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

### Ratings

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Good <img src="#" alt="Green" /></th>
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<tbody>
<tr>
<td>Are services safe?</td>
<td>Requires improvement <img src="#" alt="Yellow" /></td>
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<tr>
<td>Are services effective?</td>
<td>Good <img src="#" alt="Green" /></td>
</tr>
<tr>
<td>Are services caring?</td>
<td>Good <img src="#" alt="Green" /></td>
</tr>
<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good <img src="#" alt="Green" /></td>
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<tr>
<td>Are services well-led?</td>
<td>Good <img src="#" alt="Green" /></td>
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We carried out an announced inspection at MRS Aldergrove on 20 February 2018. Overall, the practice is rated as good. Our key findings across all the areas we inspected were as follows:

- An effective system was in place for managing significant events and staff knew how to report events using this system.
- Clinical risk was effectively managed and recognised as the responsibility of all staff. However, some health and safety risk assessments were due for review.
- Staff were aware of their responsibilities in relation to child and adult safeguarding. An adult safeguarding policy was not in place for the practice. Systems were not always used to identify vulnerable patients.
- The arrangements for managing medicines minimised risks to patient safety. A safe process was in place for the monitoring of high risk medicines.
- Staff were aware of current evidence based guidance and they referred to this guidance to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- A programme of clinical audit was in place and there was evidence that audit was having an impact on outcomes for patients.
- Patient feedback showed patients were treated with compassion, dignity and respect, and were involved in their care and decisions about their treatment. The patient feedback survey was not being utilised to its full effect.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The patients had access to a variety of health leaflets and information.
- Patients found it easy to make an appointment and urgent appointments were available the same day.
- Staff said they felt engaged, supported and valued in the workplace.
- There had been a change in leadership in September 2017 and the new practice manager was in the process of revising and strengthening governance systems to ensure they were fit for purpose to support the delivery of high quality care and good outcomes for patients. The health governance workbook had been introduced. Practice meetings were not taking place on a regular basis.
- Staff were aware of the requirements of the duty of candour and complied with these requirements.
The Chief Inspector recommends:

- An adult safeguarding policy is developed for the practice that reflects local arrangements.
- Staff have access to an alarm system so that they can summon assistance in an emergency.
- Regional level work is pursued to ensure that referrals to secondary care are not lost within the NHS system.
- Regional level work is pursued to ensure that the risks associated with no Lablinks/DMICP interface are mitigated.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice
We always ask the following five questions of services.

**Are services safe?**

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

- All staff were aware of how to report a significant event. Locum staff did not have access to the electronic reporting system.
- When things went wrong patients received support, relevant information and a written apology.
- Child safeguarding procedures were in place. However, an adult safeguarding policy that reflected local arrangements was not in place. All staff, including non-clinical, staff were trained to the appropriate level for their role.
- Risks to patients were assessed and well managed.
- Medicines were managed safely in the dispensary. Transportation of medicines requiring cold storage was not in accordance with policy.
- There was no evidence that an annual workplace health and safety inspection had taken place. Health and safety risk assessments were not up-to-date.
- There was no panic alarm system in place for staff to summon assistance in an emergency.

**Are services effective?**

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above average.
- Practice staff assessed needs and delivered care in line with current evidence based guidance.
- A programme of clinical audit was in place.
- The practice valued and encouraged education by providing staff with training opportunities to deliver effective care and treatment.
- Patients were actively supported to live healthier lifestyles through health promotion and wellbeing initiatives.
- There was evidence of appraisals and personal development plans and support for all staff.

<table>
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<th>Are services caring?</th>
<th>Good</th>
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<td>The practice is rated as good for providing caring services.</td>
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- Patients were treated with compassion, dignity and respect, and were involved in decisions about their care and treatment. |
- The patient’s experience survey from March 2017 demonstrated that patients were satisfied care at the practice. |
- Information for patients about the service available was accessible. |
- Systems were in place to maintain patient and information confidentiality. |
- We received 10 comment cards and interviewed four patients. All of the feedback was positive about the standard of care received. |

<table>
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<th>Are services responsive?</th>
<th>Good</th>
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<td>The practice is rated as good for providing responsive services.</td>
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- The patient’s individual needs were central to the planning and delivery of their care. |
- The service was flexible to ensure patients’ needs were met in a timely way. The needs of the reservist population meant the practice could provide treatment and care at very short notice. |
- Patients found it easy to make an appointment and urgent appointments were available the same day. |
- All referrals to the physiotherapy service were made by the doctors and patients were seen within 10 days. |
- Effective medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover. |

<table>
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<th>Are services well-led?</th>
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<td>The practice is rated as good for providing well-led services.</td>
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- There had been a change in leadership in September 2017 and the new practice manager was in the process of revising and strengthening governance systems to ensure they were
fit for purpose to support the delivery of high quality care and good outcomes for patients.

