RAF Honington Medical Centre

Quality report

Honington
Bury St Edmunds
IP31 1EE

Date of inspection visit:
15 May 2018

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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 by the practice and patients.

Ratings

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

Chief Inspector's Summary

This practice is rated as Requires Improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement
Are services effective? – Requires improvement
Are services caring? – Good
Are services responsive? – Good
Are services well-led? – Requires Improvement

We carried out an announced comprehensive inspection at RAF Honington Medical Centre on 15 May 2018. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice fostered an ethos of patient centred care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The majority of the workload for Honington Medical Centre is musculoskeletal and mental health. The delivery of care to meet this need was responsive and effective.
- A small proportion of the practice workload (less than 5% of activity) involved chronic disease management and this required improvement. Recall systems were not effective and patients' conditions were not always reviewed in a timely way.
- Due to inconsistent clinical coding, the practice was limited in its review of the effectiveness and appropriateness of the care it provided. The practice had not assured itself that care and treatment was always delivered according to evidence- based guidelines.
- Patients found the appointment system easy to use. Barriers to accessing appointments had recently been remedied and patients reported that they were better able to access care when they needed it.
- Whilst there was a focus on learning and improvement, there was scope to deliver a wider programme of quality improvement work and to achieve improved outcomes for some patients.
- Recent leadership changes at the medical centre had brought about a change in culture. Staff told us that they felt more able to discuss issues and were more confident that they would be listened to and could influence change.

We saw one area of notable practice:

In 2016 Physiotherapy Direct Access Clinics were introduced at PCRF Honington, resulting in demonstrable improved outcomes for patients who can gain quicker access to a physiotherapist without the need to see a GP beforehand (so alleviating a perceived stigma). Between January and March 2018, 71% of new patients waiting to see a physiotherapist were seen within 5 working days, compared to an East Region average of 54% and an overall PCRF average of 55%. Within the same timeframe, DNA (Patients who did not attend their appointment) rates were reduced to 3%, compared with an overall PCRF DNA rate of 7%. In 2017 PCRF Honington was awarded the Clinical Innovation award from the Trustees of Headley Court which is a prestigious award given annually to the best audit or project across all defence rehabilitation services.

The Chief Inspector recommends:

- A review of formal governance arrangements including systems for assessing and monitoring risks and the quality of service provision should be embedded and understood by all staff.
- Address the significant backlog in electronic summarising.
- Peer review of medical records and prescribing decisions and to ensure that national best practice guidance is adhered to.
- Ensure that the programme of clinical improvement work is targeted to maximise improvements in patient outcomes and that proposed changes are discussed and implemented in a timely way.

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser, a practice nurse specialist adviser, a practice manager adviser, a medicines team inspector and a PCRF advisor.

Background to RAF Honington Medical Centre

RAF Honington Medical Treatment Facility is located in Honington near Bury St Edmunds. The treatment facility offers care only to forces personnel. Dependants and children must register at an NHS practice. At the time of inspection, the patient list was approximately 1400. Occupational health services are also provided to personnel and a small number of reservists.

In addition to routine GP services, the treatment facility offers minor surgical procedures, physiotherapy services and travel advice. Family planning advice is available, with referral onwards to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams.

At the time of our inspection, the facility had an acting Senior Medical Officer (lead GP) and two full time GPs (both civilian), three practice nurses, a pharmacy technician who worked in the practice dispensary and 15 RAF medics. (The work of a military medic has greater scope than that of a health care assistant found in NHS GP practices). The facility was led by a

warrant officer, supported by a deputy and a number of administrative staff. The facility was also attached to a primary care rehabilitation service (PCRF) which provided physiotherapy and exercise rehabilitation. The PCRF was led by a Physiotherapy Officer and employed a further two physiotherapists and three exercise rehabilitation instructors. A Regional Clinical Director assumes overall accountability for quality of care at the Medical Centre.

