- A patient participation group or similar type of collective forum was not established to seek the views of patients.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.
- Completed CQC comment cards from patients supported our findings, that there was an open door policy when it came to patient input and feedback.

**Continuous improvement**

- Despite the limitations related to the unstructured approach to audit, the SMO keenly promoted quality improvement activity (QIA). This was a standing agenda item at the practice meetings. A QIA log was in place indicating the issue, improvements made and impact. Besides the 10 quality improvements logged, we noted others, including the patient information leaflets developed specifically for the practice. It was clear that the SMO considered feedback from patients, complaints and significant events as opportunities to improve the practice.
- Following the inspection, the SMO and practice team acted swiftly on the constructive feedback we gave them and within 48 hours provided us with evidence to demonstrate the changes they had made and further changes they planned to make.