- The practice now had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- A management action plan (MAP) had been developed to direct the practice in areas it needed to improve on.
- Staff said they felt engaged, supported and valued in the workplace.
- Staff were aware of the requirements of the duty of candour and complied with these requirements.
- A new four-weekly rolling meeting structure had been developed and it was due to be introduced.
- 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.
- Patient feedback systems were not being utilised to their full potential and this was identified on the practice MAP.
Our inspection team
Our inspection team was led by a CQC inspector. The team included a GP specialist adviser, a practice nurse specialist adviser and a CQC inspection manager.

Background to MRS Aldergrove
MRS Aldergrove is a medical centre providing a primary care service to a registered patient population of 1296 military personnel and their families. In addition, the medical centre is the lead facility in Northern Ireland for the provision of occupational healthcare and rehabilitation services to a reserve population of approximately 2500. A low dependency ward is located on the premises and managed by the medical centre. This facility was closed at the time of the inspection due to a shortage of staff. It was due to close permanently at the end of March 2018. MRS Aldergrove is a GP speciality training practice and was re-validated in April 2017.

Located in a single storey accessible building, the practice operates an appointment only system with emergency appointments available each day. As well as routine doctor/nurse appointments, clinics that were available to patients included: vaccination; travel health; cholesterol checks; well person; smoking cessation; asthma; family planning and blood pressure monitoring. A dispensary was available in medical centre. Affiliated services include physiotherapy, rehabilitation and podiatry, Department of Community Mental Health, community midwifery and health visiting.

The mixed civilian and military staff team was comprised of a Senior Medical Officer (SMO), three GPs, a senior nursing officer, six practice nurses, two pharmacy technicians, two physiotherapists and an exercise rehabilitation instructor. A practice manager managed the day-to-day operation of the practice supported by a deputy practice manager and a team of three administrative staff.

The medical centre was open from 08:00 to 16:30 Monday to Thursday and closed for lunch 12:30 to 13:30. It was open on Friday from 08:00 to 13:00. Shoulder cover arrangements were in place until Dalriada Urgent Care was operational from 18:00 on weekdays. This service also provided emergency care on weekends and public holidays.

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 the inspection we reviewed a range of information CQC holds about the practice. During the inspection we:
Spoke with a range of staff including the SMO, practice manager, two pharmacy technicians, a GP, two practice nurses, two administrators and a physiotherapist.

Spoke with four patients who were attending the practice during the inspection.

Reviewed 10 comment cards completed by patients who shared their views and experiences of the service.

Looked at information the practice used to deliver care and treatment, including anonymised patient records.

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 effective system in place for reporting and recording significant events.

- The senior nursing officer (SNO) was identified as the lead for significant events. Permanent staff had access to the standardised Defence Medical Services (DMS) wide electronic system used to report, investigate and learn from significant events, incidents and near misses (referred to as ASER). Locum staff did not have access to the system and could complete a paper significant event form, which the practice manager uploaded to the system. The practice manager was looking into locum staff having electronic access to ASER. The practice manager actively encouraged staff to use the system to report events, including quality improvement initiatives.

- Using examples, staff illustrated how significant events were managed through the ASER system. A number of staff told us how significant events had been raised in relation to how NHS services managed referrals. Two examples indicated a risk to the patients concerned. Given the emerging theme, the matter had been placed on the risk register and had been escalated to the Regional Clinical Director. At practice level, a dedicated administrator tracked and monitored all referrals to NHS services.