Are services safe?	Requires improvement

We rated the practice as requires improvement for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice had safety policies including adult and child safeguarding policies which were reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance.
- There was a system to highlight vulnerable patients on records and a risk register of vulnerable patients.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. We found one anomaly where a PCRF locum staff member had allowed their professional registration to lapse. However the matter had been dealt with swiftly. Disclosure and Barring Service (DBS) checks were undertaken where required (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).
- There was an effective system to manage infection prevention and control.
- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.

- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment to patients.

- Individual care records were not always written and managed in a way that kept patients safe. Some care records we saw showed that work was needed to ensure that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Locum clinicians would not be able to easily see intended treatment plans for some patients.
- The system to manage hospital letters was not failsafe as there was no documentation on the medical record to show who has read and actioned these letters for the patient.
- There was a backlog in electronic summarising at the practice of 1208 patients. A staff member had recently been allocated time to address this significant backlog and this work had commenced. However the risk remained that patient needs were unknown prior to summarising.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results.
- Clinicians used a standardised referral letter template but audit of the quality of referral letters made had not been undertaken.

Safe and appropriate use of medicines

The practice's systems for appropriate and safe handling of medicines required improvement in some areas:

- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice had carried out an appropriate risk assessment to identify medicines that it should stock. The practice kept prescription stationery securely and monitored its use.
- Arrangements for dispensing medicines at the practice kept patients safe.
- Access to the dispensary was restricted to authorised staff only.
- There was a named GP responsible for the dispensary.
- Written procedures were in place and reviewed regularly to ensure safe practice.
- Staff had access to British National Formulary (BNF) and prescribing formulary. However staff did not always prescribe, administer and supply medicines to patients in line with legal requirements and current national guidance. The practice's prescribing audit highlighted issues with the quality of prescribing, for example, incorrect frequency of the drug-dosing advised. Errors had not been discussed with the accountable clinician and so an opportunity to improve individual prescribing practice had been overlooked. There was no peer review of prescribing at the practice.

- Patients' health was not always monitored to ensure medicines were being used safely and followed up on appropriately. For example, patients who took DMARDs (disease-modifying anti rheumatic drugs) did not have shared care protocols uploaded into their notes, there was no evidence of recall dates being set for blood testing and no response from the clinicians when one patient failed to collect their DMARDs for a month.
- We noted that RAF Medics (not defence medics) were counter signing controlled drugs (CD) administration. The practice's own standard operating procedure states that a nurse, medical officer, second Ph Tech or defence medic must provide the second check on CD prescriptions.
- Prescriptions were signed before medicines were dispensed and handed out to patients.
- The repeat prescription system required review to ensure that clinicians could see the number of medicine issues, alongside the review date on the medical record.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- Personal alarms were on order as the main panic alarm was not loud enough to attract staff attention. Since our inspection, this issue has been rectified and the main panic alarm is now loud enough to attract attention.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. However not all staff could recall the learning from some recent significant events. Case reviews had been undertaken where suicide was known to be a risk. Welfare arrangements and the support available to patients was discussed. Information sharing between line managers, SSAFA, Padre and clinicians had been reviewed.
- There was a system for receiving and acting on safety alerts. The practice learned from patient and medicine safety alerts.

Are services effective?	**Requires improvement**

We rated the practice as requires improvement for providing effective services.

Effective needs assessment, care and treatment

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Whilst staff had access to guidelines from NICE, we saw instances where these were not being followed to deliver care and treatment that met patients' needs, specifically the management of long term conditions. Clinical meetings had been held but minutes did not

contain a record of any discussion of best practice guidance or changes to practice in light of newly issued guidance. Staff told us that they met regularly (often informally) to discuss best practice guidance, but there was no formal system for reviewing NICE guidance and no formal protocols had been generated. Peer review between GPs did not take place to further ensure that guidelines were followed.

- The Defence Primary Health Care (DPHC) Team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. Staff we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.