- The monthly practice meetings provided a forum for discussing significant events. Although the practice manager and staff said informal team meetings took place, the last recorded formal practice meeting was held in October 2017. Significant events was not an agenda item at that meeting; nor were significant events or risk management identified as an item on the practice meeting standing agenda. The practice manager advised us significant events were discussed at the Healthcare Governance meeting, and the most recent of these meetings was held in November 2017. Staff said lessons learnt as result of significant events were shared in the weekly newsletter circulated to staff by Defence Primary Health Care (DPHC).

- One of the pharmacy technicians was the lead for managing national patient safety alerts. They logged and disseminated the alerts to staff. Doctors also received the alerts directly. All staff we spoke with provided examples of alerts they had received.

- When unintended or unexpected safety incidents happened 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

There was scope to improve the embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
• Arrangements for safeguarding required some improvement to ensure they reflected relevant legislation and local requirements. An adult safeguarding policy was not in place for the practice that took account of local arrangements. The SMO was the lead member of staff for child safeguarding and one of the other doctors was the lead for adult safeguarding. Effective deputising arrangements were in place. The SMO and another doctor had completed level 3 training in child safeguarding which was refreshed every three years. The staff we spoke with demonstrated they understood their responsibilities in relation to safeguarding. All staff had completed safeguarding training relevant to their role.

• The practice had systems in place to monitor children who were deemed ‘at risk’ or who could be subject to safeguarding arrangements. There were 150 to 200 children aged 0 to 16 registered with the practice at any one time and young people aged 16 to 17 were also registered.

• Staff provided an example of how a vulnerable patient was supported. It was clear they worked closely with the Department of Community Mental Health (DCMH) team, the welfare team and the unit command to ensure the patient’s safety and wellbeing. Although a register was established for the station to identify patients who were vulnerable, it was not held specifically at the practice. The alert facility within the patient record system; Defence Medical Information Capability Programme (DMICP) was not routinely used to identify the patient was vulnerable when the medical record was opened.

• The SMO attended the station unit health committee (UHC) meetings each month and the welfare needs of vulnerable service personnel were discussed at this forum. A vulnerable patient register was held at unit level but this would not include dependants of military personnel. The doctors met formally with the welfare team every six weeks. We noted from the minutes of the meeting in December 2017 that a health visitor was also in attendance.

• Notices were displayed advising patients that chaperones were available if required. Nurses acted as chaperones and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

• Practice staff were mindful of the security and safety needs of the large reservist population they provided an occupational health service to. Measures were in place when liaising with other health services so that these patients were not identified as reservists.

• The Senior Nursing Officer (SNO) was the lead for infection prevention and control (IPC) and had completed training relevant to the role. An IPC policy was in place. We noted that IPC audits were carried out every six months. The last audit was completed in February 2018 resulting in an overall compliance score of 97%. Actions were identified in relation to the environment and equipment. One of the actions was for staff to complete IPC training relevant to their role and the practice manager confirmed this had been achieved. Appropriate standards of cleanliness and hygiene were in place. The practice manager monitored the cleaning contract and schedules. They were in the process of negotiating the contract to secure cleaning twice a day rather than just the once.

• All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. The practice manager was the lead for waste management and had reviewed and revised the approach to waste management to ensure it was managed and disposed of appropriately.

• Effective arrangements for managing medicines, obtaining, prescribing, recording, handling, storing and the security of medicines. One of the pharmacy technicians was the lead for
medicines management. Standard operating procedures in relation to medicines were up-to-date. Medication was stored securely and appropriately documentation was maintained to ensure the patient received it safely and it was accounted for.

- The cold storage unit for medicines, including vaccines was monitored twice a day (except weekends and public holidays) to ensure temperatures were within the correct parameters. A temperature data logger for continuous monitoring of vaccines and other pharmaceuticals was located in the medical fridge.

- The dispensary at Aldergrove was the main dispensary for other military medical centres in Northern Ireland. Effective processes that could be tracked were in place for dispensing to these medical centres. Vaccines were transported in cooler bags with ice packs. Thermal temperature indicators (temperature dots) were used to ensure the vaccines did not exceed the temperature threshold. Although, staff identified no problems with temperature control during transit, we were advised by a pharmacist at regional level that transportation of medicines in cooler bags and the use of temperature dots were not in accordance with policy.

- Patients on high risk medicines were effectively managed to maximise their safety. Read codes were applied for patients prescribed such medicines along with an alert on their record and a review and/or test date. The nurses monitored attendance for review and followed up any non-attenders. Medicines prescribed through a shared care agreement were also closely monitored.

- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The PGDs were audited to ensure compliance and the three yearly competence checks of PGD users were up-to-date. Nurse prescribing was mainly for patients with asthma and an asthma prescribing audit was undertaken on an annual basis. One of the doctors was identified as the mentor for nurse prescribers and had regular peer review with the nurses to discuss and reflect on prescribing practice.

- Any medication errors were recorded as significant events on the ASER system. We noted a medicine’s error was reported in January 2018. To prevent a similar error occurring again the medicines lead had put a new process in place and this had been communicated to staff (including locums) at a practice meeting.

- A safe but labour intensive system was established for the tracking and monitoring of cytology and haematology samples. Nurses checked the blood results book and LabLinks each morning and followed up on any anomalies. Lablinks was not connected to DMICP for security reasons and this meant the system in place relied on nurses downloading, scanning and manually entering test results onto DMICP. Whilst the practice was doing all it could reasonably do to mitigate the risks associated with this lack of system integration, risks remained due to potential human error and staff absence.

- 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. They also monitored each clinical member of staff’s registration status with their regulatory body. All 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.

Monitoring risks to patients

Risks to patients had been identified.
• The practice manager was the lead for health and safety and had completed relevant experience for the role. The station health and safety department (referred to as SHEF) supported the practice manager in the provision of health and safety for the practice. The practice manager advised us that the SHEF team were responsible for undertaking annual workplace health and safety inspections. Since taking up post in September 2017, the practice manager had been unable to secure evidence to confirm such an inspection had taken place. The full range of workplace risk assessments were not in place and those that were available had not been reviewed since 2016. The practice manager advised us that risk assessments were usually generated and/or revised following a workplace inspection.

• A risk register was established for the practice. An electronic ‘issues log’ was in place and staff could log issues that had the potential to be included on the risk register. We could see that staff regularly used this. The practice manager monitored the ‘issues log’.

• A legionella risk assessment and evidence of routine measures taken (checks of water temperature outlets) to minimise the risk of legionella were not held by the practice as it was the responsibility of the SHEF department. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.

• Electrical and portable appliance testing (PAT) had taken place in accordance with policy. PAT testing was completed in November 2017. An equipment log showed the servicing of equipment was up-to-date. The practice manager was the lead for equipment management. An equipment audit was carried out in November 2017 and received a green rating. The next assurance visit was due April 2018. Snap inspections of user management checks were carried out on a monthly basis.

• The practice manager was aware of their role in the reporting and management of incidents, including when and how to report in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

• Because of the on-site airfield, a fire service was in operation for the station. A fire policy and procedure was in place. A fire risk assessment was completed in 2016 and was due again in 2019. Records showed the fire alarm and firefighting equipment were checked each Friday. The last fire drill took place in September 2017. Staff were up-to-date with fire training.

• A portable screen being used to separate the waiting room and provide privacy for patients using the dispensary meant not all patients in the waiting areas could not be observed by staff. The practice manager said they would risk assess the waiting area and look at alternatives to using the portable screen.

• The practice manager closely monitored the staffing levels alongside the patient population to ensure there were sufficient numbers of staff to meet patient need. This was important given the absence of staff due to deployment and other types of absenteeism. Although the low dependency unit (LDU) was to close permanently in March 2018, it was closed at the time of our inspection due to a shortage of staff for the provision of 24-hour cover. This meant the two health care assistants who worked on the LDU had increased the staff capacity for the practice.

Arrangements to deal with emergencies and major incidents

The arrangements in place to respond to emergencies and major incidents required improvement.

• The staff emergency call system in consultation and treatment rooms had not been in working order for some time. The practice manager had reported this and had added it to the risk
A meeting was due to take place between the practice manager and a representative of the Defence Infrastructure Organisation (DIO) to discuss securing alarms for staff.

- The station fire service was the first responder for an emergency or major incident on the station. An emergency kit, including a defibrillator, oxygen with adult/child masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book was available. Routine checks were in place to ensure the required kit and medicines were available and in-date. Medicines we checked were in date.