Monitoring care and treatment

Management, monitoring and improving outcomes for people

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

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

- There were two patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. For one of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For both diabetic patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were 27 patients recorded as having high blood pressure. We reviewed the treatment and care offered to these patients and found that current NICE guidance had not always been followed. We found that some hypertensive patients who were prescribed medication to manage their condition had not been appropriately recalled. Patients with high blood pressure readings had not been re-tested and there was no evidence within the patient record that blood tests and hypertension review dates had been set for the future.
- We saw that 11 patients had a blood pressure reading of 150/90 or less.
- There were 24 patients with a diagnosis of asthma. Of these, 12 had had an asthma review in the preceding 12 months which included an assessment of asthma control using the 3 Royal College of Physicians questions. We looked at medical records for five asthmatic patients and noted that their smoking status had not always been captured. There was also no record as to whether smoking cessation advice had been offered to asthmatics.
- Due to Read code errors, the practice could not easily provide information about patients with a new diagnosis of depression. The acting SMO undertook a review of the practice's data and submitted a report to us after our inspection. There were 12 patients with a new diagnosis of depression in last 12 months. All had been reviewed within 10 to 35 days of the date of diagnosis.
- The practice had not reviewed its antibiotic prescribing and so was not proactively

supporting good antimicrobial stewardship in line with local and national guidance.

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 DPHC 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 May 2018 showed :

- 100% of patients had a record of audiometric assessment, compared to 99% regionally and 99% for DPHC nationally.
- 93% of patients' audiometric assessments were in date (within the last two years) compared to 93% regionally and 86% for DPHC nationally.

There was evidence of some quality improvement work including clinical audit, but this did not always lead to improved outcomes for patients:

- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. When we reviewed the CAF we saw that a number of areas that had been highlighted remained problematic. Nevertheless, the practice had a plan in place to action the areas where the practice was falling short.
- A programme of clinical audit was in place but when we spoke with staff, it was unclear how the practice approach to this work had been decided. There was no evidence of discussion to ensure that clinical audit was relevant to the practice population and would drive ongoing improvement in outcomes. Most clinical audit work commenced in April 2018 and conclusions had yet to be made. A prescribing audit was undertaken 1 February to 1 March 2018 and identified a number of prescribing errors, including 10 incorrect dosage instructions and two unsigned prescriptions. However outcomes had not been discussed with prescribing clinicians and so individual practice had not been improved. An audit of waiting times was undertaken across 2017/2018 and concluded that some patients waited over 30 minutes to be seen by a clinician. The reasons had been collated and proposed changes implemented.
- Minor surgery was provided, but no minor surgery outcomes audit had been undertaken.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation.

- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

Coordinating care and treatment

Staff worked well together and with some other care professionals to deliver effective care and treatment. However there were gaps.

- The practice met regularly with welfare teams and line managers to discuss vulnerable patients and their dependants. We interviewed members of the welfare team and noted that their close working relationship with the medical centre had led to action to protect minors.
- PCRF staff fostered close working relationships with training wing Chain of Command to ensure that trainees were appropriately supported to recover. Patients we spoke with highlighted how this supported them to get back into training, but only when the risk of re-injury was reduced. We noted an example where an exercise rehabilitation instructor had been involved in arranging leave for a trainee who required remedial recovery time.
- The Medical Centre shares a building with the PCRF service which provides physiotherapy and exercise rehabilitation for patients. Referral into the service is either via a primary care clinician or via self-referral. Patients were able to obtain swift access to the PCRF and strong partnership working arrangements resulted in co-ordinated and person-centred care for patients.

Helping patients to live healthier lives

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

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- All new patients were asked to complete a proforma on arrival. The practice nurse followed up any areas of concern, such as raised blood pressure. However, due to the significant backlog in summarising, some of these risks may be unknown to the practice staff.
- PCRF staff attended initial mandatory training sessions for Trainee Gunners at the outset of their training to deliver sessions around injury prevention and nutrition.
- The practice offered basic sexual health advice including the issue of free condoms and referred on to local clinics in the community for more comprehensive services including family planning.
- Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs.
- 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 24 out of 25 eligible women. This represented an achievement of 96%. The NHS target was 80%.
- There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a

female sample taker was always available.

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

- 95% of patients were recorded as being up to date with vaccination against diphtheria compared to 96% regionally and 95% for DPHC nationally.
- 95% of patients were recorded as being up to date with vaccination against polio compared to 96% regionally and 95% for DPHC nationally.
- 72% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 80% regionally and 77% for DPHC nationally.
- 93% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 93% regionally and 91% nationally.
- 95% of patients were recorded as being up to date with vaccination against Tetanus, compared to 96% regionally and 95% for DPHC nationally.
- 41% of patients were recorded as being up to date with vaccination against Typhoid, compared to 38% regionally and 52% for DPHC nationally.

The Typhoid vaccine has a lower uptake than other vaccinations. Current guidance state DMS practices should offer the Typhoid vaccination to personnel before deployment and not to routinely vaccinate the whole population.

Consent to care and treatment

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

When providing care and treatment for young recruits aged between 16 and 18 years, staff carried out assessments of capacity to consent in line with relevant guidance.

Are services caring?	Good

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We received 50 patient Care Quality Commission comment cards in total. Of these, 35 were entirely positive about the service experienced, five were mixed and ten were negative. Patients praised the 'very good service from medical staff and ERI' and the 'clean

building with exceptional facilities'. However some patients stated that they had experience 'long waits in the waiting room', 'cancelled appointments' and one patient said that they had needed to chase a referral to hospital. We looked into this latter feedback and noted that the patient had been referred prior to choose and book coming into place. They had now attended their appointment with no negative consequence. The practice acknowledged that the new choose and book system facilitated a more robust system for following up referrals.

- Results from the practice's Patient Experience Survey showed patients felt they were treated with compassion, dignity and respect. For example:
    - 92% of patients said their privacy and dignity was respected and maintained throughout their visit.
    - 82% of patients said they were confident that the Medical Centre would keep information about them confidential.
    - 88% said they were confident that the Medical Facility takes into consideration their needs when planning services.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.

Involvement in decisions about care and treatment

- The clinicians and staff at the practice demonstrated that they recognised that the junior personnel they provided care and treatment for, could be making decisions about treatment for the first time. Staff demonstrated how they gauged the level of understanding of patients, avoided overly technical explanations of diagnoses and treatment and encouraged and empowered young patients to make decisions based on sound guidance and clinical facts. We spoke with patients who were attending for physiotherapy appointments and they told us that they were well supported to understand their injury, to set realistic personal goals and to commit to their care plan in order to achieve best results in terms of their recovery.
- Interpretation services were available for patients who did not have English as a first language and staff knew how to access them.
- The Choose and Book service had been implemented and was used to support patient choice as appropriate. (Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).
- Data received form the patient experience survey, July 2017 to May 2018 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:
    - 72 % of patients said there is clear information available about services for patients and how to obtain them.
    - 80% of patients said they were given full information about any drugs or medicines they are prescribed, including their side effects.
    - 74 % of patients said they are offered information and choice about any care received.

The data presented by the practice was not benchmarked against regional and national averages for DMS, or against the previous year's performance.

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw that information that was age

appropriate and relevant to the patient demographic was prominently displayed and accessible. For example, we saw posters for symptoms that may suggest a sexual health screening appointment would be useful and on the importance of completing any prescribed course of treatment.

- The practice acted in a compassionate way toward any patient that had to be discharged on health grounds. We saw that the practice reassured these patients and signposted to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions.
- Practice staff told us that they proactively identified patients who were also carers and that a code was added to their records in order to make them identifiable and so that extra support or healthcare could be offered as required. However no carers are currently registered at Honington Medical Facility.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- Conversations with receptionists could not be overheard by patients in the waiting room.