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

- The practice had a comprehensive business resilience plan in place for major incidents such as power failure or building damage although it was overdue for 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). The Scottish Intercollegiate Guidelines Network (SIGN) best practice guidelines were also considered depending on the specific needs of the patient. Staff referred to this information to deliver care and treatment that met patients’ needs. They described how updates on NICE, SIGN and medicines management were outlined in the DPHC newsletter circulated to clinical staff each week.

- We asked staff for examples of improvements made as a result of NICE or SIGN guidance. The pharmacy technician highlighted how the measures in place for patients taking high risk medicines, such as methotrexate had been reviewed to ensure they were being managed in line with good practice guidance. Nurses told us about the over-40 cardiovascular screening and how it was in accordance with NICE guidance.

- NICE guidance updates was circulated to staff via email. It was also stored electronically on a shared drive (referred to as MOSS) and all staff had access to this.

- Audit/clinical meetings took place each month. There was no clear agenda for these meetings to indicate NICE/SIGN guidance was a standing agenda item. We did note from the minutes of the meeting held in November 2017 that reference was made to medical literature. For example reference was made to the literature on cervical cancer when discussing injectable contraception use. The practice manager advised us that these meetings were being developed to include a broader clinical governance scope than just audit.

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 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.

An effective system of communication with the units, alerts and diary dates was in place to recall patients for checks and/or follow up. Staff demonstrated how the system operated using the over-40 cardiovascular screening process. The practice provided the following examples of patient
outcomes data to us from their computer system on the day of the inspection.

- There were five 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 three of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For four patients the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

- There were 20 patients recorded as having high blood pressure. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. Eighteen patients had a record for their blood pressure in the past nine months. Of these patients with hypertension, 15 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 four which is 8.6% of the smoking patient population. The NHS target for this indicator is 90%. Staff advised us the data on population manager was not correct.

- There were 31 patients with a diagnosis of asthma. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. All patients had had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

- There were 57 patients with a new diagnosis of depression in last 12 months. All had been reviewed within 10 to 35 days of the date of diagnosis.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that the instance of audiometric hearing assessment was above average compared to practices regionally and nationally. It is noteworthy that audiometric assessment is an occupational requirement and the responsibility of the patient’s regular practice. 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 99.9% regionally and 99% for DPHC nationally.
- 98% of patients’ audiometric assessments were in date (within the last two years) compared to 87% regionally and 86% for DPHC nationally.

An electronic audit diary was in place and all staff could access this. It was due to be updated for 2018. Audit meetings took place and the most recent was held in November 2017. A range of completed clinical audits were available and we discussed these with staff. We also noted that some had been discussed at the last audit meeting. There was evidence of quality improvement as a result of audit. For example, the diabetes audit had led to improved patient compliance with care and treatment. The completed audits included:

- An asthma audit completed in June 2017 and due to be repeated in 12 months.
- A diabetes audit completed in July 2016. Staff acknowledged that the repeat audit was overdue and plans were in place to repeat it.
- Audits of waiting times and non-attendance at physiotherapy appointments (July-September 2017).
• Re-audit of injectable contraception (Depo-Provera).
• Re-audit of Terbinafine prescribing for fungal nail infections.
• Audit of folic acid prescribing in pregnancy/pre-pregnancy (September 2017).
• Medicines management audit (July 2016).

An internal self-assessment quality assurance tool consisting of seven domains, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance. The CAF was formally introduced in September 2009 and since then has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery. When a CAF assessment is undertaken by RHQ it is referred to as a Health Governance Assurance Visit (HGAV). A HGAV visit was undertaken in February 2017. No concerns in relation to clinical care were raised.

The SMO or their representative attended unit health committee (UHC) meetings with commanders, including a specific UHC for the large patient reservist population. UHC meetings provided a forum to review the health and fitness of military personnel.

**Effective staffing**

Evidence reviewed showed that 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 programme 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. Relevant competency checks were undertaken before staff engaged in practice or a procedure that was new to them.
- Records on the day of the inspection showed gaps in staff training. A new system for monitoring training had been introduced and staff advised us that it did not reflect the training they had completed. After the inspection the practice manager contacted us and provided evidence to confirm that all mandated training was up-to-date.
- Staff told us there was a culture of continuous learning and further education was promoted at the practice. They received role-specific training where appropriate, and refresher training. For example, there were doctors trained in aviation medicine, sports medicine and audiology. Staff administering vaccines and taking samples for the cervical screening programme had received specific training, including an assessment of competence if appropriate.
- Nurses and doctors told us they maintained their own continual professional development (CPD). Learning and support needs of staff were identified through appraisal, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months. CPD events were held locally, some involving external speakers for staff to participate with.
- The practice was approved for GP speciality training. It had been accredited by General Practice Education Committee (GPEC) following a GPEC visit in April 2017. A trainee GP was due to start in 2019. The SMO was the supervisor for trainee GPs.