Are services responsive to people's needs? | Good

We rated the practice as good for providing responsive services

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example advanced booking of appointments, twice daily sick parade for immediate access to a GP and telephone consultations.
- The facilities and premises were appropriate for the services delivered.
- The practice stated that they would make reasonable adjustments in the rare circumstance that a patient found it hard to access services and required a home visit. However there was scope to ensure that a policy for home visiting was in place to clearly guide both staff and patients.
- The practice had designed a bespoke 'fitness to work' chit which was more detailed and less ambiguous than the standard sick chit (FMed566). This meant that clinicians were better able to follow guidance around sickness periods for personnel and Chain of Command had a clearer idea of which tasks personnel could safely undertake.

Timely access to care and treatment

- The practice had recently introduced some changes to ensure improved and more convenient access for patients. 'Sick parade' (an opportunity for patients to attend the practice for advice in person) now took place twice daily to deliver more immediate access for patients and particularly trainees.
- Outside of routine clinic hours, telephone cover was provided by a GP. From 18.30 hours, patients were diverted to the NHS 111 service. If the practice closed for an afternoon for

training purposes, patients could still access a GP in an emergency. In this way, the practice ensured that patients could directly access a GP between the hours of 08.00 and 18.30, in line with DPHC's arrangement with NHSE.

- The practice leaflet gave clear directions on local accident and emergency unit access. The nearest accident and emergency department was located at West Suffolk Hospital.
- The Defence Rehabilitation Headquarters collates a dashboard of information in relation to waiting times and patients who do not attend for their appointment. These are key performance indicators as timely access to physiotherapy and rehabilitation are important for effective patient recovery. Honington PCRF was performing ahead of regional and defence-wide peers:
- For January to March 2018, 71% of new patients referred to see a physiotherapist were seen within five working days. This compares to an East Region average of 54% and an overall PCRF average of 55%. The key reason for this performance is the direct access clinic which allows patients to self-refer. Similarly 63% of new patients referred to see an ERI at Honington PCRF were seen within KPI target of five working days, compared to an East region average of 63% and an overall PCRF average of 49%. It should be noted that patient choice can impact performance against these KPIs as the patient may opt to delay making an appointment. The PCRF proactively managed DNA (patients who did not attend) rates for their clinics and had achieved above average results with 3% of patient appointments lost to DNAs in January to March 2018, compared with a PCRF average of 7%.

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

- 78% of patients said that if they have an urgent problem they are able to see a doctor the same day.
- 78% of patients said they were able to speak to a doctor or nurse by telephone for advice.
- 92% of patients said the practice opening hours were convenient and met their needs.

Some patients stated in comments cards they had filled out, that they had experienced cancelled appointments. We looked into this issue and noted that there had been a particular timeframe when GP appointments had been reduced due to the need for a clinician to accompany a military exercise. This incident had been raised as a significant event and measures put in place to prevent reoccurrence.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Defence Primary Health Care had an established policy and the practice adhered to this.
- The Warrant Officer was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.
- We spoke with five patients who told us that they felt comfortable and knew how to complain if the need arised. They confirmed that military rank would not be a barrier to them raising issues with the practice.
- We reviewed six complaints that had been submitted by patients in the past 12 months. We saw that there were processes in place to share learning from complaints. Complaints were

audited through the Common Assessment Framework (CAF). This was used to focus on improvements to the service and to ensure that designated standards were being met on the handling of complaints.

Are services well-led?	Requires improvement

We rated the practice as requires improvement for providing a well-led service.

Leadership capacity and capability

Leaders were new to their leadership roles and had worked hard to address a significant number of issues which they inherited. However they had not yet had sufficient time to embed the suite of improvements that had been required. Some systems required fine tuning in order to ensure that care for patients was safe and effective. Nevertheless the direction of travel at this medical centre was positive.