**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. Read coding, a system used to support clinical encoding 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 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.

- Summarisation of patients’ records was undertaken by the nurses and was monitored. Ninety four percent of new patient records had been summarised at the time of the inspection.

- We found the practice engaged with external health providers in an effective and timely way. Reports were usually received from the out-of-hours service (OOH) service within 48 hours of a patient having accessed treatment. These reports were scanned on to DMICP and alerts sent to a doctor to ensure they were reviewed and appropriate follow up instigated if necessary. The reviewing doctor coded problems/conditions as necessary on DMICP.

- Rigorous processes were in place to monitor referrals. Referrals were followed up if there were any concerns in relation to inactivity or delays with patients being seen. This was deemed important as there had been incidents when referrals had been mislaid or closed without the patient being seen. The practice had reported these as significant events and this gap in the wider referral system had been escalated to regional level.

- The system for managing tissue samples sent for analysis was both stringent and time intensive. This was because Lablinks and DMICP did not communicate with each other. The samples log was checked weekly and any outstanding results were followed up. Results received at the practice were logged, dated, stamped and scanned onto the patient’s record. They were then passed to the doctor to review. Despite the practice putting measures in place to mitigate the risk the system was susceptible to error.

**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 2005. They had received training in the Act from a consultant psychiatrist two years ago. Staff accurately described the type of circumstances when the Mental Capacity Act would apply to their patient population.

- Where a patient’s mental capacity to consent to care or treatment was unclear, the doctor or practice nurse assessed the patient’s capacity and, recorded the outcome of the assessment. Consent was recorded and coded for all consultations.

- It was evident from discussion with staff and patient records that patients provided informed consent for treatments such as smears. Written consent was in place for invasive procedures. Staff acknowledged that the subject of consent would benefit from closer monitoring and audit.

**Supporting patients to live healthier lives**

The practice identified patients who may be in need of extra support and signposted them to relevant services.
• All new patients to the practice were subject to a new patient health screen. The practice nurses followed up any areas of concern such as raised blood pressure.

• The practice took a pro-active approach to health promotion particularly in relation to patients at risk of developing a long term condition and those requiring advice on their diet, smoking habits and alcohol use.

• Health promotion information was displayed in the waiting area to promote specific issues relevant to the service population and its requirements. For example, there was a display on the impact of smoking.

• The practice participated in the station health fairs, which were held periodically to promote good health and lifestyle amongst the population and local community.

• Patients had access to appropriate health assessments and checks. Regular searches were 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. Flu vaccinations had been offered to all patients if they met the criteria.

• 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 159 out of 174 eligible women. This represented an achievement of 91.4% The NHS target is 80%.

• Routine searches were undertaken to monitor the status of childhood immunisations. Data we looked at showed immunisation rates for the vaccinations given to under two year olds was 100% and ranged between 100% for two to five year olds. The practice did not have the information to show how this compared regionally and nationally with DPHC figures.

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 September 2017 provides vaccination data for patients using this practice:

• 98.5% of patients were recorded as being up to date with vaccination against diphtheria compared to 96% regionally and 95% for DPHC nationally.

• 98.5% of patients were recorded as being up to date with vaccination against polio compared to 96% regionally and 94.9% for DPHC nationally.

• 84% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 84% regionally and 82% for DPHC nationally.

• 84% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 92% regionally and 92% for DPHC nationally.

• 98% of patients were recorded as being up to date with vaccination against Tetanus, compared to 96% regionally and 95% for DPHC nationally.

• 32% of patients were recorded as being up to date with vaccination against Typhoid, compared to 70% regionally and 54% 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.
Are services caring?

Our findings

Kindness, dignity, respect and compassion

- During our inspection we observed that staff were courteous and helpful to patients, and treated them with dignity and respect.
- Curtains were provided in clinic rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.
- Clinic room doors were closed during consultations. Conversations taking place in clinical rooms could be overheard from the corridor. Staff managed this by the use of a radio and discouraging patients from waiting in the corridor.
- Reception staff said that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could choose whether they wished to see a male or female clinician. A chaperone service was available. Information about this was displayed in areas of the premises accessed by patients. Telephone consultations were available.
- There was an accessible toilet in the building. A room was available for baby changing and/or breastfeeding.
- We had the opportunity to speak with four patients during the inspection and they stated they were very happy with their care. We were provided with the Patient Experience Survey from March 2017 and it indicated that 90% of the 21 patients surveyed said they would recommend the practice to their friends, family and colleagues. The practice manager advised us that the patient survey system was being updated so a more recent patient survey result was not available.
- We received 10 completed comment cards prior to the inspection and spoke with one patient; feedback was very complimentary about the practice. Themes included patients treated with dignity, respect and spoken to in a kind way.

Care planning and involvement in decisions about care and treatment

- Patient feedback via the comment cards and patients we spoke with said that clinicians involved them in decision making about the care and treatment they received. They said their views were considered; they felt listened to and had sufficient time to make an informed decision about the choice of treatment available to them. The patient records we looked at confirmed this.
- A translation service was available to clinicians if required. The practice leaflet could be made
available in alternative languages should the need arise.

**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 services and organisations.
- The practice proactively identified patients who had caring responsibilities for a dependant. They asked patients when they first registered with the practice if they had caring responsibilities. A code could be added to the patient record in order to make them identifiable so that extra support or healthcare could be offered as required.
Are services responsive to people’s needs? (for example, to feedback)

Our findings

Responding to and meeting people’s needs

The practice understood its population profile and had used this understanding to meet the needs of the patients.

- The practice provided a service to the families of military personnel so had good links with local midwifery, health visiting and social care services.
- A large number of the patient population were reservists who were required to be fit for duty at all times. The practice accommodated weekend and evening occupational health clinics as required to meet the needs of the reservist population.
- As well as routine doctor and nurse appointments, clinics that were available to patients included: vaccination; travel health; cholesterol checks; well person; smoking cessation; asthma; family planning and blood pressure monitoring. Affiliated services patients could be referred to included physiotherapy, rehabilitation, podiatry, mental health, community midwifery and health visiting.
- Access to a doctor was good for patients. Patient feedback suggested most patients were seen within 48 hours of requesting an appointment. Patients could have 15 minute appointments with the doctor and nurse. If needed, patients could book a double appointment of 30 minutes. Same day appointments were available for those patients who needed an emergency appointment. Children were always seen on the same day if an urgent appointment was requested.
- Referrals to physiotherapy were made via the doctor. Patients were always seen within the physiotherapist 10-day target.

Access to the service

- The medical centre was open from 08:00 to 16:30 Monday to Thursday and closed for lunch 12:30 to 13:30. It was open on Friday from 08:00 to 13:00. Shoulder cover arrangements were in place until Dalriada Urgent Care was operational from 18:00 on weekdays. This service also provided emergency care on weekends and public holidays.
- We were not provided with Defence Medical Services Patient Experience Survey information that showed the overall patient satisfaction levels with access to care and treatment.

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 for the handled complaints in accordance DPHC’s policy. All clinical complaints were forwarded to the SMO or, in their absence, one of the other doctors.

• We noted that information was available in the waiting area to support patients understand the complaints system. How to make a complaint was summarised in the practice leaflet.

• A log was in place for recording complaints and one complaint had been received since January 2017. Complaints were also logged on the health governance workbook, a ‘one-stop-shop’ framework that brings the strands of governance together. All staff have access to the workbook. Staff we spoke with were aware of this complaint and the outcome.

• Complaints were audited through the Common Assessment Framework (CAF). This was used to focus on improvements to the service and to ensure that designated standards were being met on the handling of complaints.
Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Good

Our findings

Vision and strategy

There had been a change in leadership as the practice manager had taken up post in September 2017. Since then the practice manager had been reviewing and revising governance processes to ensure they were fit for purpose to support the delivery of high quality care and good outcomes for patients.