The SMO had been deployed shortly prior to our inspection and the Deputy SMO was acting in the senior role. We saw evidence that the acting SMO, Practice Manager, Regional Clinical Director and Lead Nurse had taken steps towards fostering a positive culture and improved team environment. Nevertheless, leaders did not always have the previous experience to address risks and implement safe systems with ease:

- However leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. It was clear that the practice team enjoyed working together and staff told us that their team was strong, committed and reliable. Staff told us that, until very recently, this had not always been the case.
- With the current Senior Medical Officer deployed elsewhere, we identified a need to implement effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values built around the Medical Facility's mission statement, 'To Maintain the health and operational effectiveness of RAF Honington through efficient and high quality healthcare.' The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and other units such as the PCRF and welfare teams.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The medical centre planned its services to meet the needs of the practice population.
- The medical centre monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- However we noted examples where leaders and managers had not taken action to address performance inconsistent with the vision and values. There was a need to ensure that all managers were trained to performance manage staff.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. However some staff indicated that they had not been given feedback as a result of audit work and so opportunities to improve their work had been missed. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. Some medics told us that they were limited to seeing only junior patients and they felt that this limited their skills base.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.
- There were positive relationships between staff and teams.

Governance arrangements

The Medical Centre was in the process of consolidating and clarifying responsibilities, roles and systems of accountability to support good governance and management and the practice acknowledged that more work was required in some areas.

- Joint working with the welfare team, SAFFA (The Armed Forces Charity), pastoral support and Chain of Command was interactive and led to co-ordinated person-centred care.
- The PCRF delivers rehabilitation services from the medical centre. The service is well led and enables patients to access timely, holistic care. However we noted that GPs had not regularly attended multi-disciplinary meetings, due to staffing constraints and this was a missed opportunity to maintain oversight of patients with musculoskeletal care needs.
- Shared care protocols were not in place for some patients taking high risk drugs and we identified gaps in the safe management of hospital letters.
- Systems to ensure safe prescribing required review.
- Systems to ensure the effective management of long term conditions were required.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established a number of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However there were

gaps that required addressing.

Managing risks, issues and performance

There were clear and effective processes for managing many risks, issues and performance. However we identified some areas where improvement was required.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had some processes to manage current and future performance but these needed to be extended. There was a need to better manage the performance of employed clinical staff through audit of their consultations, prescribing and referral decisions.
- Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had some impact on quality of care and outcomes for patients, but this required extension. There was an absence of clear evidence of action to change practice to improve quality. Audit findings had not always been shared across the clinical team as a catalyst to improving individual's practice.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice did not always have appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. Practice meetings were held regularly and were used as an additional governance communication tool, for example to remind staff to complete all paperwork in respect of significant events. Learning needs were discussed at practice meetings and appropriate training was requested and delivered through this forum. The meetings were also used for forward planning, for example, to ensure that patient needs were met during busy clinic times and periods of staff sickness. This provided an opportunity for staff to learn about how the performance of the practice could be improved and how each staff member could contribute to those improvements.
- The information used to monitor performance and the delivery of quality care was not always accurate and useful. Staff told us that they were aware of inconsistent use of Read codes and they had recently started to address the issue in order to produce more accurate clinical searches. Staff had received training in the use of 'Population Manager' which is a clinical search facility.
- Improved management of hospital letters and the consistent and accurate recording of intended treatment plans was required to ensure that all staff could access complete and contemporary medical records.
- There were robust arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However we noted that in the PCRF, computer terminals were sometimes left unattended with clinical information showing.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and internal partners to influence its services.

- Patients were approached to feed back their views on the way care was delivered to them. We saw that recent feedback about waiting times to see a GP and better information for patients to know how to obtain test results had led to improvements.
- The PCRF and Medical Facility had adopted a strong working relationship which enabled patients to access timely rehabilitation treatment. This included a pilot approach for a direct access clinic which had led to significant improvements in patient access.

Continuous improvement and innovation

There was some evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement within the practice. For example the nursing team had engaged with the Regional Rehabilitation Unit to ensure that blood tests were being requested and recorded using the correct protocols. The learning has been rolled out across four other practices locally.
- Staff knew about improvement methods and had the skills to use them. Civilian staff provided stability and continuity of care through periods of change in military staffing. However there was scope to implement more of their ideas for improvement.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Some staff told us that it would be beneficial for leaders and managers to encourage staff to take more time out to review individual and team objectives, processes and performance.