Staff described a shared vision that was promoted by good leadership, effective communication and an open door policy. The practice was working effectively to the DPHC mission statement of:
“Delivering a unified, safe, efficient and accountable primary health care for entitled personnel to maximise their health and to deliver personnel medically fit for operations”.

Governance arrangements

- Since taking up post the practice manager had introduced the DPHC health governance workbook. We looked at it on the system and noted a comprehensive range of governance activities, including the risk register, significant events, patient safety alerts, Caldicott log, building fault log, quality improvement and audit. Each area had links to DPHC policy and other documents, such as a completed audit. The practice manager routinely monitored the workbook and confirmed that all staff had log in access. For example, staff could enter updates on the status or outcome of an audit and provide a link to the actual audit. The practice manager advised us the workbook was still under development. For instance, they were in the process of revising the risk register.

- The CAF provided an overall assessment of the governance arrangements. The practice manager was in the process of reviewing the CAF domains and was working to a dynamic management action plan (MAP) that clearly identified risk-rated actions. Actions included, developing non-clinical risk assessments, formalising methods of communication, significant event training/reporting, updating safeguarding processes and developing patient feedback mechanisms.

- The practice manager said they had good support from regional headquarters (RHQ). They provided regular reports to RHQ including a biannual assurance report. We noted that the report from January 2018 took account of challenges to the service, significant event reporting, patient experience feedback, the CAF and audit activity.

- Informal methods of communication were working well, including informal meetings. Staff were satisfied with communication arrangements and said they were kept up-to-date with developments and changes. Through our interviews we confirmed staff awareness of current issues, such as the outcome of significant events and alerts received at the practice. The practice manager acknowledged that formal practice meetings were not taking place as regularly as they should and outlined the intended meeting structure to be introduced shortly;
over a four week period the structure included a formal practice meeting, individual training, group training and a health governance meeting.

- Audit meetings were established. These meetings had been reviewed and a plan was in place to broaden the scope so as to take account of wider clinical governance matters.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities. Doctors and nurses had defined lead roles in key areas.
- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly. Staff we spoke with confirmed they were familiar with policies and other protocols and used them in the delivery of high quality care.
- A programme of quality improvement, including clinical and administrative audit, was used to monitor quality and to drive improvements.
- Effective communication arrangements were in place with unit commanders with the SMO attending regular meetings regarding the health and fitness of military personnel. The practice manager was the main link with station for issue connected with the building, equipment and health and safety.

**Leadership and culture**

- On the day of inspection the practice manager demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care.
- There was a clear leadership structure and staff told us they felt supported. They said the practice manager was well organised and a good communicator, and spoke with the staff each morning updating them on any issues. Equally, they valued the support the SMO offered. Staff said both the practice manager and SMO were approachable and took the time to listen to their views.
- Staff told us they welcomed the revised governance structure and organisation that the practice manager had implanted since September last year. They described how the leadership was effective and a no blame culture was promoted.
- Systems were in place to ensure compliance with the requirements of the duty of candour and all staff had a good understanding of the matter. Duty of candour is a set of specific legal requirements that leaders of services must follow when things go wrong with care and treatment. This included ensuring all staff understood to communicate with patients about notifiable safety incidents. We found that the practice had systems to ensure that when things went wrong with care and treatment, patients were given reasonable support, information and a verbal and written apology.

**Seeking and acting on feedback from patients, and staff**

The practice manager advised us that the patient survey system was under review so the most recent patient feedback we were provided with was from March 2017 and just one question was asked of patients, “Would you recommend this medical facility to your colleagues, friends and family?”

- A suggestion box for patients to leave feedback was located in the waiting area.
- Completed CQC comment cards from patients supported our findings that there was an open door policy when it came to patient input and feedback.
• Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

• There was no patient participation group or similar at the practice.

**Continuous improvement**

• There was a focus on continuous learning and improvement at all levels within the practice. From discussions with the SMO and practice manager it was clear the focus was on improving the quality of delivery of care for all patients. This was evident through the improvements being made to governance structures, including clinical governance arrangements.

• Quality improvement initiatives were implemented following the outcome of audits and investigation into significant events. For example, following the folic acid audit clinical staff were made aware of the need to check risk factors when prescribing folic acid pre or during pregnancy. Furthermore, following a significant event changes were made to policy and to the way the appointment schedule was worded to minimise such an event happening again.